

Public Accounts Committee

Oral evidence: Integrated Health and Social Care, HC 959

Monday 27 February 2017

Ordered by the House of Commons to be published on 27 February 2017.

Watch the meeting <http://parliamentlive.tv/Event/Index/acaa9b59-b1ef-43f7-8e56-03fd2b53604f>

Members present: Meg Hillier (Chair); Caroline Flint; Kevin Foster; Nigel Mills; Anne Marie Morris; John Pugh; Karin Smyth; Mrs Anne-Marie Trevelyan.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Ashley McDougall, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-170

Witnesses

I: Chris Wormald, Permanent Secretary, Department of Health, Jo Farrar, Director General, Local Government and Public Services, Department for Communities and Local Government, Simon Stevens, Chief Executive, NHS England, and Sarah Pickup, Deputy Chief Executive, Local Government Association.

Report by the Comptroller and Auditor General Health and social care integration (HC 1011)

Examination of witnesses

Witnesses: Chris Wormald, Jo Farrar, Simon Stevens, and Sarah Pickup.

Q1 Chair: Good afternoon everybody and welcome to the Public Accounts Committee on Monday 27 February 2017. We are here today to discuss progress on integrating health and social care. We are also going to ask some questions at the end of the session about personalisation in social care—personalised budgets—on the back of a Treasury minute that we received in response to our previous Report, Mr Wormald, so you have obviously had notice of that.

I will introduce the witnesses now. We have, from my left to right, Jo Farrar, who is Director General for Local Government and Public Services at the Department for Communities and Local Government, Chris Wormald—a regular visitor to us—who is the Permanent Secretary at the Department of Health, Simon Stevens, who is Chief Executive of NHS England and also a regular visitor, and Sarah Pickup, Deputy Chief Executive of the Local Government Association. Welcome to you, Sarah. Our hashtag today, for anyone following on Twitter, is #integration.

Before we go into the main Report, I just want to talk briefly to you, Mr Wormald and Simon Stevens, about a letter you sent us on Friday 24 February. Just to give a bit of background for those who might not be up to speed with where we are at, in July, when you published the accounts, one of the items of concern was that there was an issue about the Shared Business Services patient correspondence, where letters were found in a backlog and were being checked through. We asked some questions about that in September, which was our first opportunity to talk to you about the accounts, and at that hearing you promised to give us a regular update. The February letter is the second update—you gave us a brief one before that but this one is more detailed. I thank you for the letter but I also raise my concerns that you tell us that the NHS England incident team has now completed distribution of about 2,500 documents, triaged as potential high risk of harm, and that 173 responses have been received so far from GPs indicating cases that require further clinical review. What I really want to know is how far through the process you have got at this point, and whether those 2,500 documents of potential high risk is the high point or you are still expecting more high-risk cases to come through.

Chris Wormald: I will ask Simon to comment as well, because of course NHS England have been the people carrying this out, but that should be



HOUSE OF COMMONS

the high point. NHS England has been working through a rather large number of documents—

Chair: So that should be the high point. So we should bring Mr Stevens in at this point, on the numbers.

Chris Wormald: Yes, and the cases of potential harm should be considerably lower than that 2,500. Those are the ones that—

Q2 **Chair:** So of those 2,500, there are 173 so far.

Chris Wormald: So far. I think, and Simon will correct me if I am wrong, about 1,900 of the 2,500 have already been identified by GPs as not presenting harm. I think we have about 537 live cases, of which 173 already require further explanation.

Q3 **Chair:** And the other 573 you are waiting to—

Chris Wormald: We are either still trying to track down the person—of course, a number of people will have either left the country or not signed up with a GP—or are still waiting for the GP's initial assessment. I think we are clear that the vast majority of the backlog, which is still of course not acceptable—it shouldn't have happened anyway—

Chair: No, not at all acceptable. So, Mr Stevens—

Chris Wormald: The vast majority have been through and we are now down to—

Q4 **Chair:** First on the numbers: do you agree with those numbers, that that is the order of where you are at?

Simon Stevens: Yes, as Chris says, we were notified by SBS in March. There were 708,000 pieces of correspondence, which have been reviewed and processed; 500,000 of those have already been dealt with, and 200,000 or so are temporary residence forms. As Chris says, 2,500 required a further update, and of those, 1,971 have already been confirmed as no harm. So the vast majority—more than 99%—of the backlog that was notified to us has been reviewed and dealt with.

Q5 **Chair:** Mr Wormald, you talked about people leaving the country. Was that temporary residents, not people who have a dangerous health problem and have now left the country and cannot be tracked down?

Chris Wormald: No. I am merely saying there are a number within that 537 where the person has not been located yet. There might be a variety of reasons for that, and almost by definition, we don't know. That is one of the things we still need to be doing—

Q6 **Chair:** But in those cases, the GP responsible at the time for that patient will still look at the record?

Chris Wormald: You have to find the new GP, if there is one. These cases—

Q7 **Chair:** Can I be clear? Not all these people have an NHS number?



HOUSE OF COMMONS

Chris Wormald: Not necessarily, no.

Q8 **Chair:** Because some of them may be temporary visitors.

Chris Wormald: Yes. There might be all sorts of people in that category, but I want to be absolutely clear with the Committee: it is not that we have to track down every single person.

Q9 **Chair:** Do you know what level of seriousness those could be? Could it be someone, for example, who had a blood test that showed a serious matter requiring further investigation and who is out there somewhere in the world not knowing that, having been given the all-clear? Who is able to answer that?

Chris Wormald: I can't answer that question.

Simon Stevens: By definition, the small number of correspondence cases that are left are the ones we particularly want to chase down. They have had a clinical review initially, and now contact is being made with the GP where that is possible to identify. We obviously hope that that's the situation, but as I say, more than 99% of a huge volume of correspondence has been assessed and dealt with.

Q10 **Chair:** Okay. It is a very bad situation; I hope you will agree with that. From March last year to now, we have still not tracked down everybody. There was a backlog to begin with, so it is at least a year for these patients left who don't know that their records have gone missing and have not been sent on to the right part of the NHS.

Chris Wormald: Yes. That is obviously true, but it is an enormous number of records to work your way through. Going through 700,000 paper records, unfortunately, takes quite a while, and it has to be done properly. So that is unfortunately the length of time it has taken.

Q11 **Chair:** We have had some reports that GPs have not all been keen to do it. Is that true? Have there been any specific problems?

Chris Wormald: I don't think I have seen any reports that suggest that.

Q12 **Chair:** I know that GPs are being paid to do it. How much has it cost in total in payments to GPs? Do you know, Mr Stevens?

Simon Stevens: We have included £2.2 million of compensation for the extra time that they have incurred.

Q13 **Chair:** Okay—as you wrote in the letter to us, Mr Wormald. Mr Stevens, it is down to NHS England to discuss with NHS Shared Business Services how you are going to go forward on this and what will happen with that commercial contract. I hope that it is not going to continue or that at the very least, there are serious sanctions because of this major slip-up, or even cock-up.

Simon Stevens: Yes. As I say, we were notified of this last March. We cancelled the contract with SBS on 31 March last year.

Q14 **Chair:** What are you going to do about getting money back from them?



HOUSE OF COMMONS

Simon Stevens: That is a conversation I am having with them, given the compensation we have paid to GPs, but the arrangements from 1 April 2016 changed and there was no longer an intermediary in the transmission of pieces of correspondence between different GP practices. That arrangement has changed.

Q15 **Chair:** Did you get or are you pursuing any compensation from them for this major cock-up in the first place?

Simon Stevens: We are certainly in discussion with SBS. Obviously they are a partnership with the Department of Health, so that is a conversation we are having with them and the Department.

Q16 **Chair:** So Mr Wormald, you are wearing two hats in this.

Chris Wormald: Yes, I am—well, no, not really. Clearly the patient safety angles of this trump any shareholder interest that the Department has. So while I have two hats, one is the predominant hat. Clearly, there has to be the discussion that Simon has talked about, but, until we have finished getting all the records work done, and then come up with the formal cost, because we have not reached the end of that process yet—

Q17 **Chair:** I am not asking just about the costs for GPs. According to your letter, for a GP who has had to look at fewer than 20 documents, there is a fixed payment of £50. For individual GPs we are not talking a lot of money. Even if you add that up, the payment is £2.2 million, which is not insignificant, but surely you are looking at a bigger fine imposed on the contractor for making the mistake in the first place.

Chris Wormald: Sorry; what I am saying is that we will look at all those issues, including compensation. That will have to be discussed and agreed. We want to do that once we have finished the most important bit of this work, which is tracking down individual patients.

Q18 **John Pugh:** If any of this results in a serious claim against the NHS for clinical negligence—say one of the tests did not see the light of day and it ought to have done—is the NHS wholly liable or is the contractor in this case liable? If the NHS is liable, are the sums recoverable from the contractor?

Chris Wormald: I am not sure I can answer that question. It will depend on the individual circumstances of the situation and what role the failure to send on information played in that, so I do not think I can give you a—

Q19 **John Pugh:** What is the likelihood of there being a serious case of clinical negligence arising from this?

Chris Wormald: As we have explained, we are not at the end of the process, but so far we have not found a case in which harm has been done. That is not to say that there is not one out there, but we have not found one yet.

Q20 **Chair:** This is also about contract management. This is a contract that NHS England had with this organisation, of which the Department is a shareholder, so where does the buck stop? Is it with Shared Business



HOUSE OF COMMONS

Services or with NHS England?

Simon Stevens: As I said, this contract has now been cancelled, anyway, and the administrative arrangements that gave rise to this issue have also been changed.

Q21 **Chair:** But it came to light only because they admitted the problem. No one noticed until they admitted it.

Simon Stevens: And also because we had terminated their contract.

Q22 **Chair:** Sorry; it came to light that there was a problem before you terminated their contract?

Simon Stevens: No. We terminated their contract and then it came to light.

Chris Wormald: Again, once we have finished the most important bit of the process, which is to track down the individual cases, there will have to be a lessons-learned exercise where we will have to look at the issues that you have raised. One thing that it is very important to note about NHS England's role is that this was a series of contracts that were novated to NHS England from the previous PCTs that held them originally. So this was not a contract that NHS England signed, but one that it took on.

Q23 **Chair:** It is not a very edifying example of using an outside contractor.

Chris Wormald: No, and I hope we have not given you any impression that anyone is trying to defend or mitigate the situation. It is clearly not a good situation. We think NHS England did a very good job on the issue once it arose—

Q24 **Chair:** Do you have an idea now about how long it will take to track down the last remaining cases?

Chris Wormald: I don't think we have an exact timetable.

Simon Stevens: A matter of several months, I think. Without going over the ground we have covered, of the 708,000 items, we have already dealt with more than 707,000.

Q25 **Chair:** But there are people out there who could have something seriously wrong with them and who do not know because the letter of referral has not got to the right place or the test result has not got back. It could be a very serious point. As Dr Pugh has highlighted, there could be a claim against the Department or NHS England.

Chris Wormald: Yes, that is possible, although the work that we have been doing has been about trying to mitigate that possibility and then deal with it if it does happen.

Q26 **Chair:** You promised at the hearing in September that you would give us regular updates. Can I ask that you update us and also be very open if there is a case or cases of patients who had serious health complications or worse as a result?



HOUSE OF COMMONS

Chris Wormald: Of course.

Q27 **Chair:** Will you be open and share that information with us? It is only right that in this cock-up there is at least now transparency about what has happened.

Chris Wormald: Yes. I know you didn't mean it in this way, but obviously we can't be open about the individuals.

Chair: No, absolutely.

Chris Wormald: But about the generics of how many and all those sorts of thing—

Q28 **Chair:** You can talk in single figures or less-than-10 figures, because it would not be possible to identify someone. We just want to know how many patients have had serious health problems or worse as a result of this, because it is important that the buck stops somewhere and we have that information. We will look forward to hearing more about that when you are next in front of us, or if we could have a letter every couple of months, that would be very helpful.

Chris Wormald: Yes.

Q29 **Chair:** Thank you—or sooner if there is more information more quickly.

Can we move on to health and social care integration? This is an issue that of course we looked at in the Committee a couple of years ago—the Better Care Fund. It's just not working, is it, Mr Wormald?

Chris Wormald: Since I have been at the Department, the question of how you best integrate health and social care—

Q30 **Chair:** No, it's just not working, though, is it? The NAO Report says it is not working. You can agree with that, surely.

Chris Wormald: What I want to say is this. This is an incredibly complex set of issues—

Q31 **Chair:** Mr Wormald, we have limited time today. We could go round the houses on the challenges, but this Report says that the Better Care Fund, in terms of the integration and the saved admissions to A&E that it was supposed to achieve, has not delivered and has actually cost money. Do you agree with me?

Chris Wormald: Not entirely, no.

Q32 **Chair:** Do you agree with the NAO Report?

Chris Wormald: I agree with the NAO Report and I thought it set out very fairly where the Better Care Fund has made progress—it has in some important respects—and where it has not. My answer to the question is that I agree with the rather more nuanced picture that the National Audit Office presented of where things have improved and where they have not. We think—this is shown by the National Audit Office—that local areas report that the Better Care Fund, in the vast majority of cases, is driving



HOUSE OF COMMONS

better joint decision making. It has shown improvement across two of its metrics, as set out in the Report, and not in others, so the answer to your question is that I agree with this assessment.

Q33 **Chair:** We are just puzzling over your comment that the NAO Report was “rather nuanced”. I would say it’s fairly clear and direct, actually, about—

Chris Wormald: I thought it set out very clearly where the fund has made progress and where it still has more to do.

Q34 **Chair:** I could, for the benefit of the record, just remind you that from the total pooled budget of £5.3 billion, you estimated there would be savings in the first year of £511 million, but it did not achieve that, did it?

Chris Wormald: No. As it set out, we agreed this Report. As well as those findings, it also notes the improvements in two areas at national level—

Q35 **Chair:** Perhaps I can turn to Mr Stevens, then. Mr Stevens, were you over-optimistic in setting the targets for savings that were achievable through this?

Simon Stevens: No. We talked about this back in December 2014, and I think we had quite a frank exchange at that point. The Better Care Fund mark 1, which is what I regard this as, was an initiative by the Government to transfer funding from the NHS to social care, in recognition of the great pressures facing social care. Did it achieve its intended aim of increasing the funding available to local authorities for social care in 2015-16? Yes, it did, so in that sense it has been a success.

Q36 **Chair:** That is amazingly nuanced from you, then, Mr Stevens, because it certainly moved money from your budget to Ms Farrar’s budget or the local government budgets, but it did not actually achieve anything in terms of reducing the number of emergency admissions to A&E, did it?

Simon Stevens: I don’t think it was ever likely to, as of some sort of magic between 31 March 2015 and 1 April 2015, and I think that’s what I laid out for you in 2014.

Q37 **Chair:** You also laid it out rather nicely—better care fund maths and real-world maths—in, I think, June of last year. We thought that summed it up quite well. So really, it was all a bit of a fraud, wasn’t it? The money was going to go from your budget to the local government budgets, but was not actually going to achieve anything in terms of reducing costs to the NHS, which was one of the longer-term aims of this.

Simon Stevens: It was supporting social care financing.

Q38 **Chair:** To help to save pounds in the NHS.

Simon Stevens: To help social care funding pressures.

Chair: Okay, that’s very honest. I am going to hand over to Anne Marie Morris.

Simon Stevens: By the way, paragraph 2.4 of the NAO Report sets out the perspective on this. The point of having the opportunity cost in terms



HOUSE OF COMMONS

of the budget transfer expressed as emergency admissions was simply to remind people that if those patients were still showing up as hospital emergencies, there was a cost associated with it, and in that sense, the money needed to follow the patient.

- Q39 **Chair:** Before I pass over to Anne-Marie Morris, Mr Wormald and Mr Stevens, have either of you done an analysis of how much you need to spend on social care to reduce pounds spent in A&E, or in the health service? This is supposed to be mapped.

Simon Stevens: That is a prospective conversation, and I think that is why the Better Care Fund mark 2 is much more promising. The so-called improved Better Care Fund actually is money going into social care—it is not money taken from the NHS for social care—and I think the prospects for that are far better.

- Q40 **Chair:** I should hope it has got better than it was the first time around.

Chris Wormald: The first thing to say is that, of course, the point of funding adult social care is not simply to save money in the NHS; it is to provide adult social care. The question is whether this money is a fraud. No; it is given money to support people in need who require adult social care. That is what the £5.3 billion is spent on.

- Q41 **Chair:** Let's be clear then. Let's call a spade a spade. What we are hearing very clearly today is that the first phase of the Better Care Fund raided the NHS budget to stop a gap in local government—your predecessor cleverly worked that out—but you hope the Better Care Fund 2 will achieve this reduction in emergency admissions.

Chris Wormald: It was completely apparent in all the documents that the Government published around the spending review and elsewhere that there was a transfer here from both local government and the NHS into the Better Care Fund, which is how the £5.3 billion is made up.

- Q42 **Chair:** So no one's budget is safe in Whitehall?

Chris Wormald: The Committee has previously commented on the need to support social care, and this was a programme that did so. In terms of the relationship between the adult social care budget and the NHS budget, this is a not very well researched subject. Everyone observes that there is a relationship. A study by Kent University estimated that basically, for every £1 spent on adult social care, 34p is saved in the health service, but it depends enormously on who exactly you have spent the money.

- Q43 **Chair:** Is that the best analysis you have got to work from at the moment?

Chris Wormald: That is the best overall analysis of adult social care versus the NHS.

- Q44 **Chair:** So you are making these big policy decisions on the basis of one—

Simon Stevens: No. In addition to, as Chris quite rightly said, the Kent Personal Social Services Research Unit study, there is a study from York



HOUSE OF COMMONS

University looking at the impact of the availability of care homes on delayed discharges in the hospital sector. We know that as the availability of publicly funded home care has been constrained at the margin, that means more dependent, frail older people who are likely to be at risk of hospital admission than would have been the case seven or eight years ago, when some of these initial studies were undertaken. Our estimate is that it is probably more like £1 of social care reduction equals something like 50p worth of additional pressure on the NHS, rather than 34p, which was based on the older studies done when we were at a different point in the acuity period.

- Q45 Anne Marie Morris:** I am curious. We say that mark 2 will be better than mark 1, yet as far as I can see, you have not said you will change some of these targets; hopefully you will tell me that. Frankly, the targets were never going to be cheap. I heard what you said, Mr Stevens, about the one for admissions and the one for transfers. How will you improve the Better Care Fund mark 2? What I would like to hear from you is how you are going to measure this. What plan are you going to put in process? If you are going to ditch the admissions and transfers target—it sounds to me as though you have to, because by your admission, Mr Stevens, it was never going to work—where are we going to get any confidence that we are going to have a better version 2, as I think Mr Wormald said?

Simon Stevens: The Better Care Fund mark 2 is new funding that is being layered into social care. It is new to social care, at least; I am sure that Sarah and Jo might want to comment more on the overall social care position. But that is really only a subset of what we are doing on the broader integration agenda. We might want to come on to talk about this. The move towards integrated care, particularly in different parts of the health service, as well as social care, is now in train in 50 different parts of the country and will be ramped up dramatically. We are going to lay this out at the end of March. That is what our integration agenda looks like. The BCF mark 2 is some of the fuel in the tank for the social care funding element of that, but it is not the principal delivery vehicle for bringing about integrated care across England.

- Q46 Anne Marie Morris:** Overall, we've had a complete mismatch between delivery and promise. Over the years, what have we had? We have had the pioneers, then we had the Better Care Fund, the vanguards, the SDPs, success regimes and area, primary and acute reviews. You are trying to get off the hook—if I may say, Mr Stevens—by saying, now we are looking at the Better Care Fund, that it is just part of the bigger plan. Is there a plan? It looks to me as though we have got a lot of initiatives that simply are not joined-up.

Simon Stevens: I can see why that impression might have formed in your mind, but I would like to try to remove it. The vanguard programme, which is now a couple of years in train, is clearly producing results. We have seen a much lower rate of growth in emergency admissions per person in the vanguards than in the non-vanguards.

- Q47 Anne Marie Morris:** I think you're still avoiding the issue. We will come



HOUSE OF COMMONS

to vanguards in more detail; that was merely me explaining to you that what you are trying to do is sidestep this into a conversation about the SDPs and the overall big picture going forward. Actually the vanguards have not been such a great success. There are new models of care where people do not know what they are or what they are going to cost and yet they are supposed to be taking them into account in preparing their STPs. Let us stick with the Better Care Fund, because we will get to that—

Simon Stevens: I disagree with that and hope we will have the chance to explore that further.

Q48 **Anne Marie Morris:** We will. I want to know, so can you please tell me, how you are going to measure the mark 2 Better Care Fund's success? You have already told me that what you have measured it on so far is not going to work. Perhaps I could ask Ms Farrar.

Jo Farrar: Actually, some of the things we have measured the BCF on have worked. We are very much focusing on DTOCs, but looking at the decrease in permanent residential admissions, for example, people are not being referred to full-time care in as many numbers as they were before. We have also seen a really good increase in reablement—allowing people to be helped in their own home. That is what people want—to be helped in their own home.

Q49 **Anne Marie Morris:** If I can stop you there, Ms Farrar, those are all good things but there were two primary targets—one on admissions and one on transfers. I am still waiting for you to tell me what the new targets are going to be—not about the successes of version 1, because we know that that has failed. I want to know how we are going to be sure that version 2 works. What are the measures going to be? As far as I can see, the only one we have got is £1 to 34p and I am not even sure where that came from.

Chair: Or £1 and 50p, if we are being generous—

Chris Wormald: Just to be clear on that, you asked me what the evidence was, so Simon and I gave you the evidence. That was the straight answer to that question.

Jo Farrar: As you know, we are doing an evaluation of the Better Care Fund, which will help us to determine the new measures. Ultimately, it will be for Ministers to decide how we are going to measure the success. I think that as we get the evaluation we will start to see what we could measure to show—

Simon Stevens: I don't think you should regard the Better Care Fund mark 2 as a new initiative overlaid on the others you described. I think you should regard the Better Care Fund mark 2 simply as a way of getting some funding into social care that, together with the other changes you described, will produce the results we want to see. We will talk about those results.

Q50 **Anne Marie Morris:** Indeed. Ms Pickup, let me ask you this, because you clearly have an interest in social care and the investment in it. Do you



HOUSE OF COMMONS

believe that what we have seen so far with part 1 is going to improve with this part 2—as in the new, revamped version or whatever—Better Care Fund? Do you think that is going to help your local authorities, are we going to get better social care and how would you like to see the Government measuring it?

Sarah Pickup: The problem with all of these is that they are initiatives to put little bits of funding on the side of what is a much bigger problem. There is a very significant shortfall in funding for adult social care. Councils' spending power has gone down by 23% over the 2009-10 to 2015-16 period, and social care spending has gone down by 10%. The original Better Care Fund was going to be called the Integration Transformation Fund. It was supposed to support social care. Most of that money was already being spent on social care, so £1.1 billion was the previous NHS transfer intended to support social care that also helps the health service—without conditions about different things that were going to be achieved, but that supports the health service. The new, improved Better Care Fund—the extra money, part of which is coming from the new homes bonus, which is already in council budgets, albeit not all the same councils—is intended to put some additional funding into councils to help with the financial shortfall in the delivery of basic social care.

Council budgets overall are short of £5.8 billion by 2019-20, just in terms of basics of demography and inflation. Some £1.3 billion of that is directly for adult social care even after the new, improved Better Care Fund and assuming everybody puts up their precepts. That leaves aside the fact that the market at the moment is unsustainable. All of those things impact on the health service. However, with the Better Care Fund, the targets around things like delayed transfers were not the original purposes. Those were targets put in place to try to enable that health service to free up the money to put that extra £1.9 billion in that they had to find from their CCG budgets.

If you remember, that money was counted in both settlements. The whole of the Better Care Fund was counted in the local government settlement and the NHS settlement. Of course, therein lies a problem right from the outset.

The underlying problem is the shortfall of funding for adult social care. The Better Care Fund is an attempt to put some more money in. The new Better Care Fund is an attempt to put a bit more in. It will help. Social care would have been cut by more without the NHS transfer funds, definitely, because that was used to prevent cuts.

Q51 **Anne Marie Morris:** What you are really saying is that this is not really much in the way of more money. It is window dressing; it is just moving money from pot A to pot B, so that the social care pot can appear to be bigger. Nobody realistically was going to set any targets because that was not—I think in your words—"the purpose".

Sarah Pickup: The social care pot was bigger. The NHS transfer—that £1.1 billion that was part of the original transfer, pre-BCF—that went into



HOUSE OF COMMONS

council budgets and it absolutely helped councils prevent cuts and, in some cases, to put in new initiatives. But the problem with always thinking that by putting some money in, we will get some improvements and better things, is that we are just plugging a gap in money that has been taken away, while demand is rising.

The population of 65-plus has gone up by 15% in the period we are talking about. Actually, over 40% of adult social care budgets is not spent on older people at all; it is spent on people aged 18 to 64; 35% is spent on people with learning disabilities alone, where the pressures are equally great. There is a huge set of issues here. Although I would not dismiss BCF or improved BCF as unwelcome resource, it is not getting to the nub of the problem.

- Q52 **Anne Marie Morris:** Okay, so what we are really saying is that this is window dressing; this is about moving money. That is why I am not getting much of an answer from Ms Farrar or Mr Wormald, because there aren't any he could reasonably put forward.

Sarah Pickup: I don't think I said it to embarrass him.

Chris Wormald: We don't agree that it is window dressing. I don't think that is what Sarah said. These are real. The BCF is two things: one it is a sum of money. Yes, some of money was put together from existing resources and it is going to be supplemented by new resources in future, but I don't think anyone suggested it was anything other than putting together existing resources. Two, it is a different decision-making process aimed at enhancing the ability of the NHS and local government to take decisions jointly. It is those two things.

I don't think—Sarah can correct me—the Local Government Association or local government dislikes either of those two things. Sarah was putting it in a wider context of local government funding. We know the Government's position on that and I won't rehearse that again. It is important to be clear about what the Better Care Fund actually is. It is that pooled budget and that shared decision-making process, both of which have been widely welcomed in local government.

- Q53 **Anne Marie Morris:** It is certainly true it has been widely welcomed. In the NAO Report, I think it is 90%, when asked, had this improved integration. That is absolutely true, Mr Wormald, but that is a very subjective way of analysing the extent to which there has actually been integration because hard integration happening in practice is not the same thing as somebody ticking a box saying good or satisfactory.

Chris Wormald: I agree with that. There is one other very pertinent fact which is, of course, that CCGs and local government are choosing to put money into the Better Care Fund over and above what is required of them, which I think is very strong evidence that both the NHS and local government see the Better Care Fund as a good way of taking decisions over that money. Nobody made them do that.

- Q54 **Chair:** May I take that even further? My borough of Hackney is a pilot for



HOUSE OF COMMONS

integrating health and social care. It is about to make a decision tonight at cabinet and, it's hoped, on Wednesday at full council, to integrate fully the CCG and the local government budgets entirely. That is absolutely great. That transfers the risk to the new arrangements. Under this system, where does the risk lie when the money is pooled to the Better Care Fund?

Chris Wormald: I have discussed this with at least one member of the Committee before. The accountabilities and the statutory framework around all this have not changed. We have given local government and its NHS partners a range of new options about how you pool money, both under the 2006 Act that allowed this and, more recently, the devolution Bill, which Jo might talk about. But the end accountabilities statutorily, of course, have not been changed, and are set in the relevant Government and NHS legislation.

What I was going to go on to say—

Q55 **Chair:** To summarise, it is a bit muddled where responsibility lies, because you have a twin-headed organisation.

Chris Wormald: All I am saying—and I know the Committee has looked at this in other contexts—is that there are a range of options available to local government and other public services for how you pool money statutorily and how that money is then accounted for and who is accountable.

At one end of the spectrum is the City Deals version and there are other pooled budgets in other bits of legislation. There is not a single clear model that we apply nationally. We see that as a good thing, not a bad thing.

This is where I was going to come on to the second part of the Member's question. Integration is a journey that different parts of the country are progressing on at very different speeds. I could not say there was a single pattern of integration across the country right now and, therefore, we need a range—

Q56 **Chair:** We will come on to sustainability and transformation plans, but let's just take the example of my own borough. It is supposed to be setting an example to the rest of the country. It has taken this bold step with the local health providers and commissioners to pool the budgets but it is part of an STP. How is that going to fit into an STP with many other local authorities that are not doing the same thing? Will they all be required to do the same?

Simon Stevens: I don't think that's any different from, say, Greater Manchester, where you have got 10 local authorities and 12 CCGs. The individual boroughs are pooling at differential pace between the social care and the local NHS, alongside the broader Greater Manchester construct.

In your part of London, it is part of the North-East London NHS, but individual boroughs may have different appetites for the degree of budget pooling. I don't think that is illegitimate while individual councils make



HOUSE OF COMMONS

choices about their social care spending. Because I think we are more likely to get sensible agreements where it is between consenting adults locally rather than something that is just mandated for one side of the table nationally and the other side voluntarily.

- Q57 **Chair:** But you are going to get problems, aren't you? People could be in neighbouring hospital beds from different local authorities and there is a completely different approach, and this just exacerbates that.

Simon Stevens: That is the position right now; it doesn't exacerbate it. That is the position in Homerton versus Newham versus Barking, Havering and Redbridge today.

Jo Farrar: We see that all the time. There are several different models that you can use and different areas are on different journeys and using different models. In Hackney, the model you have described could be really effective. In the authority where I worked in Bath and North-East Somerset Council we had a similar model, but Bath and North-East Somerset is part of a wider STP, which does not preclude it from still having that model and working alongside other authorities, if you are working for the same outcomes.

What we don't want to do is unpick a lot of the governance that is already there that councils have come up with—they are democratically elected bodies and they have made their own decisions with their CCGs and they are working—by being too prescriptive across the piece.

Chris Wormald: On the particular issue you raised, I hope this creates a vehicle for addressing that. We have seen exactly the same. Jo and I did a visit to Brent a couple of weeks ago who had exactly the same issue. What they were working on was whether you could agree across all the local authorities that use that hospital a single assessment framework, and whether they could do assessments for each other, so they did not have to have 18 different systems running in the same hospital.

As Simon says, you are never going to mandate from Whitehall or the NHS the answers to all those individual problems. What we have to do, and I hope we are doing via the things we have been discussing today, is create a framework where people can address those problems locally.

- Q58 **Chair:** All I would observe is that, when money is tight, it is going to be very difficult for people to let go of some assessments and so on.

Simon Stevens: There are some things we must mandate, in my opinion. If extra social care funding comes on stream at any point, tying that towards the system that Chris just described of a trusted assessor, ensuring that at least some of that funding is geared towards the social care that older people stuck in hospital need in order to go home, that would seem to be legitimate. The question as to what budget a council puts to its social care services is obviously tied up with the bigger national debate about local authority financing and local democracy.

Sir Amyas Morse: Just quickly on that, the other area of integration it

directly relates to within health and social care is where primary care services are working together. Would you be looking to see demonstrable combination between primary healthcare and social care to keep people out of the hospital system in the first place?

Simon Stevens: Yes. There is integration on the budgetary side. Frankly, unless we are going to have floor levels of social care spending mandated and funded in every council, it's pretty hard to see how you can require a pooling of budgets. It needs to be a voluntary local agreement, where people can look into the whites of each other's eyes and make sure they are mutually contributing to the shared fighting fund. In terms of care co-ordination, care delivery, and what GPs, social workers and community nurses are doing, absolutely. Integration is happening and producing those benefits in places like Plymouth and in a number of the vanguards, which we will come on to talk about.

Chris Wormald: Again, Jo and I saw exactly what you are describing in the visit. They were very clear with us that the biggest thing was having the right professional dialogue between the individuals concerned, and then making the structures and funding add up to what they agreed. It was that way round.

Q59 Karin Smyth: I am totally intrigued by this conversation. Why on earth are we putting more money into integration when there is no evidence to suggest that it works? Page 24, paragraph 1.12 lists the small-scale schemes that we have got, and it ends by saying that a 2014 review by the Department found no evidence that it sustainably reduces hospital use or improves health outcomes. We have got a submission from the University of Birmingham, which says that it is widely acknowledged that there are major gaps in the evidence case for health and social care integration, and that, where it is achieved, it is usually because people look into the whites of each other's eyes locally. As you said, Mr Wormald, we are putting yet more money into a bigger integration pot. I am intrigued about why we think that is a good thing to keep doing.

Simon Stevens: That goes back to Sarah Pickup's point, which is that we are conflating integration with social care funding and availability.

Q60 Karin Smyth: I think it would be helpful to be clear on exactly which bit we are talking about.

Simon Stevens: I think you need both/and. You need a properly resourced social care system, and you need proper joint working at all the hand-off points and for key client groups that are doing health and social care. Just doing one is not a substitute for the other.

Chris Wormald: Look at the things that people do when they are on that integration journey. The National Audit Office correctly observes that the evidence base around this worldwide is not great. That is just a fact. That is one of the reasons why we are doing the evaluations that Jo was describing earlier. I don't think anyone seriously doubts that having one identification number for the same patient when they are shared across local government and the NHS is better than having two. I don't think



HOUSE OF COMMONS

anyone seriously doubts that having one assessor rather than several is a better thing.

Q61 **Chair:** Those are all big things to change. It is a huge issue to get the identification.

Chris Wormald: Yes, they are all difficult and complicated. On the case for integration at that level, are there practical things that people can do that clearly make things better? Yes, there are. Is it well researched and evidenced? As the NAO observed, no, it isn't.

Q62 **Chair:** It's fine to say it, but it's a huge policy initiative to say that we have got one number tracking through, which also includes entitlement and all sorts of things. Mr Wormald, we are here to discuss what has happened so far. Are you saying that this is something that the Department of Health is going to pursue?

Chris Wormald: It is one of the things that the Better Care Fund is driving. More and more areas are using the NHS number as their primary identification. That is one of the things we see areas doing. There is a whole series of things like that, which we have all known for quite some time.

Q63 **Chair:** So the NHS number is just a tracking number. Just to be clear, it's not an entitlement number.

Chris Wormald: Yes, this is just about having one number, rather than two.

Jo Farrar: The point is, though, that this is early days and we are still gathering evidence. We are not saying that integration isn't a good thing. Integration is a good thing. Older people want to have one point of contact, and to do that they need one assessment number.

Q64 **Chair:** To be clear, we're not in any doubt, whatever people's political views around the table, that there is a lot of sense for the patient to integration. What we're here to challenge is, when money has gone into a box ostensibly in the name of integration—in fact, we know it has gone to plug a hole in the budget—whether it has actually achieved some of the outcomes that were intended. That is the bit that we are concerned about.

Sarah Pickup: There hasn't been new money for integration, and there is no proposal to put new money into integration. It is about using the same money differently. There is evidence—

Chair: Sarah, you gave us a lesson in the maths of it earlier, which is also laid out in the Report, and that was very clear. I am going to move on to Anne-Marie Trevelyan, because we need to keep cracking on.

Q65 **Mrs Trevelyan:** As you all know, I speak with a Northumberland hat on, which is what good can look like. Let me help you: 36% of our population is over 65, as opposed to an average of 29%. We have potentially a lot more challenges in terms of access, but in the last year, our admissions



HOUSE OF COMMONS

into A&E have gone down by 11%, which I understood was one of the aims of the Better Care Fund transfer of funds—to encourage the NHS to find savings—though you are now telling us it was not. One way was to reduce admissions. The other was to reduce delays in transfers of care.

We have had 15 or 20 years of following our own path, trying to get that to work in terms of the integration we already do. Within the Better Care Fund, although you are generally saying that wasn't the point, is that working across the board? The NAO Report indicates that it is going the wrong way.

Chris Wormald: As the NAO Report makes clear, there are a lot of factors affecting A&E admissions—DTOCs and all that—that go way beyond the Better Care Fund. What you have just described is exactly what I meant earlier about places being at different points on the journey. There are parts of the country which have a very long history of doing this well and have been able to use the approaches in the Better Care Fund and a lot of other things to go further, and they have had some very good results. There are other areas of the country that do not have that history and that are further back—"Can we have one number? Can we have a single assessment?" All of them, as I said, are going up under the Better Care Fund. So, yes, our objective—

- Q66 **Mrs Trevelyan:** Funding it by taking money out of the NHS is not helping. You have taken it out and left it out, and the hospitals are not able to improve those targets. We have some more money in the social care arena, which would have been much worse if we had not, but the impact of that iterative process is not working.

Chris Wormald: As I said before, the purpose of adult social care is to provide help to adults. More money going in, as I think Sarah said, has helped. Has it had the impact across the NHS that it has had in the area you described, which is much further advanced than a lot of others? No, it hasn't, but has it helped? Yes, it has.

Jo Farrar: You are absolutely right that Northumberland is a really good example of where it is working. What we are trying to do is spread that best practice across the country. We are starting to see more and more areas improve. We saw virtually no DTOCs due to social care in Bedford, Newcastle and other areas in December, and that is really good progress. I think what we need to do now is make sure that we are helping those who are progressing as well. The NHS and the LGA area teams are helping us to spread that best practices.

- Q67 **Chair:** You keep using the phrase "DTOCs". Can you explain what that means?

Jo Farrar: Sorry—delayed transfers of care. I have only been back in the civil service for six months. We need to spread that best practice, but we are starting to see improvements in more and more areas of the country as a result of integration. That figure that you gave earlier about 90% of areas seeing it lead to better joint working and integration is important.



HOUSE OF COMMONS

We are all on a journey, and we started to see that everyone is on that journey, and eventually we will get to—

- Q68 **Chair:** You keep talking about this journey. It sounds like someone's life story. Is it fair to say that even if we agree that there is some improvement in joint working practice and processes, the Report shows that it is not actually keeping people out of hospitals, which was one of the points of it?

Simon Stevens: None of us is claiming that the BCF was going to do what you are claiming somebody else claims it was going to. In fact, if you look back at the discussion we had in December 2014, most of us were pretty clear about what it was likely to do and what it wasn't. NHS England's assessment of the BCF plans as of 1 December, when we were before you, was that it would produce a grand total of £55 million worth of cashable savings, so I do not think that there is any disagreement about what was added.

If I may make a related point, there was no reason for thinking that in the real world, simply moving money from one pocket to another would by itself produce magic.

Chair: Exactly. You say it very clearly.

Simon Stevens: What it did do, however, as it turns out, is ensure that the rate of growth in emergency admissions in the year 2015-16, when the extra cash flowed into social care was lower than the rate of growth in the prior year, and indeed the subsequent year.

- Q69 **Mrs Trevelyan:** So that could be counted a success. You could suggest that it is working, but you're not claiming that.

Simon Stevens: It could indeed be. I think it is working in the sense that it has provided some funding for social care that otherwise would have been—

- Q70 **Chair:** It is reducing the growth in admissions. Ashley McDougall from the NAO, perhaps you could just make sure we are clear on the numbers on this one.

Ashley McDougall: The targets that people had committed to through the original plans said that they would reduce the levels of activity in A&E by just over 3%. It was not reducing the level of growth; it was moving the admissions downwards. That was what they were planning.

On the time limit that Mr Stevens talked about, the 55 million was about April 2014. But as the Report says in paragraph 2.7, they were looking by February 2015 to save £511 million by the things they would do through the scheme. They said that they were going to reduce activity and that they would save money.

Chair: And it was by 3.5%.

Simon Stevens: That is BCF maths again.



HOUSE OF COMMONS

Chair: Well, give us another lesson in BCF maths then.

Simon Stevens: The reality is that people realised there was an opportunity cost to cutting hospital budgets for emergency admissions and instead moving it to social care. All of this stuff around exemplifying emergency targets was simply a way of making explicit what that opportunity cost was, on the grounds that the same pound cannot be spend twice. It either produces that kind of offset or some it has to be spent back in hospitals. That is why a performance element was linked to the fund, to produce the funds flow based on what actually happened in the real world.

Q71 **Chair:** As you said, there is Better Care Fund maths, but that gives the 3.5% reduction in admissions. Sir Amyas, could you pithily summarise the concerns we all share?

Sir Amyas Morse: If I understood your remarks, Mr Stevens, you were saying that this was just an illustrative thing. Even though these were described as targets, they were not really targets; they were just illustrative numbers, to give some sort of coherence to what was being said. Is that more or less what you were saying?

Simon Stevens: What I was saying is what you have at paragraph 2.4 in your Report: "the Fund required clinical commissioning groups to pull funding out of budgets used to fund hospital emergency admissions and put the funding into the budget pooled with a local authority...as a result, the scheme would only be viable if the pooled funds could still be used to pay for emergency admissions if they did not abate in-year. This was because...the same pound could not be spent twice in one year—on social care and on hospital emergency admissions. This was the background to setting the targets for reductions in emergency admissions."

Ashley McDougall: But they had to spend the same pound twice because the money had gone to the pooled fund and the CCGs retained the responsibility to pay for the emergency admissions, so they had to pay that.

Simon Stevens: Which is clearly why the BCF was not designed by any of us sitting here.

Chair: Ah, so that was then; this is now. It's all going to be fine in the future, is it? We are looking at the future of the BCF. I will let Anne-Marie Trevelyan bring this section to an end.

Q72 **Mrs Trevelyan:** I will control my amusement at the way this is going. On the website, the Better Care Fund is described as being created "to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life."

Ms Farrar, one of the questions that has been brought to me—we have seen it starkly in Northumberland, and you mentioned it earlier—is the



HOUSE OF COMMONS

reduction in residential care housing. Northumberland County Council has chosen to go against that, partly because of financial constraints, but with the argument that it is better for patients to be in their own home with community nursing care than to go into a residential care home.

For many of my constituents who are very elderly, that would not have been their choice. Putting them at the centre of the experience did not happen. They have been sent back to their homes, to live on their own, and someone comes in three times a day—lovely, lovely people, working on incredibly difficult territorial bases. Is that doing what it says, and is it cost-effective or value for money to go for that home option rather than residential care? Do you have the evidence to prove that? Too often it does not seem to be working for the elderly in particular.

Jo Farrar: When we talk to older people, what most of them want is to be independent for as long as possible. I think we will all want that as we get older. You are absolutely right; there is a need for specialist residential care for people who need it. For the majority of people, it is much better to help them in their own homes. Some of the services we see, such as reablement, which is more than people popping in three times a day, but they're really helping people to live independently and helping couples to stay together—maybe if one of them has dementia—are really important to older people, rather than thinking that the solution is necessarily residential care.

Q73 **Mrs Trevelyan:** We are obviously not talking to the same elderly couples and individuals, because a lot of mine would rather have a residential care option, with flexibility perhaps—frameworks that allow support. I just do not see where the evidence is that is saying that.

Jo Farrar: You are right. We need a mix of provision and that is what we are trying to get to, some of it for people in their own home, some of it in facilities such as Extra Care, where people still have their own front door, and some of it in a residential care home, where people might have more specialist needs. It takes a long time to change the system and some people are obviously used to one system and feel that that is the system they know. We are seeing more people who are younger starting to become older and to have more dependent needs, and they want to stay independent in their own home for as long as possible.

Sarah Pickup: When older people are in hospital and they have had an operation or treatment for a particular illness, they look very frail and unable to manage at home. There is evidence that people get placed in a care home because it seems as if they would not manage. Particularly people with dementia, out of their own environment, get placed in a care home when they could go home. You can go back and assess that, and the work we have done on reviewing case files and decisions, referred to in paragraph 1.11 of the Report, shows that a bit later you find out that people have been moved into a care home and have sold their home or moved out of rented accommodation and it turns out that they could have gone home if they had been given more time to recover.



HOUSE OF COMMONS

Of course there is a need for a balance of care, and if your need is great enough and your choice is to go into a care home, that should be a choice that is open to you. It should not be a dogmatic decision, but we should not be putting people in care homes if their needs can be met at home. Provision of a care home is not something that is needed for their cases.

- Q74 Mrs Trevelyan:** Are we assessing the holistic cost? If you are getting readmissions by those who are getting home care but are alone and are been readmitted because they have more problems, is there evidence to show that that is still the best value for money as well as the best patient-centred option?

Sarah Pickup: One of the other successful measures is the one about people who are still at home 91 days after reablement. Rather than just getting sent home with nothing, if you get reablement—if you get sent home with some support that helps you to manage if you have a changed physical condition or are more frail than you were, or if you have a dementia adviser who helps you to reorganise your home—if you get the right support and the reablement support, the evidence shows that going home is a good thing for as long as possible. That is particularly so for people with dementia—if you change their environment they can deteriorate—but it is not for everyone. So it is about a range of choices.

- Q75 Mrs Trevelyan:** So is that value for money or is it patient-centred? Honestly?

Sarah Pickup: It can be both. Reablement is a really great service because it delivers good value for money and gets people back on their feet and delivers a better outcome. There are quite a number of services like that, where you get better value and a better outcome if you can put the right resource in at the right time. One of the problems is that we do not always have enough of the right resource: the community-based resource in health as well as the community-based resource in social care.

- Q76 Mrs Trevelyan:** Do you have a view about the community bed resource—if you like, the halfway house back home—perhaps for those who are frail or for very elderly couples where the partner is not going to be able to be the full-time carer? Should we be using those community hospital beds more? Is there an assessment from the Department—from the NHS as well as from you guys—about the real value of that, of getting people out of the acute care environment, when putting them straight back home is not the ideal solution?

Sarah Pickup: That is where intermediate care comes in as well as reablement; there is a fine line between the two. It is all about getting people back to being as independent as they can be. The recent independent audit of intermediate care suggested that we were 50% short of the capacity we needed in order to really effectively deliver those sorts of transitional services to help people manage back at home. But intermediate care can also be delivered in people's own homes. Community hospitals can do it. Care homes can do it. Care homes are sometimes better placed to do it because they have different sorts of facilities from a hospital. It depends on the community hospital, because



HOUSE OF COMMONS

you have to have not just a bed and some staff, but therapies and facilities that allow you to relearn your everyday living skills.

Q77 Mrs Trevelyan: You say that we are 50% short. Is that a workforce challenge?

Sarah Pickup: That is a recent national audit of intermediate care.

Mrs Trevelyan: Is it a workforce challenge, though, that we are 50% short?

Sarah Pickup: It is a workforce challenge. It is a funding challenge. It is a “where do you put the money?” challenge. It links back to community-based versus hospital-based services, but overall it is shortfall of resources.

Jo Farrar: Some are using funding for increasing areas to put social workers in hospital with the hospital team so that they can work with older people to work out their options once they leave hospital and to help them have the confidence maybe to go back home or to do things a bit differently. That is some of the real benefit of this pooled funding.

Q78 John Pugh: May I throw you a bit of a friendly lifebelt? I am not suggesting in any way that you are drowning at the moment, but the subject of integration interests me, and the difficulties that you might have in delivering that with regard to both the Better Care Fund and the sustainability and transformation plans.

I am sorry about the preamble to this, but in section 20 of the Report on page 10, the NAO talks about “barriers to integration” and “misaligned financial incentives”, which arise “in part from the creation of payment systems in the NHS that promote competition and drive activity in hospitals.” The NAO amplifies that in paragraph 3.23, where it specifically mentions the national tariff and points out: “This mechanism works against local systems trying to reduce hospital activity through integration...NHS England’s accounting officer announced that he was open to health economies dropping the national tariff in favour of alternative funding systems.” The NAO says that the NHS is working on that, but concludes: “It is not clear how these would work in practice alongside existing regulation on choice and competition within the NHS.”

You are struggling to produce this desirable thing, integration, which we all mentioned several times, but the legislation is not too helpful. In my area, the providers regard it as very clunky and difficult. The governance arrangements are poor. Does something therefore need to change? Does there need to be better legislation, better governance or recalibration of the financial incentives in the NHS?

Chris Wormald: All those things clearly have impact. I think I debated it with Ms Smyth last time I was here—the different legislative frameworks under which the NHS and local government operate. Successive Governments since at least 1972 have been pursuing integration under a whole range of different legislative frameworks for the NHS, so I think it is difficult to say that a particular piece of legislation is what is getting in the



HOUSE OF COMMONS

way. Also, as Ms Trevelyan pointed out, there are areas of the country that, even given all those challenges, have made considerably more progress than others. It certainly does not eliminate it but, as I said last time I was here, there is clearly a big challenge from the fact both that the NHS and local government operate under very different legal frameworks and that the financial basis of adult social care and of the NHS is completely different—one being means-tested and the other being free at the point of delivery.

Personally, I think the biggest challenge is demonstrated by figure 4 in the National Audit Office Report, when you actually look at what it is that you need to co-ordinate in order to get integrated care for an individual. This diagram is particularly striking, particularly because it is not that these are large numbers of people co-ordinating things when you might think that there could be one person. If you look at the boxes, we are actually talking about a whole series of different professional skills, which only exist in individual people. The challenge that most areas find—this goes back to the conversation I was describing that Jo and I had in Brent—is getting the right types of conversation between all those professionals. The things you pointed to do not necessarily help, but I think that is the nub—

Q79 John Pugh: I want Simon Stevens's views. Do you hanker for the days of the strategic health authority?

Simon Stevens: I do not think that is what we are evolving towards. What we are going to be doing at the end of March is setting out quite clearly the NHS delivery plan for the next couple of years. That will be very explicit about what the integration will look like in each of the 44 STPs and about the move towards accountable care systems in key parts of the country. That is in part about the health and social care interface, but it is not just that; it is also about join-up of physical and mental health services, primary care and hospital services. We will be doing that within the current statutory framework—

Q80 John Pugh: Which you are happy with?

Simon Stevens: Over time, Governments have choices about the statutory frameworks involved—

Q81 John Pugh: Frankly, only Mr Mills voted for the Health and Social Care Bill, which I regard as the greatest piece of legislative vandalism we have seen.

Simon Stevens: We are not planning the next couple of years on the assumption that there will be a new omnibus piece of health legislation.

Chris Wormald: On my point that people pursued integration under previous statutory frameworks before the 2012 Act and not that much progress has been made, I think pinning one's hopes on legislation as opposed to changed professional practice is—

Q82 Chair: Can we move on to sustainability and transformation planning? In a way, all this is the warm-up.



Simon Stevens: Can I just make one factual international comparative point, to Dr Pugh's question? When you ask people in this country and other industrialised countries, "Have you experienced a problem with the co-ordination of your care?", as the Commonwealth Fund—of which I have to declare I am a trustee—does from time to time, it turns out that actually only 19% of the people who are asked in the UK have experienced a care co-ordination problem, compared with a third in Canada, Switzerland, France and Norway, and more in the US. Although we can do better, by international standards we are actually a pretty integrated and co-ordinated system. We want to be the best we can be under our own circumstances.

- Q83 **Chair:** One of the problems—it is the elephant in the room—is that healthcare is of course free at the point of delivery but social care is not. We might come on to that, but I am aware of time. We all have lots of issues we would like to discuss in this hearing, but we are trying to focus on the point in question.

On sustainability and transformation planning, let us go back and remind ourselves what we have covered in the last half an hour or so. The second bullet point in paragraph 2.7 on page 28 states: "Some 75% of local areas did not reduce delayed transfers of care as much as planned." Although you have talked about Better Care Fund maths and different approaches, Mr Stevens, these are the targets that they did not meet. The last bullet point in paragraph 2.7 states: "Some 73% of local areas did not reduce emergency admissions as much as planned." They set out plans to do it. What confidence should the performance on Better Care Fund mark 1 give us that the sustainability and transformation plans will really deliver on targets and on integration?

Simon Stevens: If the question is specifically about moderating the rate of growth in emergency admissions and emergency bed days in hospital, there is some encouraging news from the vanguards. What we are seeing with the three types of vanguard, based on the first 18 months or so of their existence, is that the GP-based vanguards have seen their emergency admissions go up a third slower per person than the rest of the country. The fully integrated hospital vanguards have seen their emergency admissions go up by about half the rate of the rest of the country. The vanguards that have been working in care homes have seen a marked difference as well—there has been a marked difference in the growth in emergency admissions between care homes that are part of the vanguard programme and those that are not. What we have to do is accelerate the roll-out of these kinds of approaches, and we have to use the STPs as a vehicle to do that.

- Q84 **Chair:** You are evaluating the STPs now, and you say you have your plan coming out this month, but it will take months to fully evaluate the 44 STPs to assess whether they have set the right targets, whether they will work and whether they will follow this best practice, won't it?

Simon Stevens: As we have spoken about previously, we are going to set out at the end of March which parts of the country are going to move first



HOUSE OF COMMONS

and fast on that, but the whole country obviously has to make the next two years and beyond work within the budgetary envelope that the NHS has. Since the STP proposals were originally drafted, there has been a chance to kick the tyres on those and refine them in the light of the contracting round between different parts of the health service going into next year. That is the basis on which we will set a clear operating plan for the NHS for the next year.

Q85 Chair: And also look at their budgets. If we go back, £1.8 billion of the £2.1 billion set aside will actually just be paying off deficits, won't it?

Simon Stevens: We are envisaging that £1.8 billion will continue to be available to trusts next year and the year after, in the way that it was this year.

Q86 Chair: So basically, the CCGs will be bailing out the trusts.

Simon Stevens: You can use whatever words you want.

Q87 Chair: A flat 1% set aside as a contingency to bail out the trusts seems to me to be raiding; in the phrase you used before, it is robbing Paul to pay Paul.

Simon Stevens: That was in respect of capital to revenue transfers.

Q88 Chair: I think you get my point; it is much the same thing. That makes us worry that STPs could just be a vehicle for masking the fact; and that they could be used as another vehicle for tackling the money issue rather than actually getting on with proper transformation. We are going to move on. I don't want to steal other people's thunder, but don't you think that is a real concern, given that the savings we are supposed to be looking at and getting out of this process have not been achieved so far?

Simon Stevens: Savings have been achieved. The NHS will have delivered in the region of about £3 billion-worth of efficiencies during the course of the current financial year. As you know, hospitals are on track to cut their deficits by in the zone of two thirds.

Q89 Chair: What we have got in front of us is a Report on the Better Care Fund, so that is real proof of what has worked and what has not, and it did not make the savings, did it—the Better Care Fund? That is what the NAO has concluded. Going back on that, if you then extrapolate forward to the STPs, if it did not work then, how can we be sure that it is going to work in future?

You talked earlier and all of you were very dismissive, frankly, about targets on the lines of "We did not set up the Better Care Fund. It was definitely just money from one place to fill a hole in the budget." That was very honest but it was actually set up with very specific targets and I just listed some of those when I read out those bullet points. Those targets did not get met and nor did the funding side.

Simon Stevens: We have exhausted that. You have a sense of our point of view on that. The indicators in the Better Care Fund mark 1 were there to correspond to the net budget transfer that was coming out of the NHS

cost to social care. That is not what we are doing now going forward with the STPs or the Better Care Fund mark 2.

Q90 **Chair:** So you are confident that the STPs will deliver and be on budget?

Simon Stevens: That is taking us to the next stage of the conversation. Let's not sugar-coat it; these are a very difficult set of circumstances for different parts of the country to have to resolve. The STP process is simply saying that the best way of resolving a shared and unified plan of action is to ensure that there is no bickering locally as to what that should be. Instead people should unite around a plan to make the best of the funding envelope that they have got. That is what we are supporting them to do. There are certain changes that we have got to make to help them get that right, and we are going to be setting those out at the end of March as well.

Q91 **Anne Marie Morris:** Mr Stevens, could you explain to me exactly how the STPs are going to work? There are the vanguard success regime, area primary and acute reviews and we still have the pilot areas, and of course the Better Care Fund is going in for version two. At the moment, I do not see a plan; I just see chaos. Please can you tell me how the STP is suddenly going to revolutionise all this, pull it all together and bring us the integration you have talked about?

Simon Stevens: I don't think any of us are claiming the latter, but if you take the success regime, they have become the STPs for their area.

Q92 **Anne Marie Morris:** In my area they are still running along separately, although the STP overrides the other. There is certainly a sense of confusion, shall I put it, in the minds of many of those running the STPs. We spoke to some of them before our previous session with you, which looked specifically at the STPs and the STP leads were distinctly confused.

Let me ask you this. Given that they do work together—these pieces—and the vanguard is, if you like, the vehicle for these new models of care and given what you have told us with regard to where we have got to, which sounds wonderful, how are we going to get those models of care, one, approved by you, two, costed, three, understood by the STP leads and then delivered by 2020? Are we smoking dope?

Simon Stevens: It would be unparliamentary of me to respond and give an assessment of whether you are or not. I don't know. I don't believe so, no.

Chair: I have rarely seen Simon Stevens lost for words, Anne Marie.

Simon Stevens: We're not looking for dope; we are looking for hope.

Q93 **Anne Marie Morris:** Can you then explain to me how it is going to happen? You are not on dope—great. What are you going to do? I can see lots of flexibility—it sounds wonderful. You say we want to mandate things. All I see is chaos. Please tell me this: how, by 2020, are we going to have something that works, where we can see that from the patient perspective?



Simon Stevens: We are going to set out a lot of detail on this in about four weeks' time, but I will give you some clues ahead of then, in anticipation of the enthusiasm with which you are pursuing the topic. We are going to formally appoint leads to the 44 STPs. We are going to give them a range of governance rights over the organisations that are within their geographical areas, including the ability to marshal the forces of the CCGs and the local NHS England staff. We will get probably between six and 10 of them going as accountable care organisations or systems, which will for the first time since 1990 effectively end the purchaser-provider split, bringing about integrated funding and delivery for a given geographical population. This is pretty big stuff, and people are pretty enthusiastic about it.

- Q94 **Anne Marie Morris:** Wow. If you deliver that, it will be quite something. But for that we need leadership. From all that you said, which is a great story, I still cannot see the leadership and the plan to actually deliver it.

Simon Stevens: We will show you where we think that leadership exists. In fact, I don't know whether this Committee does field visits, but if you do, I think it would be really instructive for you to come to some parts of the country and talk to frontline staff—including some of the leaders, for Anne Marie Morris—so that you can form your own judgment.

Chair: Perhaps we will take that conversation offline. Karin Smyth, do you want to come in?

- Q95 **Karin Smyth:** I'm currently back in 1990. What is the priority for you? Is it the rolling out of the STPs and the vanguards, integration or looking at the deficits? What are you telling the leaders of these organisations?

Simon Stevens: If we take as given the funding envelope available to the national health service for the next several years—which clearly is a very demanding set of circumstances that we have discussed previously—to succeed, there are three sets of things we've got to do. First, we've got to focus quite relentlessly on a smaller group of priorities and demonstrate that the NHS can bring about improvement on those areas. Cancer, mental health and the strengthening of primary care would be among those areas.

Secondly, we've got to streamline the governance and support local implementation of some of these new care models, including changes to the way the urgent and emergency care system responds, to help offset the pressures we have seen showing up in the system this winter. Thirdly, there is a set of big-ticket nationally co-ordinated efficiency programmes that we have to put more muscle into, to create some of the headroom to allow those first two things to occur. That is what the delivery plan will set out.

- Q96 **Karin Smyth:** And that would be charged to the newly appointed leaders of those 44 areas. That will be their very clear priority target.

Simon Stevens: Yes.

- Q97 **Karin Smyth:** If I was working in local government, what would I be



HOUSE OF COMMONS

thinking about that? How is local government being involved in that process?

Simon Stevens: We have had some of this conversation before. In many parts of the country, local authorities are actively involved in shaping the agenda that is being set by the local STPs—not in every part of the country; there are tensions in some places.

Q98 **Karin Smyth:** Will that continue to be the case post March? Where they are working together and involved at that level, they will continue to be so; there will be no particular change?

Simon Stevens: There is no compulsion that the national health service can or should bring to the stance that individual local authorities choose to take, but for the most part people are making efforts in good faith to take a view as to what would benefit their residents and mobilising behind it.

Q99 **Karin Smyth:** To go back to our earlier conversation about the Better Care Fund, which we are putting more money into mark 2, if we are putting more money into integration in that area, people working in those areas will be focusing particularly on that, so you might have different parts of the country developing quite different systems and priorities.

Jo Farrar: We are starting to see more and more come together.

Q100 **Karin Smyth:** I am not suggesting it is a problem; it might be the right thing to do. I think it is probably a natural consequence of the direction of both of these policies.

Jo Farrar: That is why we have always said that these should be locally driven initiatives, particularly the Better Care fund, to see how they fit into the wider picture. Where we are seeing them come together is in areas such as Manchester and Hackney where the local authorities are really involved—Nottingham is also really good—and where we are starting to see that the STP is providing the overarching framework. We are seeing engagement from local authorities in all the STPs now.

Q101 **Karin Smyth:** I think the Report highlights—I cannot remember exactly where—that the problem with local government, which is probably something that you cannot do anything about, is who you engage with. You have a system whereby you might be involved locally with certain senior officers but not members or leaders. That is the situation locally.

Jo Farrar: All the STPs have contributions from leaders now, so we are encouraging—

Q102 **Karin Smyth:** Elected leaders or officials?

Jo Farrar: Elected leaders. In Manchester, for example, there is a real engagement with locally elected leaders, as well as the officers.

Karin Smyth: I know. Some of us, with due respect, get a bit fed up with hearing about Manchester.

Simon Stevens: The new elected Mayor, whoever that may be, may be able to—



Q103 Karin Smyth: That involvement comes back to local people. Where do local people—the taxpayer, the voter, the patient—come in when it comes to deciding whether they want to live in an area that is directed along the Better Care Fund integration model or in one where the STP model holds sway? How are local people being involved in these discussions?

Simon Stevens: I am not sure that those are alternatives, are they?

Q104 Karin Smyth: Well, how are local people being involved in deciding how their local health and care services will look in the next two to five years?

Jo Farrar: All local authorities are involved in integration. With the STPs, the BCF and the other models, the direction of travel is really to get person-centred care, and that is what people were—

Q105 Karin Smyth: But we have established that that is different in different parts of the country. I am not making a judgment whether that is right or wrong—it depends on which officer leads that local authority and how the leadership works—but my question is, are you considering how to involve local people in deciding how they want their health and social care services to be shaped for the future?

Sarah Pickup: There has been variable engagement in the STPs. It has improved, and the guidance that went out was very clear that councils should be engaged, but because STP areas are not coterminous with council areas, or even with health and wellbeing board areas, you could be engaging very well with local government but not with all of it. There could be challenges. You might be engaging with one council leader and one chief exec, but you have to try to find a way of engaging them all.

The reason that is so critical is that councils are organisations that are really used to engaging with their local populations. Health and wellbeing boards will have done some of that; there is a health and wellbeing strategy in place in every health and wellbeing board area. Those can form the building blocks to help bring the STP together, not with the same thing in every area, but with things that local people have already agreed, the use of Healthwatch and the use of councils and their consultation processes, if councils are properly engaged—and engaged early—in the discussions about the “what”, not just informed about the “how” after the event.

There is real potential with a place-based solution, where there is proper engagement across the board and the right people with the right skills are used to help to reach communities and explain the kinds of changes that will benefit them. The worry is that it is a really challenging task to reach all the people you need to reach.

The other worry about the STPs is that the plans feature right across from acute right down to primary and social care, but the social care gap, although mentioned, is not necessarily part of the plan for achieving the delivery—understandably, in a way, because it is not part of the NHS.

However, if it is a place-based plan, it needs to be addressed, because it is part of the solution for people.

Q106 Karin Smyth: The NHS also has a duty to consult and engage on plans for change, as we know. It seems to be a glaring gap in the way these proposals are moving that local people are not being involved in these discussions. I am not talking about the so-called secrecy around producing the STPs. To reiterate the question, I am talking about how local people shape their local health and social care services in these areas over the next two to five years. If that is not a fundamental part of the discussion, I think that is a problem. I would welcome any clarification on that.

Simon Stevens: I agree with that. I think that is absolutely right. Of course, this is all playing out against a backdrop of difficult trade-offs and choices that are having to be made. There are formal mechanisms that continue to be in place—rightly so—around consultations, where substantial service changes are being contemplated, but I think there is a job of work to be done by these emerging accountable care systems in exactly the way that you describe, and I think people increasingly get that.

Q107 Karin Smyth: But it will not be mandatory.

Simon Stevens: The statutory framework within which any major service change is contemplated is intact, which contains precisely that requirement of public consultation. I do not know whether you want to talk about some of the proposed bed closures in any of the STPs—

Q108 Chair: We will be asking further questions. Before I go to Anne-Marie Trevelyan and back to Karin Smyth, my area contains seven boroughs. In London, the City and Hackney is included as one area, but there is a big range of difference between areas, even in London. The people in Hackney do not see some of those areas as their area, so Karin Smyth's point is pertinent. There is a disconnect between the administrative 44 footprints, which are somehow merged somewhere and they have no connection with the—

Chris Wormald: The 44 areas are health economies. For the reasons you have said, these things are incredibly difficult and the pattern of NHS management and local government management is different. I think this is the first time that local government has ever been at the table in an NHS planning process. Although it is difficult, messy and different in different places, I would argue that the interaction between the NHS and local government, although it can include a lot more, is deeper than it ever has been before and we are therefore on the right track here. I agree with that.

Simon Stevens: He wants that written into the record.

Q109 Mrs Trevelyan: Just to take that on, is the reality not—I do not see why we should not say so—that the STPs are driving to improve healthcare systems, processes and modernisation of medicine across healthcare areas, which would not happen with the smaller units that exist? That is



HOUSE OF COMMONS

not necessarily a bad thing. I want the best healthcare for my patients and all my constituents. If some parts of the north-east have not been doing it so well, we will ask those that have to put their backs into it and drag those areas up by creating a single framework. That is not something we should be shy of saying, but the challenge is to ensure that the populations it will affect are engaged. That is not evident yet because this has come in, seemingly from the constituent's point of view, like a bull in a china shop out of nowhere. I absolutely see the benefit of drawing it up, but is that not the reality that you should be leading on and making sure that the local government voices who connect are able to explain?

Simon Stevens: Yes, I think you have put that very well indeed. We have to recognise that there are one or two parts of the country where, frankly, bits of local authorities are suing bits of the NHS, which does not help with that kind of approach, but that is not the case in the vast majority of the country, and therefore, as you have described it, there is an effort. We cannot organise the huge change agenda that is required of the NHS exactly on 152 upper-tier local authorities. There is not the right geography for doing that, so there are some trade-offs here, but I think part of it will be about bringing other parts of an area alongside—

Q110 **Chair:** One thing that you do control is the appointment of chairs and boards. We have discussed the governance before, so I will not repeat it all, but how people are appointed to positions is varied. They suddenly appear from nowhere. I am not saying they are all bad people, but there is no local engagement in the appointment of most of those chairs. Picking up on what Karin Smyth and Anne-Marie Trevelyan have said, that is not really engaging locally.

Simon Stevens: It depends on what you mean by local engagement. It is not a panel of citizens who make the appointment, but the vast majority of the initial group of 44 chairs emerged locally from their local healthcare system.

Q111 **Chair:** But it was barely announced. As MPs, we did not know. I did a little litmus test of MPs and asked whether they knew they had a chair of their STP, and most of them did not know. If they did know, they did not know who it was. Okay, we are only one small stakeholder relatively, but there was no engagement.

Simon Stevens: Phase 1 was about marshalling a disparate group of folks locally to get this under way. Phase 2, as Anne Marie Morris and I discussed, is now moving to a different level of rigor in implementation. That is why we need to systematise this in the way that I described.

Q112 **Chair:** But the governance remains a problem. In my case—everyone has their own areas—there are seven areas with CCGs with their own governance and local authorities with their own governance. Then you have a group of people who come together in a room to become a board, but that is not reflective of all—



HOUSE OF COMMONS

Simon Stevens: I agree—it is pretty complex and to some extent we can do workarounds on that, but to some extent we are having to operate within the statutory framework that we got.

Q113 **Chair:** But when you are looking at tracking money and tracking progress against outcomes and targets you have set, where does the buck stop with an amorphous group like that, which does not actually have every stakeholder—just taking local government and health, let alone the wider engagement—around the table? Where does the buck stop? Who is in charge if something goes wrong in that area?

Simon Stevens: Nothing has changed about the existing lines of accountability or statutory governance, but to some extent what we are trying to do—recognising that it is a rather crowded and conflicted landscape in many geographies—is remove some of the veto power and take out some of the complexity of decision making so that people can actually make some decisions and get some stuff done.

Q114 **Chair:** Did you say “veto powers”?

Simon Stevens: Yes. I am talking about between different bits of the NHS—

Q115 **Karin Smyth:** To go back to the point I was making, I take up what Ms Pickup said: local government is experienced and much better, in my view, than the health service at making some of these difficult decisions with local people. It might be a helpful outcome of these deliberations to involve local government expertise more clearly in some of the debates that are going to go on around STPs, because there will be difficult choices to make, rather than keeping it within the health service. People should have the ability to come together locally somehow—perhaps brokered through local government, even if that is many different local governments in an STP area—to help with some of the decisions that are going to have to be made. It does not seem to be the case that that is being driven at a national level, and I think that would be a helpful place to start.

Simon Stevens: I think we have to be doing that. Let us be realistic among ourselves that it is not going to work everywhere, but there are a number parts of the country where, frankly, we would be looking to local authority leadership to take on more of the decision rights for what had previously been done in the national health service and to drive the thing forward.

Q116 **Karin Smyth:** I am not necessarily talking about the leadership of local government; actually, I am talking about the expertise within local government around consultation. Local government closes and opens things quite regularly in a way that the NHS finds it more difficult to do because of the way that it works locally outside local democratic control. This is a new way of operating that and it may be more fruitful.

Chris Wormald: Yes, I think you make an important point. I return to the point I made before that local government has been more involved in this process than in pretty much any other NHS process—that needs to go on.



HOUSE OF COMMONS

Nationally, we do a lot of work together. We do not necessarily agree on everything, as has been clear in this Committee, but we and our colleagues in CLG and the Local Government Association look at these issues and we recognise that we have still got a long way to go.

On the specific point about the accountabilities and the money—going back to the conversation we were having with Mr Pugh—we have all taken the view that we simply take the statutory position as it is and the money and accountabilities flow as they are, and focus on what we can do to move the world forward within that framework. There will be people who argue that you need a different framework, as I know various members of the Committee do, but we as public officials have taken the view that that is the situation in which we work, so how do we make it 1% better?

Going with that—on your point about accountabilities, Chair—is that none of the accountabilities have moved. Who is responsible for what happens in a hospital remains the board of that hospital—the CCG retains its existing accountabilities. What Simon has been describing is looking at how you pool those properly, but unless you are using one of the statutory freedoms set out in legislation for devolution or pooled budgets, the accountabilities and where the buck stops remain exactly as they were before this process. This is about how you carry out—

Q117 **Chair:** Which means risk is not being transferred.

Chris Wormald: As I said, we live with the statutory position that we have.

Simon Stevens: Yes, but we are going to push at the very edges of it.

Q118 **Chair:** That is reassuring, or something. We are getting lots of words here. We are all trying to define what this actually means in practice, as Amyas Morse was saying.

Simon Stevens: Go back to Dr Pugh's point—in the case of some of these integrated accountable systems, we would essentially like to have population budgets without contracting between the different bits, handoffs, the frictional costs and all the rest of it. We will nevertheless, within the letter of the law, act according to the spirit of what I have just described and push as hard as we can to get there without Parliament itself having to legislate. If at some point down the line you then choose to do so, that will no doubt be a welcome recognition of where the health service will have moved to in the meantime.

Chair: Mr Stevens, you are in an optimistic mood this afternoon. I wish we could share it quite so wholeheartedly. Time is marching on, and there is a big debate: I am sure you will want us all to be contributing to the debate on NHS estimates in the Chamber in a few moments.

Q119 **Caroline Flint:** Following up my colleague Karin Smyth's inquiry on how you or the STPs and those responsible are involving the wider public in decision making, would you agree that when it comes to health, particularly where social care and health are coming together, whatever



HOUSE OF COMMONS

we do from the health stand or the local government stand, individuals are ultimately going to have to take responsibility for planning their own arrangements with their families and with others? They are therefore an integral part of involving people in the decisions about how services are delivered. Do you agree with that?

Chris Wormald: Yes.

Chair: Ms Flint, who are you addressing that question to?

Q120 **Caroline Flint:** To Mr Stevens and to local government. I have not heard anything, to be honest, in the past 20 minutes that has given me one practical example of where anybody has thought about how to innovate so that the voice of those people is heard. Could you give me one example?

Chris Wormald: We are going to come on later—

Q121 **Caroline Flint:** I am asking now. Can you give us one example in the development of the STPs where there is innovation in reaching out not only to patients, but the wider public on what their thoughts are on the sort of services they should have on the ground?

Simon Stevens: One very concrete example is that for the first time, so-called high-need patients—be they people with learning disabilities, mental health problems or physical disabilities—are getting to directly control their resources and budgets in the NHS combined with their social care budgets. The term is a big jargonistic, but it is integrated personal commissioning. We have got 10,000 people, and we are on track to 50,000 or 100,000 people being able to take back control of how their money is being used on their behalf. That is potentially quite revolutionary in shifting the power to users of services from the bits of provision that have arisen over history.

Q122 **Caroline Flint:** What about the issue in terms of influencing the development of service? Let us take people who are currently in their 50s, say, who might have some input into how they might see the future of social care and health integration. How does that compare with someone who is 90 today? Those in their 50s might have a very different cultural attitude from that of their parents or grandparents. What about the views of those who have yet to need the service?

Simon Stevens: Obviously there is a big debate that is just kicking off, as you perhaps imply, on the future of social care. A number of us strongly welcome the fact that the Prime Minister has set up a review of what that needs to look like.

Q123 **Caroline Flint:** No, I am talking about influencing the planning of services now. Where is there evidence that the voices of those people are being sought?

Simon Stevens: Now, from 50-year-olds, when they—

Q124 **Caroline Flint:** In any community at the moment, we are having STPs being put together that are mapping out and planning how services will



HOUSE OF COMMONS

be provided locally. Where in the discussion today, which is about social care and health integration, is there an example of local authorities or health providers reaching out to that group of people and saying, "We are changing all this. What do you think?"?

Chair: I think you have asked the question, Ms Flint; I am just aware of time.

Sarah Pickup: There are some examples at local level. There are areas that are developing things such as social prescribing and self-care. They are using the voluntary sector and linking to wider communities. There is a self-care initiative in Wigan and a social prescribing initiative in Rotherham, and they are working with the voluntary sector and wider populations to develop community-based things that are not direct health services or even social care services, but things that can support people in understanding how their needs can be met in the future.

Q125 **Caroline Flint:** We'll be counting those things for at least 10 or 15 years, and the opportunity to do that—

Jo Farrar: Sarah mentioned the health and wellbeing boards and the engagement with HealthWatch. Local authorities are very engaged with their local populations, and local populations are really interested in health and social care, particularly people who are in their 50s and are thinking about the future. In my last authority, Bath and North East Somerset, I think we had a three or four-month consultation with a wide range of the public on the future of health and social care and provision in the area, including all the preventive services. That is quite typical of local authority areas. There is a lot of debate—

Q126 **Chair:** To finish off on Ms Flint's point, the challenge is that it is all Greek to most people. The language used is jargonistic, and the accountability is not evident. Chairs and boards appear apparently from nowhere. The average member of the public wants to find out what is going on, but they can't go to any one portal and find out very easily. I think that is really what we are driving at here: although it is supposed to be grassroots upwards, it has become rather forced from the centre, with the grassroots doing it in their own jargonistic way. It is not clear and transparent to people. Mr Stevens and Sarah Pickup, would you not agree that there is still a challenge there about how this is both presented to and influenced by the general public—the people who pay for it?

Simon Stevens: Yes, I think that is right. I also think that the Committee will recognise that what you are also telling us is that there is a need for urgency to deal with the huge pressures that are facing the system.

Q127 **Chair:** Do you think you can do that in two years?

Simon Stevens: Your report that came out this morning is, in a sense, telling us to get on with it. Those two thoughts are potentially in conflict.

Chair: Well, getting on with it, but with the right planning and in a way that we can be sure that it will be delivered. The danger is, if you go too fast with a savings target, that people are very suspicious. That is one of



HOUSE OF COMMONS

the challenges that the public see. Many people believe that it is just a cover for cuts. That is just one of the concerns that we have.

Q128 Anne Marie Morris: We have talked about Better Care and STPs, but we are still at the crux of trying to determine how we are going to integrate health and social care by 2020. While Mr Stevens would perhaps not say it entirely like this, he would quite like to see a new piece of big bang legislation on care. We got a lot from Ms Farrar about the complications of different boundaries between different local governments, and we got from Mr Wormald that we can't introduce new legislation.

It seems to me that, between the four of you, although none of you are going to actually say it—certainly not Mr Wormald—we need some legislation that will enable this integration to actually happen. It took 26 years for what happened in Northumberland to happen. We only have two.

I think the other bogey in the room, if I can put it like that, is money. Mr Stevens has been very honest and said that he does not have enough, and he has not got what was promised. When we have looked at the figures, we have actually seen that the bit that is ring-fenced is just for one part, if you like, of NHS care. There is this issue about funding.

I ask you, Ms Farrar and Mr Wormald, where have we got to with the Care Act? There is an acceptance that, unless we start putting some money into the system to pay for care, you are not going to be able to carry on robbing the NHS. Andrew Dilnot recommended that a Committee be set up to look into this. There are a number of funding options out there. What are you doing? We have two and a half years, and we need to find a way of getting more money into NHS and social care. We cannot carry on pretending that moving it between the two parts is going to give everyone what they believe this country deserves.

Jo Farrar: Yes. If we look at what happened at the last spending review, we have actually freed up money. Money has been made available to put into social care, and we are seeing that social care is being protected—I think relative to other local government services. What we are seeing in some areas is that it is not just about the money; it is not about the money at all, in fact. They are making some real progress, and we are seeing in other areas that they are not making the same progress. I think a big part of this is how people make the best use of the money and how we can look at—

Q129 Anne Marie Morris: But Ms Farrar, it is clear from what Dilnot put in his report that there is not enough money. He made it very clear that the Government have to look at this. What has your Department done to look at how we implement the Care Act part 2?

Jo Farrar: We have recognised that there are pressures. That is why we have been working since the spending review with local government to free up money for social care. We have recognised it as a priority and we have given councils the ability—

Q130 Anne Marie Morris: Forgive me, Ms Farrar, but freeing up money is not



HOUSE OF COMMONS

going to solve the problem. Dilnot made it very clear that there is a big hole that needs to be filled. Has that Committee that was recommended been set up?

Chris Wormald: Andrew Dilnot's report was actually about a slightly different issue, which was about cash for care costs and the impact on people's abilities to keep their houses. In terms of the overall position on social care spending, you will have heard my answer before. It is exactly the same answer that you will get from the Prime Minister on this subject. We recognise that there are challenges, and we have taken a series of steps, which Jo has outlined. We recognise that there are longer-term issues, but we do not see those issues as being exclusively about finance—they are also about variability and integration. As I said, you will have heard that answer before; I do not have another one for you.

Q131 **Anne Marie Morris:** Ms Pickup, can I ask you? You must surely be concerned that not a lot is happening, in terms of Care Act part 2, because it is local government that is actually having to bear the burden?

Sarah Pickup: I am more concerned about Care Act part 1, because Care Act part 2 is about assisting people not to have to face catastrophic care costs. Although that was a very valuable thing to do, at the moment we face a situation where only 8% of directors are confident of meeting their statutory responsibilities as we go into 2017-18. So that is where the big concern is: it is about the current—

Q132 **Chair:** You say 8%. Is that in England?

Sarah Pickup: 8% in England, yes. So that is about the aspirations of the Care Act.

In terms of integration and where that is going, money is a necessary but not sufficient thing. There are a whole load of other things that need to change to make integration effective, like flows, relationships and all those sorts of things, and integration not for the sake of it but to deliver better outcomes. But in terms of the Care Act part 1, we have made it very clear that despite what the Government has done to free up resources, there is still the remaining forward care gap. We think there is about a £1.3 billion here-and-now, minimum gap to sustain the care market—just to keep it going; not to get more care or better care but to make sure that care providers do not go under. That is now.

Then, looking forward, we believe that as part of an overall £5.8 billion pressure on councils, £1.3 billion of that is needed on top of what has already been promised for adult social care. Actually, it is front-loaded need, because the new Better Care Fund is back-loaded towards the end of the spending review period when actually £2.3 billion of that £2.6 billion that we need is needed in 2017-18 just to sustain the system and not to make cuts. That is not even taking account of the fact that if other council budgets are not also protected there could be a further consequence. Just for adult social care on its own, there is a gap.

Q133 **Anne Marie Morris:** Okay. So it is very clear to me that you totally agree



HOUSE OF COMMONS

that we need more money—for a minute, we can set aside whether it is part 1 or part 2. Mr Stevens, I hope you might agree with me that there is interplay between the money that comes from the state—it has got to come from somewhere—and the amount of money that individuals pay, because social care is means-tested. So you have got the bit that gets paid for by the taxpayer, through the Government, and you have got the bit paid for by individuals. What I am seeing is that because more and more individuals are not aware that the state will not pick them up at the end, they are not making any provision at all, which puts pressure on the NHS. I would have thought you would be concerned about part 2, because if we do not do something about people putting something aside for their future care, the loser will be the NHS and ultimately it will still be a problem for the taxpayer.

Simon Stevens: I am not going to say anything that I have not said before. But what I have said before on this topic, both here and to the House of Lords Committee that has been looking at this as well as the CLG Committee and the Health Select Committee, is that, from an NHS point of view, a three-step process would make great sense. First, seeking to deal with some of the pressures Sarah Pickup has talked about in the here and now. Secondly, using the STPs as the vehicle to advance the care integration agenda that we have talked about over the next several years. And thirdly, in parallel with that, a more fundamental look at the way social care financing links to other aspects of the retiree security offer that the country makes to our older people. The third of those, of course, is nothing to do with the NHS, and I therefore strongly welcome the fact that the Prime Minister has signalled that that is something that she has initiated.

Q134 **Karin Smyth:** Ms Pickup, I appreciate that you are concerned about part 1 of the Care Act. In fact, it was postponed in July 2015, just after the general election, because the Local Government Association was one of the major movers in that postponement, despite it being a Government manifesto commitment. I think it does matter to people, actually. They are concerned about it.

Mr Wormald, I think you do not want to elaborate on what you have written before. I do not have it in front of me, but I asked the NAO for a Report on what planning is now going on in the Department for the Care Act part 3, because we have been told that it will come into force in April 2020—conveniently just before the next election. I understand that a committee is looking at that, and I think the wording was that they needed the time from now till then to review the work and so on.

Given that it was a manifesto commitment and it was postponed fairly late on in the day, one would have thought that a lot of work would have already been done so it should not require another three years of work from the Department to come up with how it will be implemented. My question is this: is it going to be implemented? Or is it April 2020 long grass for 2025?

Chris Wormald: These are the Dilnot recommendations—



HOUSE OF COMMONS

Karin Smyth: Yes, the Care Act part 2.

Chris Wormald: As I say, the Government have set out their position.

Q135 **Karin Smyth:** The Government have said April 2020, so why is it taking so long in the Department to do further work that is already being done? It means that we cannot say any more than how it is going to be implemented in 2020. What is that committee doing?

Chris Wormald: We would set out how it would be implemented nearer the time, which is a long way away. The Government have set out their position on when it expects to implement that.

Q136 **Karin Smyth:** What is the committee doing? What is happening inside the Department to make this happen?

Chair: Walk us through this committee. Does it meet weekly or monthly?

Chris Wormald: I am not sure which committee we are referring to.

Q137 **Chair:** The one that Dilnot recommended was set up—the working group. The central Government, local Government, financial services—the Dilnot Commission report, page 40. I'm sure somebody can look it up for you.

Chris Wormald: I'll need to go and check exactly the answer to that question and write to you.

Q138 **Chair:** This is a major plank of Government policy in your Department. You don't know—

Chris Wormald: Not off the top of my head, no. I don't want to give answers that would mislead the Committee.

Q139 **Anne Marie Morris:** I think we have probably got to the endgame on this. My concern is that it seems that 2020 will not be deliverable: first, because the plans still haven't been checked; secondly, because we have not sorted out where we are going to go with funding for part 1 and for NHS and social care, as it stands; and thirdly—I must admit, I am very concerned, Mr Wormald—because between you and Ms Farrar, nothing seems to be in place with regard to what we do about part 2. It is no good saying, "We will look at this in the future." You haven't really answered Ms Smyth's question. If you haven't done something by today and you can't tell us about it, then realistically I can only conclude from what the four of you have said that integrating health and social care by 2020 is not going to happen. I find that depressing.

Chris Wormald: I am answering a specific question about the implementation of Dilnot, not about the integration of care—those are separate issues. The Dilnot report deals with catastrophic care.

Q140 **Chair:** Without revisiting all the arguments that Ms Morris put out there, it is connected. If you have a failure—and we are seeing this; we will move on to workforce planning. If you have a challenge with care homes and nursing homes, and if you have people with no place to go and people who have not provided their own financing—those who could have done—there will be pressure on the NHS, so it is all interconnected.



HOUSE OF COMMONS

Chris Wormald: Yes, it is all interconnected but I would not go from, “We have selected implementation dates for the manifesto commitment that was under discussion at the end of the Parliament,” to a general comment about—

Q141 **Chair:** Well, you can pick on that particular phrase of Ms Morris’s, but you could perhaps answer a more general point: if you haven’t done anything so far, or you can’t tell us about it, can we be confident that the commitment to introducing the Care Act part 2 by 2020 will be implemented?

Chris Wormald: As I say, that is not a question I have a specific answer to here, so I will write to the Committee.

Chair: Finally on this point I will bring in the Comptroller and Auditor General, who might be able to help pin down the numbers.

Sir Amyas Morse: It sounds like a lot of exciting planning things are going on. What I am not sure about, as I listen, is this: there are two major systems that are interdependent and working more closely with each other, and both are under huge resource pressure, so if no more resource is available, how are you going to deliver some of these initiatives?

Simon Stevens: That is what we are—for the next couple of years anyway—going to try and lay out at the end of March. We are going to describe how we have to cut our cloth accordingly, and it will involve some trade-offs.

Q142 **Chair:** It is interesting that you used a phrase that I think No. 10 has used in the past.

Simon Stevens: Which phrase was that?

Chair: Cutting your cloth accordingly.

Simon Stevens: We are all tailors now.

Q143 **Chair:** How is your relationship with No. 10 Downing Street—

Simon Stevens: As strong as ever.

Q144 **Chair:** We have certainly not had any more anonymous briefings in the press. Have you had any pressure?

Simon Stevens: We are absolutely aligned around what the next phase of reform of the national health service needs to look like.

Q145 **Chair:** Okay. Well, we look forward to this happy—I was going to say “romance” but perhaps that is a bit over-optimistic—relationship between No. 10 and NHS England. I am glad to hear that you are knuckling down and getting on with it together.

Before we finish, I want to move on to the Treasury Minutes—this is to Mr Wormald and the Department primarily. For those who may not follow exactly how this Committee works, when we produce a Report, the



HOUSE OF COMMONS

Government responds in the Treasury Minute. The Department provides an answer, which is administered by the Treasury, and we get a response to our every recommendation on a regular cycle. We received the response to our second Report of the 2016-17 session, "Personal budgets in social care", in November last year. We were concerned about three of the responses in particular. We thought the responses to recommendations 4, 5 and 8 were a bit weak. For time purposes, I am not going to read through all those recommendations, but I am going to ask Anne-Marie Trevelyan to pick up on the first couple.

Q146 Mrs Trevelyan: Mr Wormald, in relation to recommendation 4, which was a request for you to review the impact of the national living wage, the response was that you had considered the impact during the spending review—not what I would consider a particularly detailed response. The LGA, as Ms Pickup mentioned, is looking into a £1.2 billion funding gap by 2020, which implies to me that there won't be enough funding to commission adequate services to meet our growing ageing population's needs. First, how do you know, if you have not done a specific review, both on the national minimum wage and more widely, how local authorities are going to have enough funding to meet that? As we have discussed, the impact goes straight back to the NHS if we are not getting that right.

Chris Wormald: Part of my answer to that is the answer I previously gave. The Government recognise that there are challenges and are looking at this issue, but they are not entirely financial. As the response set out, this was looked at in the spending review and built into the spending review outcome. The Department has commissioned a whole series of evaluations of the Care Act and how it will be implemented, most of which will report in 2019, but a number of which will provide interim reports later this year. We will receive a series of reports about how the Care Act is being implemented. We also, via the LGA, do a series of surveys of local authorities about their implementation of the Care Act. That is set out in the Minute. If you put all those things together with what we have already said about social care, we believe that is the basis of the answer to your question. We are not doing a specific study, as you describe, but we look at the questions that the Committee is raising.

Q147 Mrs Trevelyan: You don't intend to be able to say to us, "The impact of the national living wage has been x on that budget." That is a very clear part of the whole answer. That is a question that every MP and people who pay their taxes want to know the answer to. What is the impact of that very clear change in national policy?

Chris Wormald: We are not doing a specific study on that question. We are looking at the overall funding of adult social care with our colleagues at CLG.

Q148 Mrs Trevelyan: Ms Pickup, did you say it is possible for the LGA, at a local level, to make an assessment of the national living wage?

Sarah Pickup: We have estimated the impact with our colleagues in the Association of Directors of Adult Social Services, and it was between £500



HOUSE OF COMMONS

million and £600 million last year and this year. I think it was £520 million—I haven't got the figure in my head. It more than accounted for the increase in funding that was available through the precept. What happened is that new pressure was created and ate up all the funding, which could otherwise have addressed some of the other pressures. That is not to say that we are against the national living wage; it is just about it being a new burden that used up resources that were claimed to be provided for demographic and deflationary purposes.

Q149 Mrs Trevelyan: How much of the flexibility available to councils to increase their precept could cover that particular part of the funding gap?

Sarah Pickup: The flexibility of the precept at 2% didn't quite cover the first-year cost.

Chair: It wasn't done by area anyway.

Sarah Pickup: Most areas took the 2% in 2016-17; very few didn't. The total that was raised was not as much as the estimated cost of delivering the national living wage through care fees.

Q150 Chair: To help Mr Wormald along with this, you have got an estimated cost from the Association of Directors of Adult Social Services. Will they be solidifying into actual costs and impacts—potentially closures or reductions in facilities in their area? I am sure Mr Wormald is listening with open ears to this.

Sarah Pickup: Every year, the Association of Directors of Adult Social Services does a budget survey, and it asks about the uplifts in fees that have been paid to providers. You would expect the uplifts in fees to have to reflect the cost of the national living wage, so the uplifts in '16-17 were much higher than they had been in previous years, when they had been squeezed in order to make savings. That is partly the impact of that; but we will not know the full impact until we have got another year's data.

Q151 Chair: Mr Wormald, it is not a big step from what Ms Pickup has described happens in local authorities, if you are extrapolating from that a national picture.

Chris Wormald: No, that sort of information—information collected by CLG from the local government finance system—is exactly what we look at; and exactly what Sarah has just described is the more useful information. What you want to know is the overall effect on fees, or whatever. As I said, we are not doing something specific on the national minimum wage. We do look at what are the cost pressures across the system, in the way that I described.

Q152 Chair: One of the points of our recommendation was that this is a major Government policy change and we know that across different sectors—other Committees are looking at this too—it is having a very big impact. We see this all the time; one Government policy has an unintended consequence somewhere else. No one is saying they are necessarily against the living wage, but you have got to be able to absorb it into the sector you are responsible for. You and Ms Farrar have a responsibility to



HOUSE OF COMMONS

make sure that care homes survive, and it would be very helpful to know how much this particular cost on homes is preventing them providing the support that our constituents need.

Chris Wormald: Yes, I understand what the Committee is asking for. I am just setting out the work that we have in train, which does not include a specific study of the type you are describing. I am quite happy to go back and consider this issue if the Committee feels strongly, which it clearly does. But, as I have said, I am setting out the work that we have in train at the moment, which looks at the overall cost pressures in the system but does not have a specific study of the type you describe. But I am quite happy to go and consider it.

Q153 **Chair:** It is just that it could be that while the Treasury gives with one hand to people who get the living wage, the cost is falling elsewhere, and sometimes on individuals who cannot afford to pay it.

Chris Wormald: That particular policy is not really important to this debate, but clearly the Government made a statement about what it thought people should be paid, and it did expect all parts of the economy, whether in the public or private sector, to absorb those costs. So the impact on a public sector employer is no different from any other employer, and the approach across the piece was that we expected those costs to be absorbed. But I completely understand the Committee's question, and the work we do at the moment does not specifically answer your question, as I have set out. But I am happy to go and look at what we might do in that area.

Q154 **Chair:** It sounds like you have got some of the work being done already in local government.

Chris Wormald: Yes, we are quite happy to go and look at what information we have already. What I don't want to do is launch another study.

Chair: We do not, in this Committee, try to make recommendations that require acres more extra unnecessary bureaucracy to come up with a figure. We hope that you could use what you have got to try and get some of the answers that we think are important to taxpayers.

Q155 **Mrs Trevelyan:** On recommendation 5, Mr Wormald, looking at the fragility of the social care market putting people at risk, as we have discussed at some length already: the recommendation that you were going to publish a national market position statement in your role as the national steward for the social care market seems to have been downgraded in favour of allowing stakeholders to feed into a markets hub, which you will keep an eye on. If you are not stewarding how exactly are you keeping an eye on this from the Department?

Chris Wormald: There are two parts to this. There is the formal role that CQC plays for us in monitoring those care providers whose stability has a significant impact. They currently monitor—I think it is about 42 care providers; and that is a very formal thing. Now of course the vast majority of the information that they look at is commercially confidential, but there



HOUSE OF COMMONS

is a clear system there run by the CQC to look at that extremely important part of market stability. At the other end of the scale local authorities have a duty to market manage in their particular area, which picks up a lot of the smaller providers. Then what we do, as it says here, is we bring together the information that we produce on the hub that we launched in November '16, which not only gives that sort of information but has the sort of good practice around commissioning and market management that local authorities use, which we do in conjunction with our local government colleagues.

Q156 Mrs Trevelyan: So with that monitoring, what is your assessment of the state of the market?

Chris Wormald: At the moment there are obvious pressures of the types that people have described. When we look at overall bed numbers they are relatively stable. There is quite a lot of churn. That is what we see when we look across the market overall. This is something we discuss with our colleagues at Communities and Local Government and in the Local Government Association. We keep a careful eye on it.

Mrs Trevelyan: Ms Farrar, what would be your assessment?

Jo Farrar: I would agree with that. We are monitoring capacity, and it has remained broadly stable.

Q157 Mrs Trevelyan: And adequate?

Jo Farrar: Yes—broadly stable and adequate, but as we talked about earlier, we need to look at what type of care provision we need. This goes back to the conversation that we had earlier when we were looking at the need to have a mix of provision.

Chris Wormald: Words like “adequate” are quite difficult because, as we have discussed with this Committee before, it is very different in different parts of the country. We recognise the concerns that are out there, about market stability, particularly in high-cost areas of the country. As we have discussed with the Committee before, there are parts of the country where there is considerable pressure, particularly in London where you have high prices, and in other areas—yours may be one of them—there is a reasonable amount of spare capacity. That is why the local government focus, looking at the more particular market, is frequently better than a broad-brush national statement.

Sarah Pickup: On the care home market specifically, there is a wider market that has a big proportion self-funders using it, so even if the total number of beds has not gone down, the number of beds accessible to councils is going down, so some providers are not providing to local authorities. That is worrying.

In a way, the bigger market worry is the home care market. Many home care providers have been handing contracts back to councils, because they say that they cannot deliver for the prices that the councils can afford to pay. So there are market worries, and the markets are slightly different.



HOUSE OF COMMONS

Q158 Mrs Trevelyan: Which comes back to the whole issue of if you are the stewards, as part of whole bigger integration programme, are you comfortable as the accounting officer for the NHS that you are not going to end up with the bill because we are not able to find the right social care framework?

Chris Wormald: As I have set out, we recognise the pressures that are out there, and I think Sarah has put it quite well. While the headline numbers are not showing a huge problem right now, there are clearly signs of pressure that concern us.

Q159 Mrs Trevelyan: Is getting that right for you to lead on, or is that a DCLG issue?

Chris Wormald: I think it is shared between us—

Q160 Mrs Trevelyan: That is never a good thing. Who will lead on it? Someone should lead, otherwise we will get nothing.

Chris Wormald: There is a joint programme board, which is run by Jo and one of my directors general. We try to join up on these issues. In the end, we are talking about private businesses, which are ultimately responsible for their own conduct and financing. As we have set out for the Committee, we have a role in looking across the market as a whole and, particularly, in ensuring that if there are problems in the market they are flagged early to local authorities. That is why we have the CQC regime that I was describing.

Q161 Karin Smyth: It is an odd market though, isn't it? We have the increasing demand of elderly populations—there is plenty of demand out there, and there will be no shortage of people who will need the care—but people are not flooding into the market to provide that care. Essentially, there is not enough profit, is there? What action do you or the DCLG take where, in these places of high cost, there is essentially no market, or it is not worth someone coming into the market? What is your role?

Chris Wormald: I do not think that we vet the areas like that, do we, Jo?

Jo Farrar: We have no evidence like that at the moment.

Q162 Karin Smyth: You have no evidence that there are not enough care providers in any parts of the country?

Jo Farrar: No, what we see are different positions in different parts of the country. As Sarah said, in the south, for example, we have more constraints on care provision, as opposed to care homes, and in other areas we see that there is a difference in terms of the pressures on residential care. As I said, the number of beds remains stable; we just need to make sure that they are providing for the right needs of the people in those areas.

Sir Amyas Morse: May I ask something?

Chair: Very briefly, Sir Amyas.



HOUSE OF COMMONS

Sir Amyas Morse: Do you actually prepare summary reports on the state of the market? I am sure that the Committee would find it interesting to see that.

Jo Farrar: No, that's not something we do.

Chris Wormald: I will go and check what we do prepare. I don't think we prepare anything on that.

Q163 **Chair:** The point we are trying to get across is that there is huge need. If there is some lack of provision, you are the stewards at the Department of Health. Then there will be all sorts of knock-on impacts. Once a home has closed, you cannot just replace it overnight. It is just not going to happen very fast. Once you get to crisis point, this could be a very serious issue. We are concerned that you did not respond very clearly.

I will move on to recommendation 8 before we finish. Our recommendation was that you should set out, when people have money for overlapping purposes, how they can spend it in a way that represents value for money, and particularly how different bodies issuing the payments—DWP, the Department of Health and maybe some local authorities, in their personal budgets—are working jointly to provide a clearer and more efficient process. In your response, there were lots of warm words, but in paragraph 8.5 in the Treasury Minute, on page 22, you just restated what the benefits were rather than actually talking about how you might want to work better with the DWP to make sure that these are properly integrated so that all the money from budgets coming into a house—Caroline Flint, if I remember rightly, made this point at the time—come in and are seen as part of the whole. Have you got the right reference there?

Chris Wormald: Yes, I have got the right reference. I am not sure I have got anything we would need to add to that statement. I will go and check the position on the specific question you asked. I think on that recommendation, we agreed that we would write to you in the summer on these issues alongside your request.

Chair: I don't know if Caroline Flint wants to follow up, because she asked the original question.

Chris Wormald: Let me check and come back to you. I had that one in—

Q164 **Chair:** Okay. We didn't necessarily expect it to be an easy answer—that you would magically click your fingers and it would be sorted—but there was a logic to our line of questioning and where we were. There was a gap. If we are talking about integration, integrating those budgets is pretty key too.

Chris Wormald: As I said, I was looking at that one. We promised to write to you in summer 2017, and we were going to do so. If you haven't found the rest of our answer helpful, let me go away and see if there is a more helpful and clearer answer I can give you.

Q165 **Chair:** Just to make it easier for you for Treasury Minutes, we want not



HOUSE OF COMMONS

just words but things that really mean something. If there is a disagreement, then at least we know where we stand. We may come back and still call you in on a disagreement, but where we are not clear—just on a positive, though, we did think that the responses to recommendations 2 and 3 were much better. You are commissioning research to see how personal budgets contribute to outcomes. We were quite excited by that session and by the possibility of what personal budgets could deliver. In terms of impacts on the health budget, there is a real benefit there too, potentially. We were pleased with that and the answer to recommendation 3, so it is not all bad news. We do like to play fair.

Chris Wormald: That is very kind of you, Chair. Let me take away the answers you find less clear and see if there is a clearer version. As I said, if there is a disagreement, we will set it out.

Chair: Thank you. Plain English is always a good thing, and plain English for where STPs are, Mr Stevens, would be great as well.

Q166 **Karin Smyth:** It has taken me a while to find my reference earlier to the documents; my apologies. To be clear to Mr Wormald's staff, our response was on the Care Act part 2, and our concern was about the Department not providing assurance in the response that the plan was properly resourced. This is about publishing guidance in summer 2018, with a final regulation in 2019. I am not sure where it has come from, from the way it is given to us in Committee, Chair.

Chris Wormald: If the Clerk could let me know, I will come back on that.

Q167 **Chair:** Thank you very much indeed for your time. I am glad to know that Mr Stevens and No. 10 are getting along just fine. Let's see how long that lasts.

Simon Stevens: We look forward to seeing you next week for our weekly appearance before the Public Accounts Committee.

Q168 **Chair:** We try to spread them out. I think we give the Department of Health and NHS England first refusal on dates, but don't tell the other Departments, or they will all get very jealous.

Simon Stevens: It's just a question of which day of the week, at this rate.

Q169 **Chair:** We are looking at so many issues with you, Mr Stevens.

Simon Stevens: We relish the opportunity.

Q170 **Chair:** We need our weekly fix. I have to say, that is the first time I have ever seen you speechless, so congratulations to Anne-Marie Morris for that one.

Simon Stevens: Yes. Thank you, Anne-Marie Morris.

Chair: A little win for us in the PAC on that one. Thank you very much indeed for your time. Our uncorrected transcript will be up on the website



HOUSE OF COMMONS

in the next couple of days, and we will send you a copy. Our report on this is unlikely to be out before Easter, because bizarrely, we are having a week off for the Easter recess, having just come back. Thank you very much for your time.