



House of Commons  
Health Committee

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**Public Expenditure**

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**Second Report of Session 2010–11**

***Volume I***

*Report, together with formal minutes, oral and written evidence*

*Additional written evidence is contained in Volume II, available on the Committee website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom)*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

### Membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)<sup>1</sup>  
Rosie Cooper MP (*Labour, West Lancashire*)  
Nadine Dorries MP (*Conservative, Mid Bedfordshire*)  
Yvonne Fovargue MP (*Labour, Makerfield*)  
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David Tredinnick MP (*Conservative, Bosworth*)  
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Dr Sarah Wollaston MP (*Conservative, Totnes*)

The following was a member of the Committee during this inquiry:  
Fiona Mactaggart MP (*Labour, Slough*)

### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom).

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).  
Additional written evidence may be published on the internet only.

### Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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<sup>1</sup> Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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## Summary

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The October 2010 Spending Review has imposed tough settlements on both health and social care, and sets a highly challenging context for the delivery of health and social care services over the next four years. In both cases efficiency gains will need to be made on an unprecedented scale if care levels are to be maintained and the quality of services improved.

The local government settlement will have an inevitable impact on the provision of social care. The Secretary of State told us that the Spending Review settlement, coupled with the two year pay freeze, will provide councils with the necessary resources to sustain current eligibility levels for social care. The evidence submitted to us, including the evidence submitted by the Government itself, does not allow us to agree. Councils will need to sustain further efficiency savings of up to 3.5% per annum to avoid reducing their levels of care, and this will not be easy.

In this context the Government is placing understandable emphasis on the 'extra' funding for social care, through the Personal Social Services grant and the £1bn through the NHS. However, the majority of our witnesses were concerned that the increases in the PSS grant will not be reflected in changes in actual spending on social care.

The health settlement represents a significant challenge to the NHS, requiring efficiency savings on an unprecedented scale. It is vital that these savings are made by efficiency gains rather than making cuts. Unfortunately, we do not believe that the Government is providing a clear enough narrative on its vision of how these savings are to be made.

In addition, these savings will need to be made in the uncertain landscape of the NHS reorganisation following the White Paper. The reorganisation will bring its own costs, both direct and indirect, and the Government will need to maintain close financial oversight in the transition period. It is unfortunate that the Government has not yet provided even a broad estimate of the likely costs of the reorganisation.

Improving the interaction between health and social care will be critical if the necessary cost savings on both sides are to be realised. The potential to make savings in this area has long been acknowledged, but has not yet been properly achieved. We doubt whether the current institutional or policy structures are fit for the purpose of achieving the goal of improved partnership between health and social care. It is not enough for the Government to exhort change in this area: there must be a formal policy infrastructure that recognises the importance of achieving a better overall interface between the two sectors.

The allocation of £1bn from the NHS revenue budget recognises the interaction between health and social care, but there is a risk that the sum will be focused on funding certain limited services, rather than being directed towards providing a better overall interface between the two sectors which will bring about longer-term improvements in efficiency, preventive care and reablement.

# 1 Preface

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1. The Committee launched its inquiry into Public Expenditure in July 2010. The Committee received 27 written memoranda and held four oral evidence sessions, with officials from the Department of Health; the NHS Confederation, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (Adass); the British Medical Association (BMA), Royal College of Nursing (RCN), and UNISON; and the Secretary of State for Health. The Specialist Adviser to the inquiry was Professor John Appleby, Chief Economist, Health Policy, at the King's Fund and we are grateful to him for his assistance with our work.

## 2 Introduction

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2. Following the Spending Review settlement of 20 October 2010 the NHS does not face budget reductions on the scale of other departments but the challenge facing the NHS is still substantial. The settlement has left the health service needing to make unprecedented levels of efficiency savings if it is to maintain levels of care and improve the service it provides. Some have argued that this process will be complicated, delayed or even thwarted by the planned restructuring of the NHS.

3. There is even greater pressure on the social care sector, which is also required to make unprecedented efficiencies. The intensity of the pressure on social care could have an impact on the ability of both services to realise the significant savings that could result from better integration of health and social care.

4. The scale of the challenge is daunting, and the risks of non-delivery are significant. Achieving these ambitious aims will require leadership and innovation. In particular, delivery of these objectives will be impossible without the active engagement of the clinical and managerial staff in the NHS.

5. We believe there is an urgent requirement for the Government to provide a clearer narrative on how this challenge will be met; how services will be changed; and the model of care that will be delivered.

6. In this inquiry, we have inevitably concentrated on financial controls and efficiency gains. It is important, however, to retain a focus on the experience of patients and clinicians. Efficiency gains unavoidably involve change and it is important that the process is managed in a way which retains the confidence of patients and clinicians.

7. The Committee is conducting a parallel inquiry into the future of commissioning which represents an important part of this restructuring. We do not therefore intend to comment in detail on the White Paper proposals in this report, beyond observing that a key consideration in its assessment of those proposals will be their ability to facilitate the delivery of the efficiency gains required by the Spending Review settlement.

8. Successful delivery of this efficiency gain is fundamental to securing the core social policy objective of the NHS—equitable access to high quality healthcare; the size of the NHS budget relative to total government expenditure also makes it fundamental to the delivery of the Government's wider economic policy objectives.

9. This Report is intended to present a snapshot of the key implications and risks arising from the Spending Review. It will provide an overall context for our subsequent inquiries.

## 3 Social care

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### The Spending Review settlement for social care

10. The Local Government formula grant as a whole is being reduced, by an average of 26% in real terms over the Spending Review period.<sup>2</sup> Social care is not funded solely from the Local Government formula grant: it is also funded from revenue from council tax and client contributions. Department of Health figures indicate total local government spending on adult social care was £13.631 billion in 2008–09.<sup>3</sup> This represents 12% of local authorities' total net current expenditure of £113.1 billion.<sup>4</sup> In his evidence the Secretary of State for Health, Rt Hon Andrew Lansley MP, was at pains to emphasise “it is important to understand that the headline overall real-terms reduction in formula grant over four years does not necessarily translate into a corresponding reduction in the resources available for social care”.<sup>5</sup> The Spending Review document stated:

the Spending Review settlement means that while on average, central government funding to councils decreases by around 26 per cent over the next four years, councils' budgets decrease by around 14 per cent once the OBR [Office for Budget Responsibility]'s projections for council tax are taken into account<sup>6</sup>

11. The implications of the spending settlement on social care will differ significantly between local authorities and the total picture will not become clear until individual authorities know their settlement and have taken decisions on Council Tax.

**12. The Local Government Spending Review settlement is a tough one (though in line with many others across government) that cannot fail to pose a challenge for the successful delivery of social care. Although councils do have the additional revenue stream of council tax, this will only dampen the cuts to a certain degree, with the Spending Review itself placing the actual decrease in funding at around 14%, still an enormously challenging figure. It would also be unwise to regard this level of social care income as 'safe', at a time when councils will be trying to divide scarce resources between competing priorities, and when councils' ability to seek additional revenue from council tax payers will be limited and could lead to variation.**

13. The Personal Social Services (PSS) Grant is being moved into the formula grant element of the Local Government budget from 2010–11, and will increase by £1 billion in real terms, reaching a total of £2.4 billion by 2014–15.<sup>7</sup> Although this £1 billion of funding is frequently described by the Government as 'additional' funding for social care, it should be considered in the context of the much decreased overall formula grant:

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2 HM Treasury, *Spending Review 2010*, Cm 7942, October 2010, p 50.

3 Ev 86

4 National Audit Office, *Briefing for the House of Commons Health Select Committee – Health Resource Allocation*, December 2010, paragraph 4.1

5 Q 321

6 HM Treasury, *Spending Review 2010*, Cm 7942, October 2010, p50

7 HM Treasury, *Spending Review 2010*, Cm 7942, October 2010, paragraph 2.15

<b>Personal Social Services Grant and Local Government Formula Grant – Changes</b>					
	2010–11 Baseline	2011–12	2012–13	2013–14	2014–15
PSS Grant <sup>1</sup>	1.3bn	1.9bn	2.3bn	2.4bn	2.4bn
Nominal Change		+ 0.6bn	+0.4bn	+0.1bn	-
Real Terms Change		+ 43%	+18%	+2%	-3%
LG Formula Grant <sup>2</sup>	28.0bn	25.0bn	23.4bn	23.2bn	21.9bn
Nominal Change		-3.0bn	-1.6bn	-0.2bn	-1.3bn
Real Terms Change		-12.4%	-8.5%	-3.4%	-8.0%

Source: Committee Office Scrutiny Unit

Notes.

Personal Services Grant is part of the Local Government Formula Grant  
Excludes ring-fenced grants and funding for Council tax freeze

14. Other than the rise in funding, the major change to grant funding for social care is that those elements that had previously been protected areas of spending have now had their ring fences removed. The Secretary of State explained to us that this was because ‘we take the view that local authorities, in the context of having to deliver unprecedented levels of efficiency, have to be given the flexibility to be able to make those decisions, to be sure that they can do it most effectively’.<sup>8</sup> This was supported by the Local Government Association.<sup>9</sup>

15. The obvious consequence of this approach is that there can be no guarantee that actual changes in spending on social care will reflect the changes in the PSS grant. Dr Peter Carter of the RCN warned that ‘the problem with not ring-fencing [...] is that it is often the budgets for people who are most vulnerable and most impoverished and are least able to fight for themselves that are raided’.<sup>10</sup> Other witnesses took a different view: Adass told us there would be “a moral imperative”<sup>11</sup> to spend on social care sums earmarked as such in the grant, while Simon Burns MP, Minister of State at the Department of Health, told a Westminster Hall debate on 11 November “there will be a determination and a positive attitude to ensure that the money is appropriately spent on what it is designed for”.<sup>12</sup>

**16. Although we welcome the Government’s identification of additional resources for social care, through the mechanism of the Personal Social Services Grant, the fact is that this funding is now part of the general local authority revenue grant which will reduce from £28 billion this year to £21.9 billion in 2014–15. Given the pressures on local authority spending overall, the majority of our witnesses expressed serious concern that changes in the PSS grant will not be reflected in changes in actual**

8 Q 321

9 Q 220 [Mr Sparks]

10 Q 297 [Dr Carter]

11 Q 217

12 HC Deb, 11 November 2010, col 186WH.

spending in social care. The decision to end ring-fencing of PSS grants means that the total level of social care spending is now at the discretion of local authorities. Even though this may be welcome in principle it has the practical effect of introducing an additional element of uncertainty into the plan for meeting demand for health and social care.

17. We urge the Government closely to monitor the relationship between the level of PSS grant and actual social care spending. In the meantime the Government must shore up the ‘positive attitude’ to spending of social care funds by clearly communicating its expectations to local government.

### The £1 billion from the NHS Budget

18. A further sum of £1 billion per annum (starting at £800 million for the first year of the Spending Review period) is also being made available from the NHS Resource budget to fund social care. The Secretary of State told us that, from this sum, £150 million in 2010–11 (rising to £300 million per year for the rest of the Parliament<sup>13</sup>) will be spent on reablement, providing services such as physiotherapy, occupational therapy and home adaptations to those returning home after a hospital stay. The remaining sum will, Mr Lansley told us, be spent on ‘a much wider range of activity done fundamentally in a preventive character’.<sup>14</sup>

19. We understand that the new Operating Framework for the NHS, due to be published shortly, will set out to PCTs and local authorities the basis on which this latter sum will be distributed.<sup>15</sup> In the meantime, we have been told that the funds will be ‘effectively ring-fenced’<sup>16</sup> and will “formally be transferred from primary care trusts to local authorities on the basis of an agreed plan as to how this is to be spent”.<sup>17</sup> Mr Lansley also told us that “there will be a line of accountability to ensure that they are spent for purposes that deliver improvements in health gain as well as social care support”.<sup>18</sup> But when asked whether the distribution would be conditional on an improved interface between departments, the Secretary of State said he would not use the term ‘conditional’.<sup>19</sup>

20. We strongly support working towards an improved interface between health and social care, and we recognise the efficiencies and improvements in the quality of care that could result from this process (see Chapter 4). The distribution of this sum for social care from the NHS revenue budget is a key opportunity to drive positive change in this interface. The Secretary of State’s description of a formal transfer of funds based on a jointly-agreed spending plan suggests an approach based on the provision of particular services in isolation. It will be an opportunity missed if this sum is not distributed with the primary aim of developing a better overall interaction between

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13 HC Deb 11 November 2010, col 184WH

14 Q 326

15 Q 327 [Mr Lansley]

16 Q 324 [Mr Douglas]

17 Q 312

18 Q 321

19 Q 312

**health and social care which could have a much wider impact on efficiency, prevention and reablement than the more limited funding of certain services. We expect that the distribution guidelines set out in the Operating Framework will grasp this opportunity.**

## Making funding meet demand

21. The social care sector is facing additional pressure from demographic changes, as an increasing proportion of the country's growing population reach an age where they are likely to need care. The generally accepted figure for this demographic pressure (agreed to by the Department of Health and the LGA) has been a 4% cost increase per year. In its memorandum the LGA told us "the reality is therefore that if local authorities cannot achieve this additional 4% then services will suffer—even before any funding cuts".<sup>20</sup>

22. The Secretary of State assured us repeatedly that the social care settlement would be enough for councils to meet social care demand without tightening their eligibility criteria. It was suggested to him that his view was that 3% compound efficiency gains by local authorities over four years, combined with the two year pay freeze, the £1 billion transfer from the NHS and the extra £1 billion from the PSS grant, would be sufficient to reconcile the pressures of supply and demand for social care.

I wouldn't disagree with that, but you say "sufficient". In my view and on the basis of the discussions we have had with local authorities on their ability to sustain current eligibility, the risk is that I agree with "sufficient". It is not sufficient to do everything; it is sufficient to sustain the position we are in. Sometimes that is difficult. There are still difficult decisions being made in local authorities about what their eligibility criteria are.<sup>21</sup>

23. In later exchanges, Mr Lansley qualified his remarks somewhat, stating that 'there is, in our view, *generally* no need for local authorities to reduce eligibility to social care'<sup>22</sup> and, 'local authorities are very much aware of the demands for their social care. They do not regard cutting eligibility for social care support as something that they will *immediately* resort to in order to fund other priorities'<sup>23</sup> (our emphasis). In addition, as Mr Lansley made clear, the fact that he considers the resources provided as adequate for maintaining current eligibility levels will not necessarily be reflected at a local level: 'we have given them the resources: I am explaining to you why I think that those resources are consistent with them not having to cut eligibility to social care, but we are not taking powers to require that or to control it'.

24. This was underlined by David Sparks of the Local Government Association:

Each individual local authority will be in a different position and because you are talking about money that largely comes from the settlement, i.e., the general pot as opposed to ring-fenced money, it will inevitably be linked to all kinds of decisions that will be made over the next couple of months in relation to individual council

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20 Ev 110

21 Q 330

22 Q 346

23 Q 345

budgets. So there is absolutely no guarantee that we can make in relation to any of your questions [about maintaining eligibility criteria]. Some local authorities might consider all of those as potential options. It depends on the circumstances of those local authorities.<sup>24</sup>

25. The King's Fund has prepared a note for the Committee setting out the potential social care funding gap following the Spending Review 2010.<sup>25</sup> The analysis is necessarily based on various assumptions, but seeks to take into account the Spending Review settlement, the increase needed to meet growing care needs, and the impact of the Government's two year pay freeze. The analysis presents the likely funding gap based on three scenarios: that between 2011–12 and 2014–15 social care spending will be fully protected by councils (i.e. a real terms cut of 0%); that there will be some protection – a real terms cut of 7%; and no protection at all, a real cut of 14% (in line with the Spending Review assumption set out in paragraph 10). The King's Fund concluded:

On the assumption of average reductions in baseline spending (not including the PSS grant) of 7% over four years [the middle scenario], by 2014–15, the funding 'gap' will be around £1.23 billion – about 8% of estimated spend in that year. Over the whole four year period, the gap is equivalent to around 2% on average per year.

[...] On the assumption that there is no real cut (that is, spending increased in line with the GDP deflator), then increasing demographic needs and rising costs are more than covered over the first three years, but leaves a shortfall of around £270 million in 2014–15. However it is unlikely that most Councils could afford to completely protect adult social care spending in this way given that it is the largest area of their controllable spending. The worst case scenario is no protection at all – with a 14% real cut in spending. On this basis, by 2014–15, the funding gap widens to around £2.2 billion – about 15% of the actual spend in that year.<sup>26</sup>

26. The analysis concludes that the Spending Review settlement (coupled with the public sector pay freeze) 'should ensure sufficient funding to more than cover assumed funding needs in 2011–12 and 2012–13. However, under an assumed 7% real cut in social care spending over the Spending Review period, in 2013–14 a gap starts to open, reaching an estimated £1.23 billion in 2014–15'.<sup>27</sup> The following graph sets out this analysis:

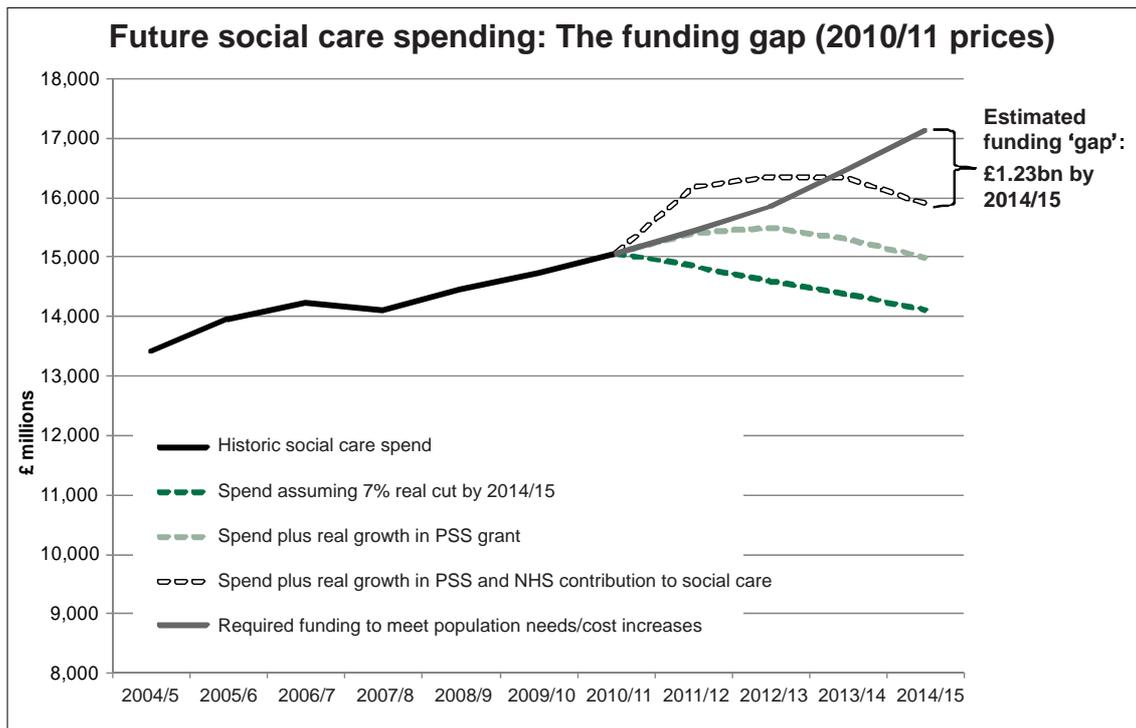
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24 Q 197

25 Ev 131

26 Ev 131–132

27 Ev 133



27. Any potential funding gap will obviously vary at local authority level, as will the options for addressing it. The main option, if, as stated by the Secretary of State, eligibility criteria are to remain unaffected, would be to use resources more productively to produce efficiency savings to cover the gap. The King's Fund analysis states 'efficiency savings of around 2% a year for the period of the Spending Review would be enough to close the estimated funding gap under the 7% scenario. If the baseline scenario is closer to a real cut of 14% however, then efficiency gains of around 3.5% per year would be required'.<sup>28</sup>

28. The question is whether local authorities are capable of producing genuine efficiency savings at these levels. Local authorities have a track record which demonstrates their ability to deliver cash releasing efficiency savings of between 2 and 3% each year,<sup>29</sup> and the LGA argued that it would be 'reasonable' for adult social care departments to offer 3% cash releasing efficiency savings per year, but noted that 'to do this councils would need to squeeze every last potential pound [...] and pursue other ideas ruthlessly'.<sup>30</sup> Adass noted that the Local Government submission on adult social care to the Spending Review had warned that cash releasing savings of 3% per annum were possible but challenging, and that this would 'include genuine efficiencies but to get to 3% would also have to include measures such as raising the level of income collected from charges and in some cases eligibility criteria'.<sup>31</sup> In supplementary evidence, Richard Douglas, Director-General, Policy, Strategy and Finance at the Department of Health, made clear that the Government's assumptions include increases in charges in line with inflation.<sup>32</sup>

28 Ev 133

29 Ev 125

30 Ev 111

31 Ev 126

32 Ev 127

29. We note that the Government's evidence quotes Adass figures for 2009–10 which demonstrate efficiency gains limited to 2.5%. Furthermore, the Government notes that 'this figure should be treated with some caution, as it includes savings from service reduction and income generation. If only value for money savings are considered, the efficiency rate falls to 1.8%'.<sup>33</sup> Against the background of the requirement for an efficiency gain of between 2% and 3.5%, this evidence calls into question the Secretary of State's assertion that the necessary efficiency gains could be made without restrictions on eligibility criteria. Indeed, the Secretary of State noted that this state could only be achieved with 'unprecedented' efficiency gains in social care.<sup>34</sup>

30. The Secretary of State argued that the NHS would be able to make its own unprecedented efficiency savings because it was starting from 'a relatively high platform of resources' and a period of declining productivity. He said 'you have a more realistic prospect of delivering greater productivity in the years ahead than if you started with a relatively low level of spend when you had been increasing productivity'.<sup>35</sup> Unfortunately the position which the Secretary of State describes in the NHS does not prevail in the social care sector. Although overall gross expenditure on adult PSS rose in real terms by 57.4% between 1997–98 and 2007–08, this is in contrast to spending on the NHS, which doubled in the same period.<sup>36</sup> At the same time, the social care sector has already tackled much of the low-hanging fruit in reaching its earlier, substantial, efficiency gains.<sup>37</sup>

31. The ability to make this level of efficiency gain will also vary significantly across different councils. Andrew Cozens of the LGA noted that some local authorities would have more scope to make savings than others, depending on the current structure of their social care systems. In particular, he said that 'the quantum [of efficiency savings] is achievable but it is not spread evenly across the country'.<sup>38</sup>

**32. The evidence submitted to us, including the evidence submitted by the Government itself, does not allow us to conclude that the Spending Review settlement, coupled with the pay freeze, is enough to allow councils to 'sustain' care levels without restricting eligibility criteria. Our analysis shows that, depending on spending decisions by individual councils, the social care sector will need to deliver efficiency gains of up to 3.5% per annum throughout the Spending Review period to avoid reducing their levels of care. We intend to monitor the delivery of these key objectives on a regular basis throughout the Parliament.**

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33 Ev 88

34 Q 318

35 Q 389

36 Health Committee, *Public Expenditure on Health and Personal Social Services 2009*, HC (2009–10) 269-i, Table 34b.

37 Ev 110

38 Q 198

## 4 Interface between health and social care

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33. Improving the interface between health and social care will be essential if the unprecedented savings in both sectors are to be achieved. Adass noted that there was plenty of potential for improving the interaction between these services:

[most people] want seamless services which ignore organisational boundaries. There are some excellent examples of integrated working between health and social care but they are, in general, exceptions other than the rule. They also tend to focus on specific areas of spending such as adults with learning disabilities or with mental health problems. Most of the £120 billion spent on health and social care is spent on older people with long term problems and/or complex problems. Very little of this is spent in an integrated way. This means that public resources are at times wasted or spent unnecessarily.<sup>39</sup>

34. The potential was clearly recognised in the Government's evidence<sup>40</sup> and by the Secretary of State:

It is very clear, when we look at where efficiency, quality and productivity can be best improved, that the interface between health and social care has for a long time been one of the areas that is most susceptible of improvement. The resources that we are making available through the spending review – even this year we have found £70 million in savings to support reablement – are specifically directed at delivering those gains in efficiency.<sup>41</sup>

**35. Improving the interaction between health and social care will be very important if the necessary cost savings on both sides are to be realised. The potential to make savings in this area has long been acknowledged, but has not yet been properly realised. We believe that it is mission-critical to successful delivery of the Nicholson Challenge to achieve a quantum leap in the efficiency of this interface.**

36. Although the Secretary of State rightly recognised that movement in this area has been slow, the NAO has found examples of improvement in recent years:

In our discussions with a number of PCTs and local authorities, they reported that integrated working and joint commissioning had increased in the last few years and provided a number of examples of how effective joint working was being facilitated:

they have reciprocal places on each other's committees;

representatives from the PCT may meet as a board with the council's cabinet in order to facilitate better joint working;

many Directors of Public Health are joint posts;

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39 Ev 125–126.

40 Ev 88

41 Q 311

their finance departments meet regularly, usually around once per quarter;

they shared targets e.g. NHS vital signs indicators; and

their Chief Executives meet regularly.<sup>42</sup>

37. The LGA and Adass agreed that the relationship between health and social care was improving, and that discussions on improving the interface were gradually becoming more positive, although they noted that this was often dependent on individual relationships and that negotiations were often set back when key individuals moved on or left the service.<sup>43</sup>

38. The NAO found that particular complications to improving the interface further included the ‘grey areas’ that result when it is not clear which organisation should be responsible for a particular item of expenditure, and instances when the cost is incurred in one organisation and the benefit realised in the other.<sup>44</sup> The LGA also flagged up the complexity of the interplay between the two systems (especially with tightening resources and charges in the social care sector meeting the ‘free at the point of use’ NHS).<sup>45</sup>

39. The King’s Fund noted that NHS reorganisation could have a negative effect on the interface, as ‘the abolition of PCTs and consequent loss of co-terminosity with local authorities is likely to undermine progress made in building relationships at the local level. Nevertheless, the creation of local health and wellbeing boards [proposed by the White Paper]– which will require a different approach driven less by top-down direction and more by locally determined solutions – could create an opportunity to improve on the current situation’.<sup>46</sup> This links into concerns about the abolition of Local Area Agreements, which the NAO had found to be one of the biggest factors in facilitating partnership working between the NHS and local government in tackling health inequalities.<sup>47</sup>

40. Although many witnesses have stressed the benefits to both sides that may come from improving these relations, it was striking that most examples we heard involved additional spend on the social care side to realise cost savings on the healthcare side. In general, this involved preventing unnecessary admissions to hospital and allowing earlier discharge from hospital. As Nigel Edwards of the NHS Confederation noted: ‘the most cost-effective way, often, of preventing that admission and moving patients on are well-designed packages of social care’.<sup>48</sup> This was supported by Sir David Nicholson, who told us ‘at the end of the day, the people that social care are providing services to are the very people we have in our hospital beds. So I have encouraged the NHS to look very carefully at social

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42 National Audit Office, *Briefing for the House of Commons Health Select Committee – Health Resource Allocation*, December 2010, paragraph 5.3

43 Q 223 [Mr Cozens]

44 National Audit Office, *Briefing for the House of Commons Health Select Committee – Health Resource Allocation*, December 2010, paragraphs 5.4 and 5.5.

45 Q 194 [Mr Cozens]

46 Ev 107

47 National Audit Office, *Tackling Health Inequalities in life expectancy in areas with the worst health and deprivation*, HC 186, Session 2010–11, July 2010.

48 Q 170

care, to think jointly between health and social care, about how they might use that resource and not to revert behind their boundaries'.<sup>49</sup>

41. The Department of Health has stated that improved care of patients with long-term chronic conditions could save up to £2.7 billion, for example by avoiding unnecessary emergency hospital admissions.<sup>50</sup> The NAO has also said that 'economic modelling for our reports on dementia and end of life care found that there was scope to reduce the number of hospital admissions and length of stay; for example, we identified that around 40% of beds were occupied by elderly people who no longer had a clinical need to be there'.<sup>51</sup>

42. Sarah Pickup of Adass told us that the situation had certainly been problematic in the past, but there were signs it was improving:

I think that, for a long time, there has been a lot of measurement in local government about how well we work with the Health Service and there hasn't been, in a sense, equal measure in the NHS about how well they work in partnership with adult care because the ways the systems work and the priorities and the indicators are different. But I think we are hearing a different language coming out of the Department of Health in terms of the NHS and the partnership working and that £1 billion shift of resources is part of that language. If we talk to colleagues now in Strategic Health Authorities and in the Department of Health and in PCTs, I feel there is a more genuine intent to move forward with some of the partnership things that perhaps have been a bit not quite the top of the list of priorities before. If you look at the QIPP processes, the Quality, Improvement, Productivity and Prevention processes, that Health are going through to achieve their efficiencies, they are increasingly featuring those interface services because we recognise that we will all benefit and they are being measured on the extent to which those overlap into adult social care.<sup>52</sup>

**43. We strongly support the objectives of improved partnership between health and social care but doubt whether the current institutional or policy structures are fit for the purpose of achieving them. The examples which are quoted often involve demonstrating how better developed social care services will relieve the burden on the healthcare system as well as improving outcomes and experience for patients. There is ample evidence to support these objectives, but delivery involves more than cooperation and improved discharge procedures. It requires a serious commitment to plan and deliver coherent delivery systems ('pathways of care') which are complicated by institutional differences.**

**44. The allocation of £1 billion to social care through the NHS budget is a step in the right direction in that it formally recognises the interaction between health and social care, but we are concerned that it may be too tightly focused to bring about a genuine wider improvement in the interface between the two services. In general, there is a risk of the 'better interface' becoming a by-word for the health service seeking to achieve its**

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49 Q 98

50 Department of Health, *NHS 2010–2015 From Good to Great. Preventative, people-centred, productive*. Cm 7775, December 2009, p10

51 National Audit Office, *The NAO's work on the Department of Health*, June 2010, p9.

52 Q 223 [Ms Pickup]

own efficiencies by asking social care to take on more. The Government must do more to bring about improved relations and interaction more generally between the two sectors, as this could ultimately contribute to broader cooperation, more imaginative efficiencies, and more significant savings on both sides. It is not enough for the Government to exhort change in this area: there must be a formal policy infrastructure that recognises the importance of achieving this.

## 5 Healthcare

### The Spending Review settlement for healthcare

45. The Department of Health was one of only two departments (the other being the Department for International Development) for which the Government had pledged to protect funding. In the Spending Review the Department was allocated an increase in its Resource budget, with cumulative growth reaching 1.3% in real terms by 2014–15 on the assumptions used in the Spending Review. The Administration budget (i.e. the Department's 'back office' costs) within the Resource budget falls in real terms by 33% by 2014–15. This is in line with the average decrease across departments of 34%. At the same time, the Department of Health Capital budget will fall by 17% in real terms by 2014–15 (compared with an average decrease across departments of 29%) on the assumptions used in the Spending Review.

46. As we have seen, the Spending Review also committed the NHS to set aside funding within the Resource budget, growing to £1 billion by 2014–15, to fund social care (including a specific allocation for reablement services).

**47. The Department of Health takes up a significant portion of the Government's total funding across departments: by 2014–15 the Department of Health will account for 33% of the total Resource budget and 11% of the total capital budget. The ability of the NHS to operate within its settlement is therefore vital to the achievement of the Government's spending plans.**

48. There has been some political debate regarding the Government's description of the Spending Review settlement as a real-terms increase. The fact of the matter is that the question of whether or not the settlement fulfilled this description depends on which particular parts of the settlement are included in the calculation. The 1.3% real terms increase in the Resource budget (on the assumptions used in the Spending Review) is consistent with the Coalition Government's commitment on health spending. However, this cumulative real terms growth for the NHS is significantly reduced if the additional £1 billion NHS funding for social care (which will be formally transferred to local authorities on the basis of an agreement with the NHS, rather than spent directly by the NHS itself) is separated out, as demonstrated by the following table:

<b>Additional Funding for Social Care in NHS Resource Budget (£ billion)</b>						
	<b>2010–11 (baseline)</b>	<b>2011–12</b>	<b>2012–13</b>	<b>2013–14</b>	<b>2014–15</b>	<b>Cumulative Real Growth %</b>
Additional Funds in NHS Resource budget for social care	-	0.8bn	0.9bn	1.1bn	1.0bn	
Remaining Resource budget	98.7	100.7	103.1	105.8	108.8	+ 0.4

Source: Committee Office Scrutiny Unit.

49. The discussion of whether or not the settlement could be considered a ‘real terms’ increase is also affected by whether one considers the Resource budget in isolation (as above) or the total budget (resource plus capital). The total budget (resource plus capital) increased only marginally in real terms if the additional social care funding is included, and actually was expected to fall by 0.54% in real terms by the end of the Spending Review period if this funding is excluded. The Government has confirmed that the additional social care funding is essentially a transfer from the NHS capital budget.<sup>53</sup>

50. This debate has now been overtaken by events. Since the Spending Review, the Office for Budget Responsibility (OBR) has revised its earlier forecasts for the GDP deflator.<sup>54</sup> This is the general measure of inflation used by the Treasury to calculate inflation-adjusted or real figures, and in particular, is the measure used in the Spending Review to calculate NHS funding in real terms. For three of the four years of the spending review the OBR has now revised its GDP deflator forecasts upwards. The cumulative GDP deflator from 2011–12 to 2014–15 is now forecast to be around 0.65% higher (10.49% instead of 9.84%) than the estimate used in the Spending Review. As the cash rise in the total NHS settlement announced by the spending review was 10.21% by 2014–15, the real terms increase of 0.34% over four years is now forecast to be a real cut of around 0.25% - equivalent to an average annual real cut of 0.062%. Compared with this year, this translates into a real cut of around £0.25 billion by 2014–15.

51. The marginal nature of the real terms increase in spending on health meant that the Government’s commitment would be vulnerable to small shifts in inflation. When questioned on this issue in the House on 7 December, the Secretary of State said:

“At the Spending Review we set out what met our commitment. I am very clear that...revenue funding for the NHS will increase in real terms...The gross domestic product deflator will move from time to time, but the commitment that we set out was clear and will continue”.<sup>55</sup>

As it stands, however, **the Government’s commitment to a real terms increase in health funding throughout the Spending Review period will not be met. This emphasises the fact that the settlement, although generous when compared to other departments, represents a substantial challenge to the NHS.**

## The ‘Nicholson Challenge’

### *Background to the Nicholson Challenge*

52. Over the past 39 years the NHS has received combined capital and revenue funding of an average of 3.9% per annum above inflation,<sup>56</sup> which has allowed it to keep pace with long-term pressures from demography, medical advances and rising patient expectations. The NHS is now in a position where it will need to make substantial efficiency gains to

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53 HC Deb, 11 November 2010, col184WH

54 Office of Budget Responsibility: *Economic and Fiscal Outlook*, Cm 7979, 29 November 2010

55 HC Deb, 7 December 2010, col 163.

56 Ev 82

allow it to continue to meet the demands made of it. Indeed, several witnesses have noted that various aspects of NHS inflation more or less cancel out any increase in funding received under the Spending Review.<sup>57</sup>

53. This state of affairs has not come as a surprise to the NHS, and it was anticipated by Sir David Nicholson, the Chief Executive, through the establishment of the QIPP (Quality, Innovation, Productivity and Prevention) programme, designed to deliver efficiency savings of £15–20 billion between 2011 and 2014. This ‘Nicholson Challenge’ was first set out in the NHS Annual Report for 2008–09,<sup>58</sup> well before the change of government and the Spending Review. The challenge reflects independent analysis, such as the 2009 report by the King’s Fund and the Institute for Fiscal Studies that also suggested the NHS would need to sustain large annual productivity increases in order to maintain the quality of its services against a background in which it was recognised that health spending was bound to rise more slowly in the immediate future than it had done over the previous decade.<sup>59</sup>

54. The public sector pay freeze for the first two years of the period will contribute to the required efficiency gains. The Committee is mindful that the achievement of the Nicholson Challenge will depend on the efforts of NHS staff whose pay is being frozen.

55. The scale of the challenge is immense. Sir David told us “It is huge. You don’t need me to tell you that it has never been done before in the NHS context and we don’t think, when you look at health systems across the world, that anyone has quite done it on this scale before”.<sup>60</sup>

56. In considering the financial constraints facing the health service it is important to remember that this efficiency challenge predates both the White Paper reorganisation and the specific Spending Review settlement: but these subsequent developments provide a new context within which the challenge must be delivered.

### **Making the savings happen**

57. Although the NHS has received a significant increase in resources over the last decade or so, this has been put to use in expanding services (‘using more to do more’) rather than focusing on making efficiency gains (‘doing more with the same’). We recognise that the current efficiency challenge is not about *cutting* £15–20 billion from the NHS budget, nor should it lead to a reduction of £15–20 billion of services. Instead the NHS must derive £15–20 billion more value from its budget, in order to meet rising demand and improve the quality of services without a corresponding increase in funding.

58. The importance of viewing the challenge in this way was stressed by the King’s Fund in its July 2010 paper ‘Improving NHS Productivity’:

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57 King’s Fund response to the Spending Review, 20 October 2010, [http://www.kingsfund.org.uk/press/press\\_releases/the\\_kings\\_fund\\_25.html](http://www.kingsfund.org.uk/press/press_releases/the_kings_fund_25.html); Ev 119 (NHS Confederation); Ev 112–113 (British Medical Association); Nuffield Trust briefing, *NHS resources and reform: Response to the White Paper Equity and Excellence: Liberating the NHS, and the 2010 Spending Review*. October 2010, p9.

58 NHS, *NHS Chief Executive’s Annual Report for 2008–09*, May 2009, p47.

59 The King’s Fund and Institute for Fiscal Studies, *How cold will it be? Prospects for NHS Funding: 2011–17*, July 2009.

60 Q 22 [Sir David Nicholson]

As the NHS grapples with significantly smaller increases in funding from 2011, there is a danger that the necessary focus on improving productivity becomes, at best, an end in itself and, at worst, a misunderstanding that the NHS needs to dramatically cut budgets, reduce services for patients, and sack staff. The NHS will need to carefully select the strategies which, together, produce *more value* from the same or similar resource – *not* the same for less.<sup>61</sup>

59. On a general level, witnesses have told us that efforts to meet the spending challenge in a coherent way are being complicated by the lack of a clear ‘narrative’ from central government. Dr Hamish Meldrum of the BMA told us:

I think we really need to see a much better narrative than we have up till now: not only what is the rationale for actually making it that amount but actually where are these moneys going to be reinvested, what jobs are going to be needed in order to do that and, therefore, both locally and nationally, having much greater detail about the whole flow of funds and resources over the next four years.<sup>62</sup>

This was supported by Dr Peter Carter of the RCN, who told the Committee:

the current worry is that the service redesign at the moment is done on the back of needing to save money rather than the back of a good, properly thought through strategic plan which is taking a local health service forward.<sup>63</sup>

**60. The efficiency challenge for the NHS is not about cuts. It is about doing more with the same amount of money. The Government needs to ensure this fact is more clearly communicated both by the NHS itself and to the wider community.**

61. The scale of the challenge is enormous. The NHS does not have a good recent record on improving productivity. While it is widely accepted that measuring productivity is problematic and that an entirely satisfactory method has yet to be devised, ONS figures show that between 1997 and 2007, measured NHS productivity was flat or declining over the whole period,<sup>64</sup> whereas private sector productivity improvement averaged 2% per year. The Secretary of State told us that this low productivity, coupled with the ‘relatively high platform of resources’ that the NHS had been given over previous years, actually indicated that there was plenty of scope for productivity improvements.<sup>65</sup> This is true, provided that the correct mechanism can be found to turn this potential into results.

**62. There is an urgent need for a credible plan to deliver the efficiency gain which is the central requirement of the Spending Review settlement for the NHS. Many witnesses have drawn attention to the need for this plan and have expressed concern that it is not yet available. We share this concern.**

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61 The King’s Fund. *Improving NHS Productivity – more with the same, not more of the same*, July 2010, p2.

62 Q 237

63 Q 250

64 Office for National Statistics (2010). *Public Service Output, Inputs and Productivity: Healthcare*, p1. [www.statistics.gov.uk/articles/nojournall/healthcare-productivity-2010.pdf](http://www.statistics.gov.uk/articles/nojournall/healthcare-productivity-2010.pdf)

65 Q 389

63. In his 2002 review of future funding of the NHS, Sir Derek Wanless set out three funding scenarios depending on progress made in relation to future demand, supply and costs of healthcare. A study by the King's Fund in 2007 concluded that the NHS was progressing in line with the middle scenario ('solid progress') but that in the period up to 2013–14, there was likely to be a shortfall in funding of just under £21 billion. £9 billion of the shortfall was made up from factors such as real pay and prices, and capital investment, while £12 billion of the gap in funding related to the need to effect actual improvements in the quality of care, resulting from changes in the way care was delivered.<sup>66</sup>

64. This message of quality is one that we are also hearing from the Department of Health. The Secretary of State told us that the QIPP programme was "deliberately designed around the proposition that we are going to increase quality and deliver greater efficiency by the use of innovation and prevention to deliver an overall rise in quality and productivity. Productivity only captures a sense of doing the same thing with fewer inputs. We're looking not only to carry on doing the same thing, but to increase the quality of what we do by changing the design of what we do".<sup>67</sup> Sir David Nicholson assured us that it was 'perfectly possible to improve quality and increase productivity simultaneously'.<sup>68</sup> The White Paper stated that the QIPP programme would 'continue with even greater urgency, but with a stronger focus on general practice leadership. The QIPP initiative is identifying how efficiencies can be driven and services redesigned to achieve the twin aims of improved quality and efficiency'.<sup>69</sup> Edward Macalister-Smith, Chief Executive of Buckinghamshire Primary Care Trust, told us that 'it is possible to close that gap, and it is possible to do it while maintaining quality and improving patient experience. But it needs to be very, very determined and it is going to involve really quite radical changes to the behaviour and the operations of all parts of the system'.<sup>70</sup>

65. The demand pressures will mount steadily over time. It is for this reason that it is vital for the Government to ensure that the savings programme also gets results on a consistent basis across the Spending Review period, rather than focusing solely on the end point of making £20 billion worth of savings by 2014. The Department assured us that they were planning on this basis.<sup>71</sup>

66. Efficiency gains of this kind are difficult to measure. Sir David Nicholson told us that savings deriving from the tariff changes would be subject to a matrix and milestones to be published in December, with monitoring against these standards published in *The Quarter* for each quarter of the savings programme. We were told that each individual NHS organisation would also have, by March, an efficiency plan based on the expectations set centrally.

**67. The QIPP programme is the tool available to healthcare to make efficiencies, and represents a good starting point. However, the scale of the challenge is so immense that**

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66 The King's Fund, July 2010, *Improving NHS Productivity – More with the same not more of the same*, p9.

67 Q 392

68 Q 15

69 Department of Health, *Equity and excellence: Liberating the NHS*, Cm 7881, July 2010, p47.

70 Q 137 [Mr Macalister-Smith]

71 Q 398 [Mr Douglas, Sir David Nicholson]

**QIPP will need to demonstrate clear savings early in order to provide the savings programme with the momentum to proceed at a steady pace towards the £15–20 billion goal. Close monitoring and consistent reporting of performance against publicly available norms will be essential if these gains are to be seen as real improvements rather than accounting changes.**

68. Sir David Nicholson gave us the following assessment of how the savings would be made:

If you look at those savings, about 40% of them will come from essentially a mixture of things which are much more under our central control. So, for example, the pay savings, the management costs savings, the administrative cost savings, the savings on central budgets of the Department—all of those things—come to about 40% of the total savings. That is reported out and we can look at that. The second group of savings—about 20%—come from service change. So that is the thing I talked about; the movement from secondary to primary care and that sort of thing. The third lot is about 40%, which is the savings you get through the tariff in the acute sector, so driving efficiency in hospitals.<sup>72</sup>

69. The Secretary of State stressed the particular importance being placed on the reduction in management and administration costs: ‘by 2014–15, the one third real-terms reduction in administration costs across the NHS will yield a reduction in total administration costs of £1.9 billion. That is effectively one tenth of the maximum efficiency savings we are looking for’.<sup>73</sup> Nigel Edwards of the NHS Confederation cautioned that only a small proportion of savings could actually be made from administrative, management and ‘back office’ savings: “most of the money is spent on clinical care. If you want to reduce your spending, make your spending more efficient, that is, I am afraid, where you have to concentrate”.<sup>74</sup>

70. The Secretary of State is also placing significant weight on the tariff.<sup>75</sup> The tariff is already being used to generate 3.5% efficiency gains in the NHS in 2010–11.<sup>76</sup> If the tariff is to drive 40% of the £15–20 billion efficiency gains required by the Nicholson Challenge then this equates to £2 billion of savings in the acute hospital sector per year. This is roughly equivalent to 5.5% of the PCT allocation spent on general and acute secondary care, and potentially even more for some services, since not all acute sector services are covered by the tariff.<sup>77</sup> Edward Macalister-Smith told us that in his area he expected the majority of savings to be made from provider efficiency resulting from a squeeze of the

72 Q 399

73 Q 356

74 Q 146 [Mr Edwards]

75 The calculated price for a unit of healthcare activity, under the Payment by Results scheme, as paid by PCT Commissioners to treatment providers (i.e. acute hospitals). Services such as mental health and community care are currently excluded from the tariff.

76 Q 79. Unlike in previous years, in 2010–11 there was no uplift in tariff prices and a 3.5% efficiency requirement was imposed to cover pay and price inflation.

77 In 2010–11 the PCT announced opening allocation was set at £80bn [National Audit Office, *Briefing for the House of Commons Health Select Committee – Health Resource Allocation*, December 2010, p8]. 44.8% of primary care trust expenditure was spent on general and acute secondary care [ibid, p17], which would be equivalent to £35.8bn of that £80bn.

tariff: “it has got to make that productivity gain in the acute hospital and that is going to be tough”.<sup>78</sup> The NHS Confederation also raised concerns about the pressures on acute trusts.<sup>79</sup> The Secretary of State insisted that achieving 40% of savings through the tariff would not be simply about squeezing costs rather than improving quality and efficiency: “the tariff is driving best practice and efficiency. We are going to develop the tariff to do these things and it will be a powerful instrument to make it happen”.<sup>80</sup> But reducing the tariff does not, in itself, produce efficiency gains, although it does put hospitals under more pressure to reduce costs. It may be that hospitals meet the squeeze on tariffs by ceasing to provide services, or by subsidising unprofitable lines with profitable ones, without actually improving efficiency.

**71. We are concerned that 40% of the necessary efficiency improvements are to be derived from tightening the tariff. There is no guarantee that reductions in the tariff will always result in genuine efficiency gains, and there is a risk that the quality of services could suffer if changes are driven by reductions in the cost of the tariff alone. There should not just be across the board cuts in the tariff. It needs to be revised to remove perverse incentives and encourage best practice.**

### **NHS reorganisation**

72. The efficiency challenge is inescapably tied up with the restructuring of the NHS, as set out in the Government’s White Paper, *Equity and Excellence: Liberating the NHS* (July 2010). Described in the foreword as a ‘bold vision’, the major reforms set out in the paper include the devolution of commissioning from PCTs to GP consortia, the establishment of an independent NHS Commissioning Board, the conversion of all NHS Trusts to foundation trust status, a significant reduction in the number of NHS bodies, and a radical streamlining of the Department’s own NHS functions. We are conducting a separate inquiry into the most significant of these changes, the transition to commissioning by GP consortia, and this Report is not an analysis of the White Paper proposals. The transition to the new structure coincides more or less exactly with the Spending Review period and will frame the spending plans for the NHS.

73. Presenting the White Paper to the House, the Secretary of State said ‘I recognise that the scale of today’s reforms is challenging, but they are designed to build on the best of what the NHS is already doing’.<sup>81</sup> In evidence to us on 20 July 2010 Mr Lansley stressed that, for the majority of clinicians in the NHS the restructuring was ‘not an upheaval, it is an empowerment’.<sup>82</sup> He continued this theme when appearing before us for the current inquiry on 23 November: ‘what I am proposing is an evolution. I have never called it a revolution’.<sup>83</sup>

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78 Q 138

79 Ev 120

80 Q 389

81 HC Deb, 12 July 2010, col 663.

82 Oral evidence taken before the Health Committee on 20 July 2010, HC (2009–10) 380, Q 1

83 Q 359

74. Witnesses to the inquiry have described the reforms in more drastic terms. Sir David Nicholson, Chief Executive of the National Health Service, told us that ‘the scale of the change is enormous—beyond anything that anybody from the public or private sector has witnessed, really’.<sup>84</sup> John Appleby, Chief Economist at the King’s Fund, told the Treasury Committee on 1 November ‘This is not about tinkering around the edges [...] It is about some radical alterations in the structure and fabric of health care—closing hospitals and centralising some services, which are some of the big things that the NHS has found difficult to do over its history’.<sup>85</sup>

75. The Secretary of State told the Committee that the White Paper reforms feed into the efficiency challenge by ensuring ‘that those who are responsible for making clinical decisions do so alongside the resource consequences’ and by promoting the better integration of services between community and hospitals.<sup>86</sup> We have also heard from Sir David Nicholson that the dual challenges of efficiency savings and service reorganisation needed to be ‘not parallel but mutually reinforcing’.<sup>87</sup> We agree that this is necessary, but we have heard numerous warnings of the risks involved in combining the tight spending envelope and the need for unprecedented efficiency savings with the large-scale reorganisation of NHS structures. The Department of Health’s own analytical strategy document for the White Paper acknowledges these risks:

There are clear risks associated with the transition period. For example, SHAs and PCTs will cease to exist, but there will be a reliance on them in the short-term around both managing the transition period and delivering ongoing efficiency savings, such as those associated with the QIPP programme.<sup>88</sup>

76. The Nuffield Trust, in their recent briefing on the White Paper and Spending Review, set out the risks of trying to combine the reorganisation with the need for efficiency savings:

Even if well managed, widespread organisation reform can mean services stand still for a period rather than progress. If managed poorly, services and finances may suffer. There is clear evidence that organisations distracted by reform can experience major financial and service failure. Failure can take several forms; these include a lack of control of expenditure, rushed service changes, or more fundamentally, a decline in the quality of care. This is the more worrying because quality is less readily measurable than finance, and in the current financial climate there will be much attention to the bottom line.<sup>89</sup>

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84 Q 34

85 Oral evidence taken before the Treasury Committee on 1 November 2010, HC (2010–11) 544-II , Q232

86 Q 349.

87 Uncorrected transcript of oral evidence taken before the Health Committee on 19 October 2010, HC (2010–11) 513-i, Q 92

88 Department of Health, *Equity and Excellence – Liberating the NHS: Analytical Strategy for the White Paper and associated documents*, p14. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117351.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117351.pdf)

89 The Nuffield Trust briefing, *NHS resources and reform: Response to the White Paper Equity and Excellence: Liberating the NHS, and the 2010 Spending Review*. October 2010, p3

77. Dr Peter Carter of the RCN highlighted that these concerns are also shared by staff on the ground:

This is a heck of a challenge. The £15 billion to £20 billion on its own [...] is absolutely massive, has never been done before, and that on its own would be a major challenge. The White Paper on its own would be a major challenge. Put the two things together and this is as big and as complex as you could get.<sup>90</sup>

78. In particular, the reorganisation is going hand in hand with the White Paper commitment to reduce NHS management costs by more than 45% over the next four years, with the aim of freeing up further resources for front-line care. The White Paper stated that:

[...] as a result of the record debt, the NHS will employ fewer staff at the end of this Parliament; although rebalanced towards clinical staffing and front-line support rather than excessive administration. This is a hard truth which any government would have to recognise.<sup>91</sup>

79. The reduction in management pre-empts the reorganisation, but it raises questions about the delivery of both the reorganisation and the Nicholson Challenge. We know the direct costs of the management reductions (we were told that it would cost up to £900 million in redundancy costs, but that it could 'save £880 million, recurrently'<sup>92</sup>), but there will be wider implications for the control of the restructuring and, in particular, the ability of the system to sustain a focus on the delivery of healthcare during a time of such upheaval. Professor Chris Ham told us:

[...] there are always risks associated with a big reorganisation change of this kind because for a couple of years at least the people involved in that reorganisation are distracted from the core business. While they are reorganising the structures, the focus on improving care for patients and getting better efficiency will often take, sadly, second place.<sup>93</sup>

80. The King's Fund has stressed the important role that managers had to play in delivering both efficiency savings and a successful reorganisation:

Leadership time and capability need to be dedicated to furthering the QIPP agenda and ensuring effective implementation, while also taking forward the radical changes to the organisation of the NHS that are in the pipeline. This will not be easy at a time when substantial cuts are being made to management costs. It is vital that the contribution of managers and leaders of local systems is recognised alongside the drive to empower frontline clinical tariffs.<sup>94</sup>

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90 Q 243 [Dr Carter]

91 Department of Health, *Equity and excellence: Liberating the NHS*, Cm 7881, July 2010, p11.

92 Q 44 [Sir David Nicholson]

93 Uncorrected transcript of oral evidence taken before the Health Committee on 16 November 2010, HC (2010–11) 513-ii, Q 246.

94 The King's Fund, *Improving NHS Productivity – more with the same not more of the same*, July 2010, p27.

81. Nigel Edwards of the NHS Confederation told us ‘some of the managerial control systems and other more standard techniques that we have relied on in the past to get financial balance may work less effectively, because of the changes that are happening’.<sup>95</sup>

82. Sir David Nicholson assured us in Committee that he was aware of these risks and would be taking appropriate action, recognising that although the reorganisation was unusually ‘bottom-up’ and ‘fluid’, there was a need for ‘more stakes in the ground’.<sup>96</sup> Specifically, he told us that:

there is no doubt in my mind that in some ways we are going to have to centralise more power in the very short term to deliver the benefits in the medium and long-term [...] we will have to take a very tight rein in relation to the management of finance.<sup>97</sup>

This tight control would be supported by the new Operating Framework in December and the preparation over the next few months of detailed plans for individual organisations.

**We welcome Sir David’s recognition of the need for close financial oversight during this transition period. We believe there must be more detail in the Operating Framework and over the coming months on the exact nature of these controls and, in particular, how they will address the transitional arrangements from PCTs to commissioning consortia.**

83. It is important to recognise that these changes are already happening and that the absence of a clear plan risks undermining both a logical approach to the savings programme and the opportunity to use this process to develop higher quality services for patients. The new Operating Framework needs to provide this narrative.

84. We have already discussed the importance of selling the challenge as making efficiency gains rather than simply ‘cuts’. Unfortunately we are increasingly hearing examples that fall into the latter category. At the time of writing, increasing numbers of news stories were appearing in the media about PCTs struggling to meet costs and services being rationed. Pulse reported on 23 November that many PCTs were ‘warning their plans rely on huge cuts and ‘spending all contingency funds’<sup>98</sup>; the Yorkshire Post has reported that North Yorkshire PCT will be ceasing to offer IVF treatment to new patients, stopping minor surgery at GP clinics, and delaying non-urgent hospital treatment<sup>99</sup>; while the local press in Kent is reporting that the Eastern and Coastal Kent PCT has ordered GPs to delay referring to hospitals ‘low-priority’ treatments (such as hip and knee replacements and some cases of cataract surgery) in an effort to ease pressure on beds and cut overspending.<sup>100</sup> In terms of

95 Q 144 [Mr Edwards]

96 Q 373 [Sir David Nicholson]

97 Q 371 [Sir David Nicholson]

98 Pulse website, 10 November 2010, *GPs face debt crisis as PCTs fall £300m into the red*, <http://www.pulsetoday.co.uk/story.asp?storycode=4127669>

99 Yorkshire Post, 22 October 2010, *Services axed as care trust battles huge debt*. <http://www.yorkshirepost.co.uk/news/Exclusive-Services-axed-as-care.6594054.jp>

100 This is Kent, 12 November 2010, *Health chiefs block non-urgent operations in bid to save money and keep beds free*. <http://www.thisiskent.co.uk/news/Hospitals-block-non-urgent-ops/article-2877584-detail/article.html>

job losses, the RCN has already identified almost 18,000 NHS posts at risk in England,<sup>101</sup> while UNISON noted “already there are reports coming through of hundreds of jobs being threatened across the country”.<sup>102</sup>

85. The BMA told the Committee: ‘We are already seeing that, in some places, the challenge is not being addressed in a terribly evidence-based or logical way, in that you are relying on happenstance of people retiring or leaving the service to try and make savings. What you will need, if you are going to try to achieve the sort of savings that are talking about, is a fairly massive reconfiguration of the way services are delivered’.<sup>103</sup>

86. Dr Carter argued that the process was being handled in a way that could serve to complicate the problem: ‘Our fear is that what we are going to see is a squeeze on the acute hospitals without the reinvestment in the community infrastructure, which is going to make a difficult situation even worse’.<sup>104</sup>

87. Although the Secretary of State rejected the suggestion that PCTs were in meltdown,<sup>105</sup> it is evident that the impending reorganisation is already affecting the functioning of certain PCTs. Sir David Nicholson acknowledged that it was ‘a big challenge’ to deliver the efficiency programme in such a context, especially away from the pathfinder consortium<sup>106</sup> sites:

If you were to ask me whether I think we can sustain 152 independent PCTs between now and 1 April 2013, I would say that we cannot. Increasingly, in parts of the country, we see that we cannot do that now. That is not to say that we want to abolish them, or that we would abolish them statutorily, but we need to make arrangements so that we can pool the capacity that we’ve got. Hence, in London, they’re looking at clustering organisations together and having one management team to run a series of PCTs. I have absolutely no doubt that that will be the model across the country as a whole. So, you will see PCTs being clustered together with single management teams in order to sustain the management capacity, both to enable them to devolve the responsibilities to the local government and consortia and, on the other hand, to enable them to hold on to the accountability chain, which is going to be so critical for us over this period.<sup>107</sup>

**88. Sir David Nicholson has acknowledged the risks of delivering the efficiencies programme over the transition period to the new NHS structures, and we are encouraged by his determination to maintain tight financial controls during this time. However, we are concerned that there has been a lack of co-ordination in the period since the White Paper was published, and the Government has not communicated a**

101 Royal College of Nursing, *Frontline First Interim Report*, November 2010, p5.

102 Q 239 [Mr Collis]

103 Q 233

104 Q 277 [Dr Carter]

105 Q 377

106 Sites in the pathfinder programme, whereby groups of GP practices (consortia) are supported in taking forward GP commissioning of services ahead of the formal transfer from PCTs under the White Paper timetable.

107 Q 372

**clear narrative to support PCTs and other NHS organisations in implementing the reforms.**

89. To compound the problem of these indirect costs and risks, the direct cost of the reorganisation remains unclear. The National Audit Office's recent report on machinery of government changes examined the costs and risks of such changes, and concluded that reorganisation costs tend to be significant; that the ability of central government bodies to identify reorganisation costs was very poor; and that central government bodies were weak at identifying and systematically securing the benefits they hoped to gain from reorganisation.<sup>108</sup> It is important that the NHS reorganisation does not follow this pattern.

90. The analytical strategy for the White Paper discusses the factors that will contribute to the cost of the reorganisation,<sup>109</sup> but at the time of writing, the Government had not produced an estimate of the cost of the reorganisation, beyond the statements of redundancy costs mentioned above. The Government has made reference to the figure of £1.7 billion that derives from the requirement originally set out in the NHS Operating Framework for 2010–11 (under the previous Government) for PCTs to set aside 2% of funds for the purposes of non-recurring 'service transformation' costs. In a Westminster Hall debate on the implications of the Spending Review for the NHS, Simon Burns MP, Minister of State at the Department of Health, stated that the Government recognised 'that amount of money as money that can or could be used for reorganisational purposes'.<sup>110</sup> Although this sum may be earmarked for 'service transformation' purposes, it pre-dates the current Government and cannot be regarded as an accurate estimate of the costs of implementing the specific proposals of the White Paper.

91. The estimate of reorganisation costs of £2–3 billion, as proposed by Professor Kieran Walshe of the Manchester Business School,<sup>111</sup> has been widely cited, and may provide a more accurate indication of the reorganisation costs. Ultimately it is for the Government to demonstrate that it has made its own assessment of the reorganisation costs, to publish these figures, and then monitor the actual costs against their budget.

**92. The cost of the White Paper reorganisation emphasises the need to achieve the higher end of the £15–20 billion of efficiency savings identified in the Nicholson Challenge. These costs must be clearly identified and planned for, if the spending challenge is to be achieved. It is unfortunate that the Government has not yet provided even a broad estimate of the likely reorganisation costs; and it is unhelpful for the Government to continue to cite the £1.7 billion figure, as it does not relate to their specific proposals. The next round of White Paper documents must present a clear assessment of the likely costs, both direct and indirect, and demonstrate how they are to be accommodated into wider spending plans.**

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108 National Audit Office, *Reorganising Central Government*, HC 452, Session 2009–10, March 2010.

109 Department of Health, *Equity and Excellence – Liberating the NHS: Analytical Strategy for the White Paper and associated documents*, p5. Available at: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_117351.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117351.pdf)

110 HC Deb, 11 November 2010, col 179WH.

111 Professor Kieran Walshe, *Reorganisation of the NHS in England*, *BMJ* 2010; 341:c3843 (16 July 2010):

## Conclusions and recommendations

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1. The Local Government Spending Review settlement is a tough one (though in line with many others across government) that cannot fail to pose a challenge for the successful delivery of social care. Although councils do have the additional revenue stream of council tax, this will only dampen the cuts to a certain degree, with the Spending Review itself placing the actual decrease in funding at around 14%, still an enormously challenging figure. It would also be unwise to regard this level of social care income as 'safe', at a time when councils will be trying to divide scarce resources between competing priorities, and when councils' ability to seek additional revenue from council tax payers will be limited and could lead to variation. (Paragraph 12)
2. Although we welcome the Government's identification of additional resources for social care, through the mechanism of the Personal Social Services Grant, the fact is that this funding is now part of the general local authority revenue grant which will reduce from £28 billion this year to £21.9 billion in 2014–15. Given the pressures on local authority spending overall, the majority of our witnesses expressed serious concern that changes in the PSS grant will not be reflected in changes in actual spending in social care. The decision to end ring-fencing of PSS grants means that the total level of social care spending is now at the discretion of local authorities. Even though this may be welcome in principle it has the practical effect of introducing an additional element of uncertainty into the plan for meeting demand for health and social care. (Paragraph 16)
3. We urge the Government closely to monitor the relationship between the level of PSS grant and actual social care spending. In the meantime the Government must shore up the 'positive attitude' to spending of social care funds by clearly communicating its expectations to local government. (Paragraph 17)
4. We strongly support working towards an improved interface between health and social care, and we recognise the efficiencies and improvements in the quality of care that could result from this process. The distribution of this sum for social care from the NHS revenue budget is a key opportunity to drive positive change in this interface. The Secretary of State's description of a formal transfer of funds based on a jointly-agreed spending plan suggests an approach based on the provision of particular services in isolation. It will be an opportunity missed if this sum is not distributed with the primary aim of developing a better overall interaction between health and social care which could have a much wider impact on efficiency, prevention and reablement than the more limited funding of certain services. We expect that the distribution guidelines set out in the Operating Framework will grasp this opportunity. (Paragraph 20)
5. The evidence submitted to us, including the evidence submitted by the Government itself, does not allow us to conclude that the Spending Review settlement, coupled with the pay freeze, is enough to allow councils to 'sustain' care levels without restricting eligibility criteria. Our analysis shows that, depending on spending decisions by individual councils, the social care sector will need to deliver efficiency gains of up to 3.5% per annum throughout the Spending Review period to avoid

reducing their levels of care. We intend to monitor the delivery of these key objectives on a regular basis throughout the Parliament. (Paragraph 32)

6. Improving the interaction between health and social care will be very important if the necessary cost savings on both sides are to be realised. The potential to make savings in this area has long been acknowledged, but has not yet been properly realised. We believe that it is mission-critical to successful delivery of the Nicholson Challenge to achieve a quantum leap in the efficiency of this interface. (Paragraph 35)
7. We strongly support the objectives of improved partnership between health and social care but doubt whether the current institutional or policy structures are fit for the purpose of achieving them. The examples which are quoted often involve demonstrating how better developed social care services will relieve the burden on the healthcare system as well as improving outcomes and experience for patients. There is ample evidence to support these objectives, but delivery involves more than cooperation and improved discharge procedures. It requires a serious commitment to plan and deliver coherent delivery systems ('pathways of care') which are complicated by institutional differences. (Paragraph 43)
8. The allocation of £1 billion to social care through the NHS budget is a step in the right direction in that it formally recognises the interaction between health and social care, but we are concerned that it may be too tightly focused to bring about a genuine wider improvement in the interface between the two services. In general, there is a risk of the 'better interface' becoming a by-word for the health service seeking to achieve its own efficiencies by asking social care to take on more. The Government must do more to bring about improved relations and interaction more generally between the two sectors, as this could ultimately contribute to broader cooperation, more imaginative efficiencies, and more significant savings on both sides. It is not enough for the Government to exhort change in this area: there must be a formal policy infrastructure that recognises the importance of achieving this. (Paragraph 44)
9. The Department of Health takes up a significant portion of the Government's total funding across departments: by 2014–15 the Department of Health will account for 33% of the total Resource budget and 11% of the total capital budget. The ability of the NHS to operate within its settlement is therefore vital to the achievement of the Government's spending plans. (Paragraph 47)
10. The Government's commitment to a real terms increase in health funding throughout the Spending Review period will not be met. This emphasises the fact that the settlement, although generous when compared to other departments, represents a substantial challenge to the NHS. (Paragraph 51)
11. The efficiency challenge for the NHS is not about cuts. It is about doing more with the same amount of money. The Government needs to ensure this fact is more clearly communicated both by the NHS itself and to the wider community. (Paragraph 60)
12. There is an urgent need for a credible plan to deliver the efficiency gain which is the central requirement of the Spending Review settlement for the NHS. Many witnesses

have drawn attention to the need for this plan and have expressed concern that it is not yet available. We share this concern. (Paragraph 62)

13. The QIPP programme is the tool available to healthcare to make efficiencies, and represents a good starting point. However, the scale of the challenge is so immense that QIPP will need to demonstrate clear savings early in order to provide the savings programme with the momentum to proceed at a steady pace towards the £15–20 billion goal. Close monitoring and consistent reporting of performance against publicly available norms will be essential if these gains are to be seen as real improvements rather than accounting changes. (Paragraph 67)
14. We are concerned that 40% of the necessary efficiency improvements are to be derived from tightening the tariff. There is no guarantee that reductions in the tariff will always result in genuine efficiency gains, and there is a risk that the quality of services could suffer if changes are driven by reductions in the cost of the tariff alone. There should not just be across the board cuts in the tariff. It needs to be revised to remove perverse incentives and encourage best practice. (Paragraph 71)
15. We welcome Sir David's recognition of the need for close financial oversight during this transition period. We believe there must be more detail in the Operating Framework and over the coming months on the exact nature of these controls and, in particular, how they will address the transitional arrangements from PCTs to commissioning consortia. (Paragraph 82)
16. Sir David Nicholson has acknowledged the risks of delivering the efficiencies programme over the transition period to the new NHS structures, and we are encouraged by his determination to maintain tight financial controls during this time. However, we are concerned that there has been a lack of co-ordination in the period since the White Paper was published, and the Government has not communicated a clear narrative to support PCTs and other NHS organisations in implementing the reforms. (Paragraph 88)
17. The cost of the White Paper reorganisation emphasises the need to achieve the higher end of the £15–20 billion of efficiency savings identified in the Nicholson Challenge. These costs must be clearly identified and planned for, if the spending challenge is to be achieved. It is unfortunate that the Government has not yet provided even a broad estimate of the likely reorganisation costs; and it is unhelpful for the Government to continue to cite the £1.7 billion figure, as it does not relate to their specific proposals. The next round of White Paper documents must present a clear assessment of the likely costs, both direct and indirect, and demonstrate how they are to be accommodated into wider spending plans. (Paragraph 92)

# Formal Minutes

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**Thursday 9 December 2010**

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper	Mr Virendra Sharma
Nadine Dorries	Chris Skidmore
Yvonne Fovargue	David Tredinnick
Andrew George	Valerie Vaz
Grahame M Morris	Dr Sarah Wollaston

Draft Report (*Public Expenditure*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 92 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Second Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for publishing with the Report.

[Adjourned till Wednesday 15 December at 9.00 am

## Witnesses

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### Tuesday 12 October 2010

Page

**Richard Douglas CB**, Acting Permanent Secretary (and Director General for Finance and Chief Operating Officer), **Sir David Nicholson KCB, CBE**, Chief Executive, National Health Service, **David Flory CBE**, Deputy Chief Executive, National Health Service, and **David Behan CBE**, Director General, Social Care, Local Government and Care Partnerships, Department of Health

Ev 1

### Tuesday 26 October 2010

**Nigel Edwards**, Acting CEO and Policy Director, **David Stout**, Director, Primary Care Trust Network, and **Edward Macalister-Smith**, Chief Executive, Buckinghamshire Primary Care Trust, National Health Service Confederation

Ev 19

**Councillor David Sparks OBE**, Vice-Chair, LGA, Dudley Metropolitan Borough Council, **Andrew Cozens**, Strategic Adviser for Children, Health and Adult Services, Local Government Group, Local Government Association, **Richard Jones**, President, and Director of Adult and Community Services, Lancashire County Council, and **Sarah Pickup**, Honorary Secretary, and Director of Adult Care Services, Hertfordshire County Council, Association of Directors of Adult Social Services

Ev 29

### Tuesday 9 November 2010

**Dr Hamish Meldrum**, Chairman of Council, British Medical Association, **Dr Peter Carter**, Chief Executive & General Secretary, Royal College of Nursing, **Allison Roche**, Assistant National Officer, and **Guy Collis**, Policy Officer, UNISON

Ev 39

### Tuesday 23 November 2010

**Rt Hon Andrew Lansley CBE, MP**, Secretary of State, **Richard Douglas CB**, Director General, Policy, Strategy and Finance, Department of Health, and **Sir David Nicholson KCB**, Chief Executive, National Health Service

Ev 59

## List of printed written evidence

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1	PEX 01 Department of Health	Ev 82
2	PEX 08 UNISON	Ev 99
3	PEX 12 The King's Fund	Ev 104
4	PEX 13 Local Government Association	Ev 107
5	PEX 18 British Medical Association	Ev 112
6	PEX 19 Royal College of Nursing	Ev 114
7	PEX 20 NHS Confederation	Ev 118
8	PEX 26 Association of Directors of Adult Social Services	Ev 122
9	PEX 01A Department of Health supplementary	Ev 127

10	PEX 01B Department of Health supplementary	Ev 128
11	PEX 12A The King's Fund supplementary	Ev 131
12	PEX 18A British Medical Association supplementary	Ev 133
13	PEX 20A NHS Confederation supplementary	Ev 134
14	PEX 13A Local Government Association supplementary	Ev 134

## List of additional written evidence

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(published in Volume II on the Committee's website [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom))

1	PEX 02 Royal College of Speech and Language Therapists
2	PEX 03 Professor Nick Bosanquet
3	PEX 04 Research in Motion
4	PEX 05 Optical Confederation
5	PEX 06 LighterLife
6	PEX 07 Vodafone UK
7	PEX 09 Help the Hospices
8	PEX 10 Cambridge Weight Plan
9	PEX 11 Genetic Alliance UK
10	PEX 14 The Stillbirth and neonatal death charity
11	PEX 15 Manchester Joint Health Unit
12	PEX 16 Royal College of Physicians
13	PEX 17 Changing Faces
14	PEX 21 Royal College of General Practitioners
15	PEX 22 Mencap
16	PEX 23 Southern Cross Healthcare Group Plc
17	PEX 24 Philip J Burgan, Maria Mallaband Care Group Limited
18	PEX 25 Skills for Care
19	PEX 27 The Royal College of Radiologists

# List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report will be printed in brackets after the HC printing number.

## Session 2010–11

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512