House of Commons
Health Committee

Public Expenditure

Thirteenth Report of Session 2010–12

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

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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.

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Andrew George MP (Liberal Democrat, St Ives)  
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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.

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.

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

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1 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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1 Introduction

1. One of the Committee’s first inquiries at the beginning of this Parliament was into expenditure on health and social care in the light of the Spending Review settlement. As we said at the time:

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.

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...

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.2

2. One year on, we have reviewed what progress has been made in order to assess how the health and social care systems are coping in these more stringent financial conditions. Our terms of reference for this inquiry were to examine:

- The plans being made by NHS bodies to enable them to meet the Nicholson Challenge3
- Where changes are being proposed, and whether the NHS is succeeding in making efficiency gains rather than cuts
- The cost of the continuing reorganisation of NHS structures in line with the provisions of the Health and Social Care Bill
- The impact on the provision of adult social care of the 2010 Spending Review settlement and the removal of ring-fencing for social care grants
- The impact on NHS plans of decisions currently being made by local authorities
- The ability of local authorities to make the necessary efficiency savings
- The use of the additional £1bn funding for social care made available through the NHS budget
- Progress on making efficiencies through the integration of health and social care services

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3 The name that has been given to the objective of generating 4% efficiency gains year on year for four years.
• Progress on, and implications of, changing the tariff structure

3. Our key priority has been to examine the extent to which health and social care authorities have been able to do more with the same level of real resources or whether they have had to reduce the quality of services provided in order to make ends meet.

4. The Committee took oral evidence from the Secretary of State, Rt Hon Andrew Lansley MP, Sir David Nicholson, Chief Executive of the NHS, Una O’Brien, Permanent Secretary, and Richard Douglas, Director General of Policy, Strategy and Finance, Department of Health, Professor John Appleby, Chief Economist, The King’s Fund, Dr Judith Smith, Head of Policy, Nuffield Trust, Mike Farrar, Chief Executive, and Jo Webber, Deputy Policy Director, NHS Confederation, and Councillor David Rogers, Chair, Community Wellbeing Board and Andrew Cozens, Strategic Adviser, Children, Adult and health Services, Local Government Group. We also received 35 written submissions. In addition, the National Audit Office prepared a briefing for the Committee on the delivery of efficiency savings in the NHS. The Committee also conducted its own survey of local authority spending on social care. We are grateful to all of those who contributed to our inquiry.

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5 The results of the survey and the questions posed to local authorities are included as an annex to this Report.
2 Meeting the Challenge: the need for service redesign and integration

5. As the Committee pointed out in its Report of December 2010, the NHS needs to deliver efficiency gains of 4% per annum over four consecutive years if it is to continue to provide a good quality, comprehensive service and meet the increases in demand coming from demographic and other pressures. It is an immensely difficult task which requires those responsible to rethink fundamentally the way that services are provided.

6. David Nicholson, NHS Chief Executive, said that the Department recognises what is being asked of the service:

Please do not think we underestimate the scale of challenge that people have here. This is a very, very different way of working, particularly for the acute sector. [...] We are going to have to focus much more on outcomes and integrated care. If an acute hospital thinks they can carry on as they are and, in a sense, salami-slice their service through efficiencies, it will not work for them. They will have more and more difficulty. They increasingly need to look at how they integrate with health and social care and to think about what sort of organisation they are going to be. They also need to look at the disposition of their services: can every DGH [District General Hospital] do everything? All those things are what people need to do. A substantial proportion of them are getting into that, but it is tough, absolutely.6

7. When the Committee asked if the Nicholson Challenge was deliverable, Mike Farrar, Chief Executive of the NHS Confederation, said

[...] yes, it is deliverable but only if significant improvements are made in terms of the way we are going about it at the moment The “if” bit relates to, first, the scale of the challenge and, secondly, the fact that in order to deliver this there needs to be action at a number of levels, which all have to come off [...] Individual organisations need to be as efficient as they possibly can and deliver savings within their boundaries. The care pathways need to be redesigned and commissioners and providers need to work together to get the most effective use of resource. There needs to be more intelligent configuration of services between acute services in order to take out capacity, which we probably cannot afford to keep if we are going to release that to deal with the extra demand. Finally, the NHS overall needs to use its ability to orchestrate at scale those areas like management of supply chain and things like that in order to deliver benefits. To make all that happen is a Herculean task.7

8. The Secretary of State told us:

The National Audit Office [...] said to your Committee [...] that most strategic health authorities told them that the model the Department had put in place to support the

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6 Q 121
7 Q 41
development of QIPP\textsuperscript{8} plans and integrated plans had been very helpful and effective, that they considered it had brought a necessary discipline to the process and that they received an appropriate level of follow-up, feedback and challenge. It is a measured process. It is absolutely not as has happened in the past. You will remember when the NHS fell into a loss of financial control in 2005–06. One of the things David and his colleagues did was to restore financial control after that period. At that time there were short-term expedients, salami slicing and budgets being cut without regard to the impact on quality. We are not contemplating any of that. We are working across the Service to our utmost to ensure that we deliver against these financial and other efficiency challenges while continuing to improve the quality of the service provided to patients”\textsuperscript{9}.

9. The evidence submitted to the Committee is therefore unambiguous. The Nicholson Challenge can only be achieved by making fundamental changes to the way care is delivered. It is neither possible nor desirable to achieve the required levels of efficiency gain through existing structures and any attempt to do so would result in a combination of inefficiency and poor quality which would (rightly) undermine public confidence in the system and represent an indefensible use of taxpayers’ funds.

10. We are concerned, however, that evidence does not suggest that the magnitude of this challenge has been fully grasped. Although it is relatively early days, and there are certainly localised examples of welcome innovation, there is also disturbing evidence that the measures currently being used to try to control the financial situation could fairly be described as “short-term expedients” or “salami slicing”. We are not persuaded that the actions currently being planned will allow the situation to be sustainable over the four years of the Spending Review.

11. The first year of this process ought to see the changes being made that will facilitate future redesign and yield further savings as the programme progresses—instead, as we discuss in the remainder of this report, we have the impression that NHS organisations are making do and squeezing savings from existing services simply to get through the first year of the programme. We heard little to persuade us that this overriding need to do things differently is being planned for in future years and we are convinced that the required level of efficiency gain will not be achieved without significant change in the care model.

12. The Committee believes that the distinction between healthcare and social care, which has its roots in institutional decisions made in the 1940s, is now a major cause of inefficiency and service breakdown. The persistent failure of successive governments to address the requirement for more integrated, patient focussed care is creating powerful perverse incentives in the care system which are driving up costs at the same time as undermining the ability of the system to meet the needs of its patients. It is also increasingly apparent that the contribution that social housing could make to a proper integrated service is also impeded by institutional structures.

\textsuperscript{8} See paragraph 15 for a definition of the QIPP programme.

\textsuperscript{9} Q 140
13. While the separate governance and funding systems make full-scale integration a challenging prospect, health and social care must be seen as two aspects of the same service and planned together in every area for there to be any chance of a high quality and efficient service being provided which meets the needs of the local population within the funding available. We would like to see best practice in this rolled out across the Health Service and underperforming commissioners held to account for failure to engage in this necessary process of change.
3 Context

Healthcare

14. Under the 2010 Spending Review settlement the NHS will receive an increase in cash funding of £12.5 billion by 2014–15. Our previous Report and the Government response that followed discussed the question of whether or not this constitutes a real-terms increase in funding. What real terms growth there may be in the settlement is negligible at best. At the same time demand is increasing due to demographic pressures, public expectations and medical advances. In their written evidence the Government set out the consequences of these circumstances:

The Department estimates this increase in cost, demand and relative cost of treatments as adding up to £30 billion of total NHS spending over this four-year period if no action were taken to mitigate these increases. To meet this additional demand, as well as the cash funding, the NHS has been asked to make up to £20 billion of efficiency savings by 2014–15 to reinvest in services, simultaneously making services more productive, driving up the quality of services it provides and the outcomes it achieves.

15. The figure of up to £20bn of savings was identified by the previous Government; since May 2010 the current Government has adopted the same target, as well as following through the plans initiated by the previous Government in 2009 as the Quality, Innovation, Productivity and Prevention (QIPP) Programme. QIPP is the umbrella term used to describe the approach the NHS is taking at local, regional and national levels to reform its operations and design services in the light of the Nicholson Challenge.

16. In July 2011, the Department of Health reviewed and signed off integrated plans submitted by Strategic Health Authorities (SHAs), incorporating local and regional proposals for not only meeting the QIPP challenge, but also managing the transition to new structures required by the Health and Social Care Bill. The Government intends the plans to change over time in response to additional requirements on the NHS and the dissemination of best practice.

17. Because of this timing, we have not been able to evaluate how effective the implementation of these plans has been. Some reporting data has been released and published in The Quarter, but the picture presented is only partial.

18. At the same time as it is planning its response to the Nicholson Challenge, the NHS is being restructured in line with the Liberating the NHS White Paper and the measures

11 Ev 43
12 Further details on the plans can be found in the Government’s memorandum (Ev 43) and National Audit Office, Briefing for the House of Commons Health Committee – Delivering Efficiency Savings in the NHS, December 2011, pp11–14 http://www.nao.org.uk/publications/1012/nhs_savings.aspx
13 The Quarter is a quarterly update from the Deputy Chief Executive of the NHS (David Flory) outlining the NHS financial position. Issues can be found at the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_087335
proposed in the Health and Social Care Bill. In our previous inquiry, the Committee heard evidence that the resulting upheaval could severely affect the ability of the NHS to make the required efficiency savings. For example, Dr Peter Carter of the RCN told the Committee last year:

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.14

19. Sir David Nicholson, Chief Executive of the National Health Service, told us in October 2010 that the two processes needed to be “not parallel but mutually reinforcing”.15 At the time these two statements were made, the White Paper process was only beginning to make itself felt: in contrast, our inquiry took place against the backdrop of deep and wide-ranging change in the health service and the uncertainties arising from the continuing passage of the Bill through Parliament.

20. Management action is, however, being taken to respond to the Nicholson Challenge. In evidence, the Secretary of State told us that although the QIPP programme technically began on 1 April 2011, some £4.3 billion efficiency savings were made in 2010–11, £240m beyond what was intended.16

Social Care

21. The Government has not set targets for efficiency gains for adult social care in the way that it has done for the NHS, but the sector faces the same dual pressures of shrinking resources and rising demand. As the Committee said in its previous Report:

The Local Government formula grant as a whole is being reduced, by an average of 26% in real terms over the Spending Review period. 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. This represents 12% of local authorities’ total net current expenditure of £113.1 billion. In his evidence the Secretary of State for Health [...] 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.”17

22. 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,

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16 Q 99. Mr Lansley attributed the additional £240m to the reduction in manager and senior management numbers that resulted from the clustering of primary care trusts (Q 111).
councils’ budgets decrease by around 14 per cent once the OBR [Office for Budget Responsibility]’s projections for council tax are taken into account.\(^{18}\)

23. In the Spending Review, what was formerly the ring-fenced Personal Social Services (PSS) grant was moved into the general formula grant that local authorities receive. The amount of money notionally ascribed to PSS is to increase by £1 billion (to £2.4 billion) by 2014–15. The Department of Health argued that this is an additional £1 billion for social care, but as the Committee said in its previous Report, this figure needs to be considered in the context of the much reduced overall formula grant (see table below from the 2010 Report).

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<td>Nominal Change</td>
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<tr>
<td>LG Formula Grant(^2)</td>
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<tr>
<td>Nominal Change</td>
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<td>Real Terms Change</td>
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24. Our previous Report expressed concern that the removal of the ringfence, at a time when councils must divide scarce resources between competing priorities, could mean that the Government’s intended expenditure on social care was not reflected in actual spending by local authorities. The question of the impact of the Spending Review settlement and changes is considered in Chapter 3.

25. Wider reform of the funding model for social care has been recently raised by the report of the Dilnot Commission on Funding of Care and Support,\(^{20}\) but even if implemented, the changes recommended by the Commission would have little impact during the Spending Review period. Our current inquiry into social care is considering the recommendations of the Dilnot Commission along with other issues relating to social care, and we will report on these matters in due course.

\(^{18}\) HM Treasury, *Spending Review 2010*, Cm 7942, October 2010, p50

\(^{19}\) Source: Committee Office Scrutiny Unit. Personal Services Grant is part of the Local Government Formula Grant. Excludes ring-fenced grants and funding for council tax freeze

\(^{20}\) Commission on Funding of Care and Support, *Fairer Care Funding: The Report of the Commission on Funding and Support*, July 2011
Integration of health and social care

26. Better integration and coordination of health and social care is accepted as a vital component of improving the quality of services and making necessary efficiency gains. In its Report last December the Committee said:

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.21

Similarly, in January 2012 a joint report by the King’s Fund and the Nuffield Trust noted that “if executed well, moving towards a new model of integrated care will help to create the foundations for sustainable delivery against the quality, innovation, prevention and productivity (QIPP) challenge in the longer term.”22

27. The Government has initiated a number of structural changes which it believes will contribute to the integration of health and social care services:

- The Payment by Results tariff will be amended from April 2012 to require the NHS to pay for reablement and other post-discharge services for 30 days after a patient leaves hospital; and since 2011, trusts are no longer being reimbursed for unnecessary readmissions.

- Health and Wellbeing Boards established under the terms of the Health and Social Care Bill and consisting of a range of office holders and representatives of local authority and healthcare bodies will, the Government says: “increase the local democratic legitimacy of NHS commissioning decisions and provide a vehicle for NHS and local authority commissioners, along with other key partners, to come together on a geographical basis to improve the health and wellbeing of the people in their area in a strategic and coherent way”.23

- Joint Strategic Needs Assessments, analysing local current and future needs, are to be undertaken through the Health and Wellbeing Board and will inform the development of a Health and Wellbeing Strategy that will in turn inform local commissioning plans.24

- The NHS Outcomes framework has been developed to measure success by the quality of outcomes which patients experience. It is acknowledged in this framework that the best possible outcomes will only come from aligning different sectors:

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22 The King’s Fund and the Nuffield Trust, Integrated Care for patients and populations: improving outcomes by working together, 5 January 2012.
24 Ibid, page 8
[..] if the outcomes that matter most to people are to be delivered, the NHS, public health and adult social care services need to be fully aligned and in some cases held to account for providing joined up or integrated services.25

28. In addition, the 2010 Spending Review made £1bn per annum (by 2014–15) available within the NHS specifically for measures that support social care and benefit health. The Department of Health has told us that up to £300m of this per annum has been set aside for reablement in order to reduce demand on social care services. The remainder in 2011–12 and 2012–13 will be transferred from PCTs to local authorities, in accordance with joint local agreements, “for spending on social care services which benefit health and improve health outcomes”.26 The table below sets out allocations over the Spending Review period.

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<td>Reablement</td>
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<td>300</td>
<td>300</td>
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<tr>
<td>Other health support</td>
<td>648</td>
<td>622</td>
<td>759</td>
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Source: Department of Health

In January 2012 the Government announced that a one-off additional payment of £150m would be allocated to PCTs for transfer to local authorities on the same basis, aiming to provide quicker discharge of patients and better reablement services in order to alleviate pressure on health services during the winter months.27

29. Our previous Report noted that this spending was a “key opportunity to drive positive change” in the interface between health and social care, but expressed concern that it might end up being used to prop up existing services rather than driving change and better interaction.28

26 Ev 49
4 Key findings from our inquiry

30. As noted in the previous chapter, we are only part way through the first full year of the implementation of QIPP plans and the Spending Review settlement. As such, it is not yet possible to conduct a full analysis of the impact and effectiveness of these measures. In the course of our evidence, however, we heard concerns about a number of trends arising from the Government’s programme. In this chapter we note the most significant. A common thread running through these issues is the marked disconnect between the concerns expressed by those responsible for delivering services, and the relative optimism of the Government.

Progress on the QIPP programme

Setting and achieving targets

31. The Nicholson Challenge requires the NHS as a whole to make 4% efficiency savings, year on year.29 However, this will require many NHS organisations in the acute sector to aim for higher savings, due to the pressure placed on this sector through reductions in the tariff.30 Monitor, the independent regulator of NHS foundation trusts, noted in its review of trusts’ annual plans that trusts have set their most challenging Cost Improvement Plans to date, aiming to achieve a 4.4% reduction in operating costs. Monitor warned that “maintaining and improving quality whilst delivering this level of savings represents a significant challenge and a potential risk for trusts”.31 Monitor has also raised the levels of expected efficiencies that it uses to inform its financial assumptions when assessing applicant foundation trusts and when risk rating investments and transactions undertaken by foundation trusts.32

32. Similarly a King’s Fund’s survey of a panel of finance directors from a variety of NHS organisations found that this pattern was extending beyond just the foundation trust sector:

All but one of the provider organisations on the panel have a productivity target of 4% or more, and over half have a target of 6% or more. This confirms a recent Health

29 Q 120
30 Q 3 (Professor Appleby). The payment by results tariff is the main hospital payment system in England, accounting for about 60 per cent of acute hospital income. Providers are paid a national price (tariff) for a given unit of activity, multiplied by the number of patients treated. The Government is planning to achieve 40% of its savings through reductions in the tariffs paid. In its previous Report the Committee expressed concern about the use of the tariff to drive a significant proportion of savings and noted that there was a risk that reducing tariffs might lead hospitals to cease to provide services, or subsidise unprofitable lines with profitable ones, without actually improving efficiency (para 70–71). See p13 of the National Audit Office briefing for further information on the tariff.
32 Specifically, the ‘downside’ case (the second, and more pessimistic of Monitor’s pressure and risk scenarios; as opposed to the ‘assessor’ case which is in line with Department of Health estimates) had been revised upwards from an in-year efficiency requirement of 4.5% in 2011–12 to 5.3%. See correspondence from Stephen Hay, Chief Operating Officer of Monitor to (among others) foundation trusts and foundation trust applicants, 27 April 2011, available at http://www.monitor-nhsft.gov.uk/home/information-nhs-foundation-trusts/correspondence-foundation-trusts-0.
Service Journal survey of 131 trusts conducted in April, which found a similar range of targets with an average target of 6%.33

33. Mike Farrar of the NHS Confederation told us that:

82% of our membership believe that it would be possible to remain financially stable this year, but they are worried about future years. There is a strong sense that most of this year’s position on the money is being dealt with by taking account of reserves or a cushion that was in the system previously.33

34. Jo Webber, Deputy Policy Director of the NHS Confederation, added:

It is not just the reserves either. It is non-recurrent savings. It is savings that you will not be able to make again next year. So, although our members did feel, when we surveyed them, that they would be able to make it this year, it gets increasingly tough.34

35. She told us that, in her view, efficiencies would inevitably threaten quality in the longer term:

This year it feels like you can keep quality up and it would not be compromised by the savings. The vast majority of our members feel confident that they are going to make the savings this year. When you start projecting this two or three years out, then that balance between quality and savings becomes more finely balanced.35

36. The Secretary of State acknowledged that the acute sector was facing “unprecedented pressure” and that it was possible that the “extent of the financial challenge” could lead some foundation trusts to use their reserves to meet their financial objectives.36

37. Sir David Nicholson insisted that the “vast majority” of changes being made under the ‘operational efficiency’ heading (some 40% of planned savings) were recurring38 and that the 40% of savings planned from national action were “all recurring”, although he acknowledged that this would only be the case if pay levels did not “bounce back” in future years.39 Sir David did note, however, that even as more data became available it would be difficult to get a definitive picture on whether savings were recurring or not, “partly because people describe things in different ways”.40

38. It is far from certain whether the targets set out in saving plans will be met, even with trusts stretching themselves. For example, on the King’s Fund July panel of finance directors, about half of those with a target of 4% or more were uncertain of meeting it.41

33 King’s Fund, How is the NHS Performing? Quarterly monitoring report, July 2011.
34 Q 42
35 Q 44
36 Q 71
37 Q 134
38 Q 101
39 Q 100
40 Q 100
41 King’s Fund, How is the NHS Performing? Quarterly monitoring report, July 2011.
Similarly, a July 2011 *Health Service Journal* survey of 244 senior managers and finance directors found that 55% were not confident that their organisation could make the savings needed. Past performance in this area is not always encouraging: in 2010–11 some 26 acute trusts delivered less than 80% of their cost improvement targets. The Audit Commission, in its audit of 2010–11 cost improvement plans from a sample of PCTs and NHS Trusts, found that “plans have been more ambitious than in 2009–10 but achievement against them has worsened”:

In 2010/11, 19 per cent of both NHS trust and PCT plans were not achieved. Overall, 23 per cent of the savings achieved were non-recurrent (2009/10 figures are not available). This means that NHS bodies will need to find extra savings in 2011/12 to match the one-off savings made in 2010/11, to reach the target of £20 billion recurrent savings.

39. We were told in evidence that there was to be a return to some year-end flexibility over spending. We welcome this development, because we believe it removes the well known perverse incentives that arise from excessive year-end inflexibility. However, this principle seems to be undermined by the case over the Christmas period of the Department of Health asking for bids for £300m of capital funding for projects beginning this financial year and ending in 2012–13. The Department asked for applications by 12 January for projects which would require at least £5m.

At a time when all NHS bodies are being required to make efficiencies and need to plan strategically to reshape services it is unhelpful for the Department of Health to require them to make bids for capital funding to such short deadlines and without adequate preparation.

40. It remains too early fully to assess the types of savings being made in 2011–12, the first year of the QIPP programme. The Government remains confident that savings are on track. Nevertheless, we have heard strong concerns from the NHS Confederation, the Foundation Trust Network and the King’s Fund, among others, about the ability of NHS organisations firstly to meet their saving plans and second, to do so in a manner that is sustainable and releases further savings in future years. We are concerned that there appears to be evidence that NHS organisations are according the highest priority to achieving short-term savings which allow them to meet their financial objectives in the current year, apparently at the expense of planning service changes which would allow them to meet their financial and quality objectives in later years.

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43 Ev 57
44 Q 144 (Mr Douglas)
45 *Health Service Journal, Exclusive: Trusts given days to apply for £300m capital fund*, 6 January 2012.
46 Ev w51
47 Ev 65
Progress on service reconfiguration

41. The evidence presented by the Department of Health states that reconfiguration of services is an essential component of long-term sustainable change and is intended to account for 20% of QIPP savings.48

42. The Committee believes that service reconfiguration needs in fact to account for significantly more than 20% of QIPP savings and that it is hard to reconcile an estimate of 20% with the evidence presented by Sir David Nicholson and the Secretary of State quoted at paragraphs 6 and 8. They state in those paragraphs—and we agree—that delivery of the Nicholson Challenge depends on fundamental change in the way care is delivered; in the Committee’s view that is simply another way of saying that services need to be reconfigured.

43. Genuine change in the way services are delivered will be necessary on both a large and small scale. Our evidence suggested that NHS organisations are focusing on trimming existing processes rather than developing new ways to deliver services. For example, John Appleby of the King’s Fund told us:

One of my concerns with QIPP is quite often that the approach taken is, ‘What is our share of the £20 billion as an organisation? How many millions is it and how do we squeeze that out of our budgets in, almost, cash terms?’ I think the approach should have been, ‘How can we improve care for patients? What is it they value that we can do more of?’ [...] Traditionally, the NHS’s approach to efficiency gains has been to lop the money off the top, that is not give it to the system in the first place and then ask questions later, as it were, and exhort the system to do as much as it can with slightly less money. I have to say, to an extent, that tactic is still being pursued.49

44. Mike Farrar of the NHS Confederation agreed with this to some extent:

My view is that what we have been doing in year one [...] is to approach the QIPP challenge in the way in which we have probably approached efficiencies previously, which is by small salami slicing around some of our costs. A lot of providers are trying to get leaner in the way they manage their processes.50

45. Dr Judith Smith, head of policy at the Nuffield Trust, suggested that PCTs were tending to “look at services at the margin, not at the core spend” and noted that this approach will make things even harder in subsequent years: “it is going to be hard for new commissioning groups that are just getting off the ground if they have to start with those difficult [core spend] decisions”.51

46. Although therefore national policy guidance has emphasised the scale of service change required to deliver the Nicholson Challenge, the Committee is concerned that local reality does not reflect the national policy objectives.
47. The Committee is particularly concerned that the statistical distinction drawn by the Department between 20% of savings arising from service reconfiguration and 40% arising from reduced tariff is misleading. National policy guidance emphasises the importance of substantial service change, while the statistical presentation appears to suggest that traditional salami slicing will yield savings which are twice as large as the savings delivered by service change.

48. The Committee regards tariff reduction as a tool not a policy. It should be used to promote necessary service reconfiguration; the danger in the present approach is that it implies that service change has only a relatively minor contribution to make to the efficiency gain required to meet the Nicholson Challenge.

49. The Government’s response to the Committee’s 2010 Report endorsed this approach. It noted that “changes to tariff prices do not, in themselves, deliver efficiency improvements and NHS organisations need to identify underlying efficiencies to enable them to live within tariff prices”.52

50. We are concerned that these important points are not sufficiently well understood. We have already noted that the squeeze on tariff payments has placed significant pressure on acute hospital services.53 John Appleby of the King’s Fund noted that this risked creating perverse effects:

If you squeeze down too much on price, trusts may think, “Is it worth us supplying this high cost service? We can’t do anything more about the cost. We simply won’t supply this service anymore and we’ll focus on other things”.54

51. Jo Webber of the NHS Confederation argued that the tariff was only partially useful: “tariff should help you to improve productivity, but there are still also the issues of rising demand and of those services that are not covered by tariff”.55 She added that “one could argue that if our demand is due to long-term conditions and an aging population, then [the tariff] does not cover, except for very precise episodes, the vast majority of where the demand is increasing”.56 Mike Farrar noted that the tariff may be effective in driving efficiency at an aggregate level, but that it could be a “crude mechanism” and did not take account of variations at a local level.57

52. The Secretary of State agreed that the tariff could be described as a “crude mechanism”, but only “if we were not, at the same time, developing the tariff and the way in which the tariff itself is structured”, for example through the development of best-practice tariffs and extending tariffs into community services.58

53 Paragraph 31
54 Q 15
55 Q 48
56 Q 49
57 Q 48
58 Q 121
53. Sir David Nicholson acknowledged that the requirement to deliver efficiency gains through service redesign remained problematic:

The area where we have had least success in year 1—and we always knew this would be the case—is the benefits of service change because it is complicated and difficult and takes a lead time to do it. [...]. We have offset some of that [with the savings made in management costs] but, particularly in years 2 and 3, I think service change will increasingly become an issue for us to tackle.59

54. Both the Foundation Trust Network and the NHS Confederation noted that service redesign was difficult to achieve without political support.60 But the Confederation warned of the consequences of not making such changes:

Without action, the NHS as a whole will start to overspend leading to serious compromises in quality. We therefore urge politicians—local and national; government and opposition—to start to make the case for change, to understand the difficulties in delivering this change and to back the leadership of the NHS to deliver it.61

55. The Secretary of State acknowledged that service reconfiguration on a large scale required action at both national and local levels, for example in developing a telephone triage system for urgent care.62 In terms of political support, he argued that managers could achieve significant reorganisations “more readily, more successfully and more quickly” than in the past by ensuring their plans fulfilled certain tests, which he set out as follows:

Are our GPs supportive as commissioners? Are our local authorities supportive on the public’s behalf? Are our patients supportive, even if reluctantly, but recognising that it delivers them the choices they are looking for? Is it clinically safe? Do we have a clinical evidence base for what we are setting out to do?63

56. The Secretary of State argued that if these tests were fulfilled managers could have “great confidence” in achieving the reconfiguration. Sir David Nicholson noted that there was service redesign “happening all the time” and that the Department had been encouraging and supporting people in effecting service change “because we want to improve the quality of service for patients”. He did, however, acknowledge that it could still be difficult for management to achieve the political support they required, especially at a local level, and that getting local agreement was “a really big challenge for local government as we go forward in all of this”.64

57. The Nicholson Challenge can only be achieved through a wide process of service redesign on both a small and large scale. These changes should not be deferred until later in the Spending Review period: they must happen early in the process if they are to
release the recurring savings that will be vital in meeting the challenge. In the meantime, we are concerned that savings are being made through “salami-slicing” existing processes instead of rethinking and redesigning the way services are delivered.

58. The reduction of the tariff is intended to encourage service redesign. This link needs to be made much more explicit if there is to be a proper understanding in the NHS and among the wider public of the scale of service change which is needed to meet the Nicholson Challenge.

**The impact of the White Paper restructuring**

59. Sir David Nicholson told us that the Government’s White Paper process had answered the question of how to make QIPP savings a reality. He said “What we have tried to do since [the reforms started] is shape the reductions, pointing in the direction of the new world”.

60. The Secretary of State told us that the restructuring process was a vital part of delivering the financial challenge:

Where QIPP is concerned, the strategy helps us to deliver that. If we did not have that strategy, we would still be sitting here discussing exactly the same financial challenge. We would still be living with exactly the same kind of challenge and you would be asking us a lot of questions about why we are not engaging clinicians more in the process of redesigning services in order to benefit patients. The fact is we are doing that.

61. However, we also heard evidence that the restructuring process is frustrating NHS organisations in their efforts to make savings. The Foundation Trust Network told us “in the short to medium term there is significant disruption in relationships as experienced people leave the NHS or are redeployed” and “with the financial pressures on commissioners, combined with the changes in personnel and disruption of historic relationships, there is growing evidence that commissioners are making unsophisticated attempts to reduce costs”.

62. In a similar vein, Judith Smith of the Nuffield Trust warned that “undertaking that challenge at the time of major health system reorganisation risks compromising the process”, while John Appleby said “[making efficiencies now] is a more complicated job, which needs to galvanise the staff to feel enthused to search out new ways of working and new ways of delivering health care to patients”. Mike Farrar told us that the reforms had
distracted his members and been a factor in organisations “starting slowly” on their savings plans.\textsuperscript{71}

63. The reorganisation process continues to complicate the push for efficiency gains. Although it may have facilitated savings in some cases, we heard that it more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings.

**Pressure on social care services**

64. In its written evidence to our inquiry, the Department of Health told us:

> The Government recognises that the Spending Review set out a challenging settlement for local government. However, the Department has sought to achieve a fair and sustainable outcome by listening to what the local government community has asked for. It has insulated the councils that are most dependent on grant funding by giving more weight to the levels of need within different areas and less weight to per capita distributions. It has also grouped councils into four bands, reflecting their dependence on central Government. More dependent authorities have therefore seen proportionally lower falls than more self-sufficient places.

> For 2011–12 and 2012–13, no authority will face more than an 8.9\% reduction in spending power (including income from council tax and NHS support for social care), with an average reduction in spending power for 2011–12 of 4.4\%.\textsuperscript{72}

65. The precise effect of the funding changes on local authorities’ spending on social care is complex. The Department of Health has stated that it is monitoring budgeted expenditure data and notes that:

> The Department for Communities and Local Government published 2011–12 budgeted expenditure data on 30 June 2011. This showed that budgeted net current expenditure on adult social care was £14,898 million for 2011–12, compared to £14,439 million in 2010–11. These two figures are not directly comparable, as local authorities have taken responsibility for commissioning services for people with learning disability from PCTs, funded through the £1.3 billion Learning Disabilities and Health Reform grant. The 2011–12 figure also does not include the additional income of £648 million received by local authorities from PCTs for spending on social care services that benefit health. Adjusting the data for these two funding streams suggests a like-for-like budgeted net current expenditure of £14,220 million in 2011–12. This represents a budgeted spending reduction of just over £200 million – or around 1.5\% – compared to last year.\textsuperscript{73}

66. Other data suggest that the difference may be larger than that 1.5\%. The Audit Commission told us:

\textsuperscript{71} Q 41  
\textsuperscript{72} Ev 47  
\textsuperscript{73} Ev 47–48
The picture of the impact on adult social care in 2011/12 from the 2010 Spending Review is far from clear. Data from several surveys is available, which each give different results.

- The Association of Directors of Adult Social Services survey suggests spending on adult social care has fallen by 6.8 per cent.
- Age UK found that spending on older people had fallen by 8.4 per cent.
- The Department for Communities and Local Government found the fall was less than 1 per cent.
- A CIPFA/BBC survey suggested a 2.6 per cent fall but with significant regional variation.74

67. In oral evidence, the Local Government Group (LGG) said that they accepted the funding figure, but added that “we feel it denies [...] the reality of the wider local government context in which this is set [...] It is our evidence that, in fact, councils, even with a degree of protection for adult social care [...] are taking £1 billion out of the system; that is the reality, rather than £200 million”.75 In a subsequent joint memorandum, the LGA and ADASS said that the ADASS survey showed that authorities were making £991m of savings on adult social care in the current year, caused by reductions in central funding, growth in demand and inflation and other cost pressures.76

68. Andrew Cozens of the LGG also said that the overall figure masked the very different challenges facing local authorities: “It makes a number of assumptions about the ability of councils to make efficiency savings on an equal basis across the country, and some councils are already more efficient than others and there is no mechanism for redistributing the savings that one council can make which are greater than another to that other council.”77 Councillor David Rogers of the LGG said that, “It is important to recognise that the average that comes from local taxes, from council tax, is 40% for social care spending and in some areas it is as high as 80% of the total”.78

69. Local authorities, like the NHS, are being asked to cope with reductions in funding through efficiency savings. The Government says that the necessary programme of efficiencies is “ambitious”, but that:

The Local Government Association and the Association of Directors of Adult Social Services both suggested, in their Spending Review submissions to Government, that efficiencies of 3% per annum were achievable in social care. The Department agrees broadly with this analysis.79

74 Ev 59
75 Q 77
76 Ev 78
77 Q 77
78 Q 80
79 Ev 48
70. The Local Government Group told us:

...we estimate that local government faces a funding gap in the order of £6.5bn in 2011–12. This gap reflects the difference between what local authorities across England would need to spend to maintain frontline services in their current form, and the income they will be able to raise from grants, fees and charges, business rates and council tax.[…]

Councils made savings of more than £3bn between 2005 and 2008 and a further £1.7bn in 2008–09. In 2009–10 councils made efficiency savings of more than £4.8m every day. Councils know that it is likely that more efficiency savings can be made, and the LG Group is investing heavily in a national productivity programme. But efficiency savings are not a quick, short-term fix and what has to be saved over the next few years goes far beyond what can be achieved by conventional efficiency savings.80

71. The Committee’s own survey of local authorities found that local authorities are making lower levels of efficiency savings in social care (3.8% in 2010–11) than across the whole organisation (4.2%) and proposed increases in efficiency savings between 2010–11 and 2011–12 are less for social care (91% increase) than for local authorities as a whole (120%).81 Andrew Cozens of the LGG told the Committee, however, that “The position next year is much more difficult to predict, and it is also difficult to predict whether councils will be in a position to continue to protect adult social care in the second year of the settlement”.82

72. The Audit Commission encapsulated some of the problems facing authorities in making efficiencies:

The policy imperative is to transform services to deliver better outcomes for users. But the pace of change is slow and is unlikely to deliver short-term, or even possibly long-term, savings. Indeed, they may require short-term investment. Focusing management time on transactional efficiencies may deliver savings but will not deliver all the efficiencies required.83

73. The Secretary of State told us that “Our general calculation—our estimate overall—is that we are looking at least at a 3.5% efficiency gain each year in order to respond to the levels of demand and cost in the service. That is what we are aiming, at least, to achieve”.84

74. Andrew Cozens gave a stark assessment of the position adult social care is in:

It has been our position [...] for some time that the social care system is close to collapse, if not fundamentally broken, at this stage simply because it is not able to
properly respond to the demands on it. Therefore, it is reacting as a crisis service in many respects. That is a trend that I anticipate will continue.85

75. We put the LGG’s assessment of the social care funding gap for 2011–12 to Una O’Brien, Permanent Secretary at the Department of Health. She thought their concerns were overstated:

[...] the ADASS construction [of the scale of efficiencies required] is based around an assumption on pay and prices and on demographic pressure. Our understanding—our judgement—is that it is not as large as that. We would not agree with the scale of what they set out because that is their interpretation of the demand pressure with pay and prices. Our view of pay and prices is more conservative than the one they have taken, so we would not share the scale of the efficiency challenge they have set out. Notwithstanding that, it still is challenging. Those decisions, then, are for local authorities in the distribution of their resources to come to a view about how they are going to manage it.86

76. The overall picture of social care is of a service that is continuing to function by restricting eligibility, by making greater savings on other local authority functions and by forcing down the price it pays to contractors for services. In each case, the scope for further efficiencies is severely limited. The Government’s response to the Dilnot Commission’s proposals due in the first half of this year will, we hope, set out how a sustainably funded system will continue into the future. The challenge for local authorities and the Government is to continue to provide a meaningful service until a new system is in place.

Access to services

77. In 2010, Andrew Lansley, the Secretary of State for Health, told us that under the Spending Review settlement there was in his view “generally” no need for local authorities to reduce eligibility to social care.87 In our previous Report, we expressed concern that “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”.88

78. The Government’s evidence to our current inquiry repeated the view expressed by the Secretary of State in 2010:

The Government believes that, if councils push forward with an ambitious programme of efficiency, there is enough funding available to make it possible to protect people’s access to care, without tightening eligibility.89

85 Q 69
86 Q 178
89 Ev 47
79. The Government expects local authorities to make efficiencies of 3% per annum in order to achieve this. Our previous Report set out why the efficiency gains required were likely to be closer to 3.5%, and that achieving even 3% would be extremely challenging.  

80. It is clear that there have been changes in eligibility criteria. Of the 148 councils that responded to the 2011 Budget survey by the Association of Directors of Social Services (ADASS), 15 had raised their eligibility criteria between 2010–11 and 2011–12 from ‘moderate’ to ‘substantial’. The Association of Directors of Social Services (ADASS) told the Committee that in most of England eligibility is now restricted to those with needs which are ‘significant’ or higher:

The ADASS Budget Survey 2011 analysis confirmed the extent of pressures being faced by Adult Social Care, identifying £1 billion worth of reductions from 2011/12 Adult Social Care budgets and a corresponding movement in raising the eligibility threshold, with 13% councils raising eligibility and 82% councils now only providing services at significant or above levels of eligibility. This shift restricts the extent of future headroom for “planned” reductions over the spending review period being absorbed by “efficiencies” as opposed to service reductions.

81. The Local Government Group agreed that there would be considerable pressure on councils’ ability to maintain care services on current eligibility criteria in the coming years. Andrew Cozens of the Local Government Group told us that:

It is too early to say what the impact will be on quality, but it certainly continues the trend of services being maintained for those inside the tent but with greater difficulties for those with lesser need in getting access to service. That is reflected both in the changes to eligibility criteria but also in the intention, for example, to reduce expenditure on care home placements and to try and cap fees levels and other issues of this kind.

82. In evidence for this inquiry the Secretary of State described the changes to eligibility criteria as “limited” in comparison with 2010–11 and said that “generally speaking, [councils] have not had to reduce their eligibility”. He did, however, note that nearly £116m of the £648m being passported through the NHS for spending on social care, and

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91 Ev 54. The four eligibility criteria are low, moderate, substantial and critical. The criteria are set out in detail under the Government’s Fair Access to Care Services (FACS) framework (Department of Health, Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care, February 2010) which councils are asked to use to describe the circumstances that make individuals eligible to receive care.
92 By “significant” ADASS is referring to those classified as having “substantial” or “critical” needs (under the ADASS 2011 budget survey it was found that 78% of councils restricted care to those with “substantial” needs or above, while 4% restricted care only to those with “critical” needs).
93 Ev 52
94 Ev 64
95 Q 46
96 Q 185
97 Q 175
intended to support integration of the two services, had been spent on maintaining eligibility criteria.\textsuperscript{98}

83. Una O’Brien, Permanent Secretary at the Department of Health, told us “we are disappointed where local authorities have made those decisions [to raise eligibility thresholds]” and said that the Spending Review arrangements were really a question of trying “to hold the position steady” until the establishment of a new and different funding system for social care.\textsuperscript{99}

84. \textbf{In spite of Government assurances, local authorities are having to raise eligibility criteria in order to maintain social care services to those in greatest need.}

85. It is deeply concerning that £116m of the £648m intended to be spent through the NHS on improving the interface between health and social care is being spent on sustaining existing eligibility criteria. This suggests that this money (which was intended to support greater integration of services) is in fact being used to maintain the existing system. To the extent that this is true it is a lost opportunity to promote the necessary process of service integration.

86. ADASS has found that 82\% of councils are only providing care to those whose needs are assessed as significant or higher. The Permanent Secretary at the Department of Health told us that the settlement was intended to “hold the position steady” until a new funding system for social care was developed. The tightening of eligibility criteria demonstrates that the settlement is not sufficient to achieve this.

\textbf{Integration of health and social care}

87. The Committee welcomed the higher priority which Government accorded to the greater integration of health and social care following the report of the NHS Future Forum in 2011. We believe this approach is the only realistic option which is capable of delivering service change on the scale required to respond to the Nicholson Challenge. We were therefore keen to assess the progress which has been made with the delivery of the objectives which the Government embraced during 2011.

88. During our previous inquiry, the LGA and ADASS told us that relationships between the two sectors was improving. This time, ADASS said:

\ldots the maturing relationship \ldots has seen integrated commissioning and existence of joint teams becoming common-place and the development of a shared, integrated outcomes framework binding the focus of health, public health and councils together. The attention upon the “patient pathway” and the mix of the health model of treatment alongside the social model of care has created an environment in which the inter-dependencies between two different cultures / organisations are now understood and evolving.\textsuperscript{100}
89. On the other hand, the Audit Commission told us that their “analysis of adult social services efficiencies in 2009–10, and those planned for 2010–11, shows that integration and working more closely with the NHS was one of the least common ways of achieving savings”.

90. We asked the Secretary of State what mechanisms or incentives were in place to encourage integration and co-operation. He told us:

The NHS financial support to local authorities is a direct incentive to [join up]. It is focused on trying to deliver that kind of joint preventative approach. We make it very clear and [...] the Bill [...] makes it clear that we are not only sustaining the legal mechanisms by which local authorities with social care responsibilities can go down the route of pooled budgets or joint commissioning. We are creating in the legislation a statutory duty to promote integrated care between health and social care which was not previously there. We are creating a statutory incentive and we have a financial incentive.

91. The Secretary of State did caution, however, that the two distinct funding systems limited the ability to integrate services:

Yes, we can get joint commissioning and pooled budgets, but we are not in a position where we can ignore the simple fact that they are separately funded. One is local authority funded, subject to a means test, and the other is NHS funded, not subject to any means test and free. The management of bringing those things together is inevitably going to be a co-ordination mechanism rather than a simple integration.

92. Councillor Rogers of the LGG and Jo Webber of the NHS Confederation both argued that Health and Wellbeing Boards could have a key role to play in enhancing integration. As Jo Webber told us, it is the only mechanism available to do this:

They will be very good if the joint strategic needs assessment works across the whole of the local community and that is the basis of some very joined-up planning. When you look at the reforms, there is not anywhere else locally where that planning is going to take place. It has to take place at the Health and Wellbeing Board level.

93. Mike Farrar warned that there needed to be greater common understanding of what integration means:

The key thing in the short term is that there has been a rally round the phrase “integration”, but in operationalising the nature of integration many people out in the system who are critical to whether we get these benefits have very different understandings and expectations of what that means in practice. It would be incredibly useful, while the Bill is still progressing, if we are going to have a legal duty
around it, to have a degree of clarity about the expectation and try and get people on the same hymn sheet.106

94. A January 2012 joint report by the King’s Fund and the Nuffield Trust, on the integration of health and social care, called on the Department of Health and the NHS Commissioning Board to “develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations” and to set “a clear, ambitious and measurable goal linked to the individual’s experiences of integrated care that must be delivered by a defined date”.107

95. Although the Committee welcomes the continuing interest and support for the priority accorded by the NHS Future Forum to greater service integration, it found precious little evidence of the urgency which it believes this issue demands—on both quality and efficiency grounds. It is a question to which the Committee will return in its Report on Social Care. In the meantime it calls on the Government and local authorities to set out how they intend to translate this aspiration for greater service integration into the reality of patient experience.

**Investment of NHS funds in social care**

96. In the Spending Review the Government did provide that there would be some funding from the NHS budget for use on social care. We said in our previous report that this money ought to be distributed with the primary aim of developing a better overall interaction between health and social care rather than simply spent on specific services, and this remains our view.108 In its response to our previous Report, the Government said:

> The Operating Framework specifically requires that PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment and the outcomes expected from this investment. The Department of Health would expect these decisions to take into account the Joint Strategic Needs Assessment (JSNA) for their local population, and the existing commissioning plans for both health and social care. This is specifically to ensure that this funding is not used in isolation from the other plans for health and social care services in any locality to ensure that the funding provides the greatest additional value [...] PCTs should work together with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.109

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106 Q 93


The Department also told us that “This represents an important mechanism for encouraging PCTs and local authorities to work outside of traditional silos, and to collaborate in order to achieve maximum impact for their investment”.  

97. The Audit Commission suggested that how well the money was being used depended largely on pre-existing relationships:

> It is too early for robust evidence on how the additional funding is being used. The experience and views of our local auditors is that areas with a strong history of partnership working are collaborating on how best to use the funding to benefit the whole system. Where relationships are less strong, it seems that agreeing shared priorities and allocating funding has been less smooth.  

98. ADASS told us: “The recent transfer of £648m from Primary Care Trusts (PCTs) to councils (2011–12) is seen as a positive move in this shared understanding, and the ADASS 2011 Budget Survey affirmed that this allocation has been largely transferred across, of which 24% is to be deployed to avoid cuts to services, 10% to cover demographic pressures, 9% to spend on additional services, and 57% yet to be decided.” On that undecided 57%, the Local Government Group said:

> Where those decisions are still to be made our anecdotal evidence is that this illustrates the, at times, difficult discussions on whether the money should be used as a substitute for services, for expanding existing services, or for meeting NHS demand for 100% additionality.  

99. On 24 August 2011 a letter was sent to all Directors of Finance at PCTs from David Behan (Director General, Social Care, Local Government and Care Partnerships, Department of Health) and David Flory (Deputy NHS Chief Executive) to establish how this year’s allocation of £648m is being spent, under seven broad categories. The Secretary of State told us:

> It is interesting, looking at the data we have about the structure of the transfer from the NHS to support social care of £648 million in this financial year, for which the data has been returned to us about how this money is to be used, that nearly £116 million is for maintaining eligibility criteria, so there is an issue in terms of that. When you begin to look at all the other things that are being done, it is about community equipment and adaptation, £32 million, £28 million plus for telecare—I was mentioning those opportunities—integrated crisis and rapid response services are £50 million, and both in South Birmingham and Kirklees, where I have been, that makes an enormous difference. It is free for those who are getting access to that service but it is doing an enormous amount to establish people in a preventative way rather than simply letting them fall into care need and then providing them with an expensive package over a long period of time. There is £117 million for reablement

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111 Ev 61
112 Ev 52
113 Ev 64
services, £50 million plus for early supported hospital discharge schemes, and bed-based intermediate care services at £61 million. There is a range of different responses which are meshing the NHS and social care together.114

100. Una O’Brien argued that the decision to passport a sum of money for social care via the NHS was encouraging new initiatives:

You are seeing in that something that is new, the forcing of that conversation by the availability of a pot of money coming through the NHS side, the bringing of local authority social services and health together where there is a common interest around the needs of their patients. While you might say the mechanisms are not being forced from the centre, we are certainly enabling, supporting and driving that “jointness”. For example, the operating framework goes out to all directors of social services and chief executives of local authorities, bringing people into a wider community of responsibility for addressing people’s needs so that we are not, if you like, limited by the route down which money flows. Obviously, we are bound by the legislative framework for social care, and what we are trying do is work within that as constructively as we possibly can.115

101. Early reports from the Health Service are that the transfer of money from the NHS to be spent on social care has been effective. That effectiveness may be because there was a very straightforward control mechanism: the money had to be spent by agreement. We do not underestimate the importance of this transfer, but the fact remains that it represents just 1% of annual funding for the NHS. Clearly there is scope to extend transfers of this kind.

102. In evidence to our inquiry on social care, Andrew Dilnot and his colleagues from the Commission on Funding of Care and Support pointed out that of the almost £150 billion spent per year on service and welfare/disability benefits for elderly people, only £8 billion is spent on social care services and around £50 billion by the NHS. A rebalancing of that expenditure, for example, could bring substantial benefits for quality of service, quality of life and cost-effectiveness. The Committee believes that, as a matter of urgency, the Department of Health should investigate the practicalities of greater passporting of NHS funding to social care.

114 Q 181
115 Q 174
Conclusions and recommendations

Meeting the Challenge: the need for service redesign and integration

1. The evidence submitted to the Committee is unambiguous. The Nicholson Challenge can only be achieved by making fundamental changes to the way care is delivered. (Paragraph 9)

2. While the separate governance and funding systems make full-scale integration a challenging prospect, health and social care must be seen as two aspects of the same service and planned together in every area for there to be any chance of a high quality and efficient service being provided which meets the needs of the local population within the funding available. We would like to see best practice in this rolled out across the Health Service and underperforming commissioners held to account for failure to engage in this necessary process of change. (Paragraph 13)

Setting and achieving targets

3. At a time when all NHS bodies are being required to make efficiencies and need to plan strategically to reshape services it is unhelpful for the Department of Health to require them to make bids for capital funding to short deadlines and without adequate preparation (Paragraph 39)

4. It remains too early fully to assess the types of savings being made in 2011–12, the first year of the QIPP programme. The Government remains confident that savings are on track. Nevertheless, we have heard strong concerns from the NHS Confederation, the Foundation Trust Network and the King’s Fund, among others, about the ability of NHS organisations firstly to meet their saving plans and second, to do so in a manner that is sustainable and releases further savings in future years. We are concerned that there appears to be evidence that NHS organisations are according the highest priority to achieving short-term savings which allow them to meet their financial objectives in the current year, apparently at the expense of planning service changes which would allow them to meet their financial and quality objectives in later years. (Paragraph 40)

Progress on service reconfiguration

5. The Nicholson Challenge can only be achieved through a wide process of service redesign on both a small and large scale. These changes should not be deferred until later in the Spending Review period: they must happen early in the process if they are to release the recurring savings that will be vital in meeting the challenge. In the meantime, we are concerned that savings are being made through “salami-slicing” existing processes instead of rethinking and redesigning the way services are delivered. (Paragraph 57)

6. The reduction of the tariff is intended to encourage service redesign. This link needs to be made much more explicit if there is to be a proper understanding in the NHS
and among the wider public of the scale of service change which is needed to meet
the Nicholson Challenge. (Paragraph 58)

The impact of the White Paper restructuring

7. The reorganisation process continues to complicate the push for efficiency gains. Although it may have facilitated savings in some cases, we heard that it more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings. (Paragraph 63)

Pressure on social care services

8. The overall picture of social care is of a service that is continuing to function by restricting eligibility, by making greater savings on other local authority functions and by forcing down the price it pays to contractors for services. In each case, the scope for further efficiencies is severely limited. The Government’s response to the Dilnot Commission’s proposals due in the first half of this year will, we hope, set out how a sustainably funded system will continue into the future. The challenge for local authorities and the Government is to continue to provide a meaningful service until a new system is in place. (Paragraph 76)

Access to services

9. In spite of Government assurances, local authorities are having to raise eligibility criteria in order to maintain social care services to those in greatest need. (Paragraph 84)

10. It is deeply concerning that £116m of the £648m intended to be spent through the NHS on improving the interface between health and social care is being spent on sustaining existing eligibility criteria. This suggests that this money (which was intended to support greater integration of services) is in fact being used to maintain the existing system. To the extent that this is true it is a lost opportunity to promote the necessary process of service integration. (Paragraph 85)

11. ADASS has found that 82% of councils are only providing care to those whose needs are assessed as significant or higher. The Permanent Secretary at the Department of Health told us that the settlement was intended to “hold the position steady” until a new funding system for social care was developed. The tightening of eligibility criteria demonstrates that the settlement is not sufficient to achieve this. (Paragraph 86)

Integration of health and social care

12. A January 2012 joint report by the King’s Fund and the Nuffield Trust, on the integration of health and social care, called on the Department of Health and the NHS Commissioning Board to “develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations” and to set “a clear, ambitious
and measurable goal linked to the individual’s experiences of integrated care that must be delivered by a defined date”. (Paragraph 94)

13. Although the Committee welcomes the continuing interest and support for the priority accorded by the NHS Future Forum to greater service integration, it found precious little evidence of the urgency which it believes this issue demands—on both quality and efficiency grounds. It is a question to which the Committee will return in its Report on Social Care. In the meantime it calls on the Government and local authorities to set out how they intend to translate this aspiration for greater service integration into the reality of patient experience. (Paragraph 95)

Investment of NHS funds in social care

14. Early reports from the Health Service are that the transfer of money from the NHS to be spent on social care has been effective. That effectiveness may be because there was a very straightforward control mechanism: the money had to be spent by agreement. We do not underestimate the importance of this transfer, but the fact remains that it represents just 1% of annual funding for the NHS. Clearly there is scope to extend transfers of this kind (Paragraph 101)

15. The Committee believes that, as a matter of urgency, the Department of Health should investigate the practicalities of greater passporting of NHS funding to social care. (Paragraph 102)
Annex – Survey of Local Authorities

Summary

1. As part of its inquiry the Committee conducted its own survey of all social care authorities in England on, amongst other things, levels and sources of funding, changes to service provision and plans for efficiency savings in the current year.

2. This report presents the findings of this survey. We surveyed all 152 local authorities in the course of June 2011. A total of 67 local authorities responded, a response rate of 44%. Appendix 1 provides details about our data analysis and Appendix 2 provides the survey that was sent to local authorities.

Key findings

- 63% of local authorities were reducing their social care budgets by an average of 6.6% (between 2010/11 and 2011/12).

- Across all local authorities that responded, the social care budget was reducing by 1.1% (between 2010/11 and 2011/12).

- Most local authorities were planning to reduce expenditure on care home placements (63% of local authorities), long-term support in the community (63%) and universal and preventative services (61%), but were planning to increase expenditure on reablement services (55% of local authorities).

- On average, budgets for care home placement in 2011/12 were reducing by 3.1% compared to actual expenditure in 2010/11, budgets for community support were reducing by 9.2%, budgets for universal and preventive services fell by 0.3%, and budgets for reablement were increasing by 9.6%.

- User charges were increasing from 13.0% to 13.5% of the total social care budget.

- Many local authorities had increased their charges for services, either moderately or substantially between 2010 and 2011. For example, 35% had increased their maximum personal charge for social care, 38% had increased their charges for residential care, and 49% had increased their charges for non-residential care items such as hourly rate for home help. Very few local authorities (0-2%) had reduced charges in these areas.

- Most local authorities reported that levels of service provision had remained about the same between 2010 and 2011—residential care (80%); community care (72%); and reablement services (39%).

- 59% of local authorities had increased levels of reablement services, probably as a result of a one-off £70 million government fund for reablement.

- Local authorities were making fewer efficiency savings in social care (3.8% in 2010–11) than across the whole organisation (4.2%) and proposed increases in efficiency
savings between 2010–11 and 2011–12 were less for social care (91% increase) than for local authorities as a whole (120%).

- In 2010–11 the most useful approaches for achieving efficiency savings were reducing payments to private sector providers, improving back-office efficiencies and increasing reablement services to reduce dependence on care.
- In 2011–12 local authorities anticipate that the most useful approaches will be reductions in payments to private sector care providers, increases in reablement services to reduce dependence on care and more efficient use of staff time.

**Distribution of funding**

3. Across all local authorities that responded, social care budgets were reducing by 1.1%, between 2010–2011 and 2011–12. Some local authorities noted that a recent change in accounting standards which had increased notional expenditure on pensions meant the like-for-like reduction might be greater. Almost two-thirds (63%) of local authorities were reducing their social care budgets, by an average of 6.6%.

4. There were a number of elements that made up these budgets (see graph below).

- User charges were increasing from 13.0% to 13.5% of budget, between 2010–11 and 2011–12.
- Contributions from primary care trusts were reducing from 12.5% to 8.1% of budget, at the same time as grants from the Department of Health are increasing from 2.5% to 8.0%. These changes are probably the result of a number of specific grants (e.g. care of people with learning disabilities) that were previously distributed by primary care trusts and are now distributed directly by the Department of Health.
- The Social Care Reform Grant was reducing from 1.6% to 0.1% of budget, between 2010–11 and 2011–12. The last year of Social Care Reform Grant funding was 2010–11.
5. We asked local authorities to provide social care spending in the following categories: care home placements (excluding respite care); long-term support in the community (including personal budgets); reablement services; and universal and preventative services. We also asked them to provide the number of people who received adult social care on 31st March 2011 and estimate the number of people who will receive adult social care on 31st March 2012 for all these categories apart from universal and preventative services, where identifying numbers can be difficult. From this data we have calculated a ‘spend per patient day’ figure (see table below). This is only a rough estimate, as it is based on the assumption that throughput is constant throughout each financial year.
### Table

<table>
<thead>
<tr>
<th></th>
<th>Care home placements (excluding respite care)</th>
<th>Long-term support in the community (including all personal budgets)</th>
<th>Reablement services</th>
<th>Universal and preventative services</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 56</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average actual spend 2010/11 per local authority (£ million)</td>
<td>60.5</td>
<td>51.9</td>
<td>3.7</td>
<td>12.7</td>
</tr>
<tr>
<td>Average actual recipients on 31st March 2011</td>
<td>1,754</td>
<td>6,695</td>
<td>406</td>
<td>No answer</td>
</tr>
<tr>
<td>Average 2010/11 actual spend per recipient day, assuming constant throughput (£)</td>
<td>94</td>
<td>21</td>
<td>25</td>
<td>No answer</td>
</tr>
<tr>
<td>Average estimated spend 2011/12 per local authority (£ million)</td>
<td>58.6</td>
<td>50.2</td>
<td>4.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Average estimated recipients on 31st March 2012</td>
<td>1,707</td>
<td>6,654</td>
<td>580</td>
<td>No answer</td>
</tr>
<tr>
<td>Average 2011/12 estimated spend per recipient day (£)</td>
<td>94</td>
<td>21</td>
<td>19</td>
<td>No answer</td>
</tr>
<tr>
<td>% change in spend per local authority</td>
<td>-3.1%</td>
<td>-3.2%</td>
<td>9.6%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>% change in care recipients</td>
<td>-2.7%</td>
<td>-0.6%</td>
<td>42.7%</td>
<td>No answer</td>
</tr>
<tr>
<td>% change in spend per care recipient</td>
<td>-0.4%</td>
<td>-2.6%</td>
<td>-23.2%</td>
<td>No answer</td>
</tr>
</tbody>
</table>

6. Most local authorities were planning to reduce expenditure on care home placements (63% of local authorities), long-term support in the community (63% of local authorities) and universal and preventative services (61% of local authorities), while 36% of local authorities were increasing expenditure on all these services. For reablement services, 39% were reducing expenditure, 55% were increasing it, and for the remainder, expenditure is remaining the same.
<table>
<thead>
<tr>
<th>Changes between actual expenditure in 2010/11 and budgets for 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing</td>
</tr>
<tr>
<td>Care home placements (excluding respite care)</td>
</tr>
<tr>
<td>Long-term support in the community (including all personal budgets)</td>
</tr>
<tr>
<td>Reablement services</td>
</tr>
<tr>
<td>Universal and preventative services</td>
</tr>
</tbody>
</table>

**User charges**

7. We asked local authorities to identify whether user charges for adult social care, between 1st April 2010 and 1st April 2011, had decreased (moderately or substantially), had stayed about the same, or had increased (moderately or substantially) for three categories: the maximum personal charge for social care; charges for residential care; and charges for non-residential care items such as hourly rate for home help.

8. The graph below shows that the maximum personal charge for social care was increased either moderately or substantially by 35% of local authorities, and kept the same by 46% of local authorities. The remainder did not have a maximum personal charge for social care. No local authorities reduced their maximum personal charge over this period. For residential care charges, there is a similar pattern: 38% of authorities had moderately increased their residential care charges, 58% had kept the charges about the same, while only 2% had moderately decreased their charges. The pattern is, again, very similar for charges for non-residential care items: 49% of local authorities had increased charges either moderately or substantially, 46% had kept charged about the same, while 2% had decreased charges either moderately or substantially.
9. The respondents also provided details of changes to other charges, such as those for transport, day care, meals and other areas such as respite care. These responses also show that these charges also increased moderately or substantially in number of local authorities.
Levels of care

10. We asked local authorities to identify whether, between 1st April 2010 and 1st April 2011, the levels of care provided to a typical service user had decreased (moderately or substantially), had stayed about the same, or had increased (moderately or substantially) for three categories: residential care; community care; and reablement services.

11. Respondents reported that the level of residential care in most local authorities (80%) had stayed the same, while in 5% of local authorities it had increased (moderately or substantially) and in 15% of local authorities it had decreased moderately (see graph below). No local authorities reported a substantial decrease in the level of care provided. A similar pattern was reported for community care: in 72% of local authorities the level of care had stayed the same, while in 15% of local authorities it had increased (moderately or substantially) and in 13% of local authorities it had decreased moderately.
12. For reablement services, 59% of local authorities stated that provision had increased (moderately or substantially). This is likely to be due, in part, to the government providing extra one-off funding of £70 million specifically for reablement services during the last six months of 2010–11. In 39% of local authorities provision stayed about the same, and in 2% of local authorities it decreased moderately.

13. Some respondents also provided details about changes to levels of care in telecare, transport services, personal budgets and other care areas such as prevention services, as shown in the graph below.

![Graph showing changes in other areas of care](image)

**Efficiency savings**

14. We asked local authorities to provide their planned and actual efficiency savings. The results are tabulated below. These show that local authorities are making less efficiency savings in social care than in other areas and that proposed increases in efficiency saving between 2010–11 and 2011–12 are less for social care (84% increase) than for local authorities as a whole (120%). However this should be interpreted with caution as there was some evidence that local authorities interpreted the ‘total local authority budget’ differently.
15. We asked local authorities to rank from 1 to 5 (1 for the biggest saving, 5 for the smallest) the 5 approaches which achieved the biggest adult social care efficiency savings in 2010/11. We provided a list of five approaches (back-office efficiencies, estate rationalisation, reduced payments to private sector providers, more efficient use of staff time and increased reablement) and gave respondents space to write in up to 5 additional approaches.

16. The graph below shows that in 2010/11 the biggest areas where efficiency savings were achieved were reduced payments per unit activity to private sector providers (29.5% of first-place rankings and 24.1% of second-place rankings) and back-office efficiencies (18.0% of first-place rankings and 13.8% of second-place rankings).

17. We also asked local authorities to rank from 1 to 5 the five approaches that they have planned for 2011/12 which they think will deliver the biggest social care efficiency savings. The graph below shows that the main areas where efficiency savings are planned are reduced payments per unit of activity to private sector care providers (27.9% of first-place rankings and 21.3% of second-place rankings) and increasing reablement to reduce dependence on care (19.7% of first-place rankings and 13.1% of second-place rankings).
Other observations

18. We asked local authorities if they had any other observations about the effects on adult social care of changes in government funding for health and social care. The main responses were:

- Concerns over rising demand for services caused by demographic changes to their populations (13 local authorities).

- Issues related to the interaction of, and joint working between, health and social care (8 local authorities). For example, that cuts to the NHS would mean increasing social care costs for local authorities, the level of bureaucracy involved in accessing NHS funding, and the opportunity for better joint working between health and social care.

- Concerns about their independent sector providers (7 local authorities). For example, the consequences of provider collapse, the quality of the care they provided, and that legal issues would make it difficult for them to economise by cutting independent care home fees.
Appendix A – Data analysis methodology

1. The response rate for this survey was 44%. Thus some caution should be used in interpreting the results across the population as a whole.

2. The initial data set generated from the survey responses was cleansed for differences in formatting and input errors. Not all respondents answered all questions. The number of responses is shown on each graphic or table. Our policy when analysing these results has been to include in the analysis all valid responses to each given question. This might mean that, for example, the population of respondents to question 2 differs slightly from the population of respondents to question 3. Where we performed calculations which draw from responses to more than one question, we only included responses which answered both questions. When making comparisons between years or where more than one question is used in a piece of analysis, only completed data sets have been included.
Appendix B – Survey sent to local authorities

Background

1. Some basic background questions

<table>
<thead>
<tr>
<th>Local Authority Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Local Authority Budget 2010–11 (£)</td>
<td></td>
</tr>
<tr>
<td>Total Local Authority Expenditure 2010–11 (£)</td>
<td></td>
</tr>
<tr>
<td>Total Local Authority Budget 2011–12 (£)</td>
<td></td>
</tr>
<tr>
<td>Are any of your budgets pooled with PCTs?</td>
<td></td>
</tr>
<tr>
<td>Name of person completing this survey</td>
<td></td>
</tr>
<tr>
<td>Contact email address</td>
<td></td>
</tr>
<tr>
<td>Contact telephone number</td>
<td></td>
</tr>
</tbody>
</table>

Finance

2. Please fill in the contribution to **social care funds** made by each of the sources below.

<table>
<thead>
<tr>
<th>You may wish to give this question to your finance department.</th>
<th>Original Amount Budgeted to Receive for 2010–11 (£)</th>
<th>Actual Amount Received for 2010–11 (£)</th>
<th>Budget for 2011–12 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges to service users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribution by primary care trusts (excluding winter pressures funding)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care reform grant from the Department of Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other grants from the Department of Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other sources (e.g. formula grant or council tax)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Please fill in **social care spending** in each of the below areas. Please map your local budget headings to these categories as closely as possible and distribute the staffing spend across these categories.

<table>
<thead>
<tr>
<th>You may wish to give this question to your finance department.</th>
<th>Original Budget for 2010–11</th>
<th>Actual Expenditure for 2010–11</th>
<th>Budget for 2011–12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care home placements (excluding respite care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term support in the community – including all personal budgets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reablement services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal and preventative services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recipients**

4. Please fill in the **numbers of people who received social care** in each of the categories below.

<table>
<thead>
<tr>
<th>Actual Recipients on 31(^{st}) March 2011</th>
<th>Estimated Recipients on 31(^{st}) March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care home placements (excluding respite care)</td>
<td></td>
</tr>
<tr>
<td>Long term support in the community – including all personal budgets</td>
<td></td>
</tr>
<tr>
<td>Reablement services</td>
<td></td>
</tr>
</tbody>
</table>
Changes to Service Provision

5. We are hoping to understand changes which your local authority has made between the start of the last financial year (2010–11) and the start of this financial year (2011–12). Please click the circle which most accurately reflects changes to your user charges for social care between 1st April 2010 and 1st April 2011, for each row.

<table>
<thead>
<tr>
<th></th>
<th>Not relevant</th>
<th>Decreased substantially</th>
<th>Decreased moderately</th>
<th>Stayed about the same</th>
<th>Increased moderately</th>
<th>Increased substantially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum personal charge for social care</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Charges for residential care</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Charges for non-residential care items (e.g. hourly rate for home help)</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Other change 1? Please specify:</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Other change 2? Please specify:</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Other change 3? Please specify:</td>
<td>o</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
6. Please click the circle which most accurately reflects changes to levels of care provided to a typical service user between April 2010 and April 2011.

Changes might include changes in number of times per week that an individual service user can visit a day centre, or changes in maximum number of hours of reablement care available.

<table>
<thead>
<tr>
<th>Changes</th>
<th>Decreased substantially</th>
<th>Decreased moderately</th>
<th>Stayed about the same</th>
<th>Increased moderately</th>
<th>Increased substantially</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential care</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Community care (e.g. day centres, help with domestic routines)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Reablement services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other area of care 1? Please specify:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other area of care 2? Please specify:</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other area of care 3? Please specify:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
## Efficiency Savings

7. Please fill in efficiency savings for your local authority for the relevant time periods.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please exclude any PCT savings from pooled budgets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Across your local authority as a whole</td>
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8. Please **rank from 1 to 5** (1 for the biggest saving, 5 for the smallest) the 5 approaches which achieved the biggest social care efficiency savings in 2010–11.

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<tr>
<th>Approach</th>
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<tr>
<td>Back-office efficiencies (e.g. use of shared services arrangements for I.T. support, etc.)</td>
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<tr>
<td>Estate rationalisation (e.g. reduction in size of premises, amalgamation of care homes)</td>
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<td>Reduced payment per unit of activity to private sector care providers (e.g. care homes)</td>
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<td>Increased reablement to reduce dependence on care</td>
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<td>More efficient use of staff time (e.g. greater number of home visits per day)</td>
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<td>Other approach 5: please specify</td>
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9. Please rank from 1 to 5 (1 for the biggest saving, 5 for the smallest) the 5 approaches you have planned which you think will deliver you the biggest social care efficiency savings in 2011–12. If less than 5 approaches are planned, simply rank from 1 downwards, e.g. if 2 approaches were used then give one of them rank 1 and one of them rank 2, and leave the other cells blank.

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<tr>
<th>Rank in 2011–12</th>
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<td>Back-office efficiencies (e.g. use of shared services arrangements for IT support)</td>
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<td>Other approach 5: please specify</td>
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**Other**

10. Are there any other observations you would like to make about the effects on social care of changes in government funding for health and social care?

Thank you for completing this survey
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 102 read and agreed to.

Annex agreed to.

Resolved, That the Report be the Thirteenth 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 printing with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 24 January at 10.00 am]
Witnesses

**Tuesday 13 September 2011**

Professor John Appleby, Chief Economist, Health Policy, The King’s Fund, and Dr Judith Smith, Head of Policy, Nuffield Trust.  
Mike Farrar, Chief Executive, and Jo Webber, Deputy Policy Director, NHS Confederation, and Councillor David Rogers OBE, Chair, Community Wellbeing Board, and Andrew Cozens, Strategic Adviser, Children, Adults and Health Services, Local Government Group.

**Tuesday 11 October 2011**

Rt Hon Andrew Lansley CBE MP, Secretary of State for Health, Una O’Brien CB, Permanent Secretary, Department of Health, Sir David Nicholson KCB CBE, Chief Executive of the National Health Service, and Richard Douglas CB, Director General of Policy, Strategy and Finance, Department of Health.

**List of printed written evidence**

1 Department of Health  
2 Association of Directors of Adult Social Services  
3 The Audit Commission  
4 Local Government Group  
5 The King’s Fund  
6 NHS Confederation  
7 Local Government Association and the Association of Directors of Adult Social Services  
8 Department of Health supplementary  
9 The Audit Commission further  
10 NHS Confederation supplementary

**List of additional written evidence**

(published in Volume II on the Committee’s website www.parliament.uk/healthcom)

1 Mencap  
2 Royal College of Radiologists  
3 Royal College of Midwives  
4 Royal College of Physicians  
5 The Learning Disability Coalition
6 Roche Products Ltd Ev w12
7 The Learning Clinic Ltd Ev w15
8 The Healthcare Financial Management Association Ev w18
9 Alzheimer’s Society Ev w21
10 Chartered Society of Physiotherapy Ev w23
11 Motor Neurone Disease Association Ev w27
12 Bliss Ev w29
13 NHS Partners Network Ev w31
14 The Health Foundation Ev w33
15 Age UK Ev w36
16 Unite Ev w40
17 Optical Confederation Ev w46
18 Stannah Lift Services Ltd Ev w48
19 North Somerset Council Ev w49
20 Foundation Trust Network Ev w51
21 Deltex Medical Ev w55
22 Association of the British Pharmaceutical Industry Ev w62
23 British Medical Association Ev w64
24 2020health.org Ev w66
25 Alliance Boots Ev w67
26 British Generic Manufacturers Association Ev w71
27 Royal College of General Practitioners Ev w74
28 Royal College of Nursing Ev w75
List of Reports from the Committee during the current Parliament

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

**Session 2010–12**

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<tr>
<th>Report Type</th>
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<tr>
<td>First Report</td>
<td>Appointment of the Chair of the Care Quality Commission</td>
<td>HC 461-I</td>
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<tr>
<td>Second Report</td>
<td>Public Expenditure</td>
<td>HC 512 (Cm 8007)</td>
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<td>Third Report</td>
<td>Commissioning</td>
<td>HC 513 (Cm 8009)</td>
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<td>Fourth Report</td>
<td>Revalidation of Doctors</td>
<td>HC 557 (Cm 8028)</td>
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<tr>
<td>Fifth Report</td>
<td>Commissioning: further issues</td>
<td>HC 796 (Cm 8100)</td>
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<tr>
<td>First Special Report</td>
<td>Revalidation of Doctors: General Medical Council’s Response to the Committee’s Fourth Report of Session 2010–11</td>
<td>HC 1033</td>
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<td>Sixth Report</td>
<td>Complaints and Litigation</td>
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<td>Seventh Report</td>
<td>Annual accountability hearing with the Nursing and Midwifery Council</td>
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<td>Ninth Report</td>
<td>Annual accountability hearing with the Care Quality Commission</td>
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<td>Tenth Report</td>
<td>Annual accountability hearing with Monitor</td>
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<td>Eleventh Report</td>
<td>Appointment of the Chair of the NHS Commissioning Board</td>
<td>HC 1562-I</td>
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<td>Twelfth Report</td>
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<td>Thirteenth Report</td>
<td>Public Expenditure</td>
<td>HC 1499</td>
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Oral evidence

Taken before the Health Committee on Tuesday 13 September 2011

Members present:

Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Dr Daniel Poulter
Mr Virendra Sharma
Chris Skidmore
David Tredinnick
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Professor John Appleby, Chief Economist, Health Policy, The King’s Fund, and Dr Judith Smith, Head of Policy, Nuffield Trust, gave evidence.

Q1 Chair: Welcome to this Committee’s first public hearing of the new political season. Neither of you needs much introduction, but could you briefly introduce yourselves for the record, please?

Dr Smith: I am Dr Judith Smith, head of policy at the Nuffield Trust in London.

Professor Appleby: I am John Appleby, chief economist at The King’s Fund.

Q2 Chair: Thank you. As you know, the Committee, in its various reports and statements over the last 12 months, has drawn attention to the ambition that is implicit in the spending plans that the Government announced last year in terms of the required delivery of unprecedented efficiency gains in both the health and social care system. The purpose of these hearings is essentially to begin the process of analysis of where we are getting to in the delivery of the objectives that are implicit in those plans.

I would like to begin by asking you both, as an overall view, what your assessment is of the progress that has been made so far in terms of the plans, because clearly we are at a relatively early stage of this? How realistic do you believe those objectives set out in last year’s public spending plans are in the context of the plans that you see being drawn up both in the health service and the social care system currently? Dr Smith, would you like to start?

Dr Smith: It is clearly an unprecedented challenge that has been set to the NHS and in a few weeks’ time we will be publishing a major review of evidence on extracting efficiency from health services. One of the main conclusions of that review is that to have the QIPP (Quality, Innovation, Productivity, Prevention) sort of approach, linking quality with productivity, innovation and prevention, is conceptually sound. Also, the approach of having a mix of central levers, such as the pay freeze and changes to tariff and so on, makes sense. However, the other important conclusion from that work—and it is useful to frame what I am about to say about progress—is that it also says that undertaking that challenge at the time of major health system reorganisation risks compromising the progress.

To return specifically to your question about progress, our sense would be that the health service is taking the challenge very seriously. As one goes out and about working with health organisations, one hears people talking a lot about QIPP and if things are “QIPP-able”. However, there are definite signs that it is proving quite difficult and challenging in many cases through the sort of things that are being revealed, sometimes through the board papers of PCT clusters, as they report on struggles in meeting the plans, and also some of the evidence from Monitor as it looks forward at the costs improvement plans that FTs have in place. There is a sense that it is being taken seriously, that people are struggling, and particularly, probably, struggling in places where already there were systemic problems, such as district general hospitals that were in trouble, perhaps in places around outer London where there are specific financial challenges and so forth. There is a sense that, yes, it is proving difficult and could yet, and may well indeed, get much more difficult as we move forward.

Professor Appleby: Perhaps I could add this. Although you said, Chairman, that it is early days for this, and in a way it is for this so-called Nicholson challenge, the NHS has been striving to make efficiency savings for years. There is a context here. It is not as if suddenly this is all brand new to the NHS. Last year there was probably a real cut in spending in England. The NHS was under pressure. The pressure has already started and it started last year in earnest.

I agree with Judith that the plans are very ambitious when you look at them. We are not just talking about a 4% efficiency rise on average, which is the figure across the whole system, as it were. That is what the £20 billion breaks down to over four years. It is when you look at different sectors, and in particular the hospital sector, you see they are under much more pressure.

One of the big problems, we think, and we put in our evidence to you, is knowing what is going on out there. There are no routine auditable data on efficiency savings. We are carrying out a couple of surveys, which we have started recently, to try and fill this gap. They are not huge surveys. We talk to finance directors in NHS organisations. We publish this as a quarterly monitoring report, and we have sent copies to the Committee. It gives us a feeling about what is going on. It is not statistically valid but it gives us a
feeling. For example, out of a sample of about 30 finance directors across England, we can see that the sort of targets they are going for are over 6% efficiency savings this year. As I say, that is on top of efficiency savings last year and the year before, and they have a prospect, of course, of three more years of this. This year most organisations will just about scrape together the money and they will get through and, nationally, the Department will be able to claim that they have met the target. The real difficulty will come next year, and then it gets worse from then on.

Q3 Chair: You referred to the fact that quite a lot of organisations are quoting efficiency gains well north of 4%, and Monitor indeed has reported average efficiency gains through the foundation trust network of over 6%. Do you get a sense that that means that in the early years the NHS is seeking to get ahead of itself in achieving more than 4%, which would be doubly unprecedented, or is that simply a higher efficiency gain in one sector and lower in another and it averages out to 4%?

Professor Appleby: It is the latter. It is partly to do with the tactics that have been adopted to try and put the NHS under severe pressure to make these savings and to make these productivity gains. You have had evidence from David Nicholson and others about the 40%-40%-20% split, about where these savings are going to come from. At the Department level there are not many levers they have to pull. They can exhort the system to make the savings but they do have a crucial lever, which is the tariff, and they can move that price lever. That is what they have been doing. They have been putting pressure downwards on the prices so that hospitals are now facing real cuts in the prices for their goods and services, if you see what I mean, which puts pressure on them to look at their costs. That is the tactic, but that is 40% of the efficiency gained through the tariff. It is only bearing down on about £30 billion worth of NHS money; 40% is £2 billion in one year. So, of course, the percentage is much higher for hospitals.

Dr Smith: The other point I would make to build on that one is, of course, that a lot of services are not covered by the tariff. Although the efficiency requirement is supposed to apply to non-tariff as well, it is not always clear whether that is being enacted in practice. There are issues about how transparent contracts are between commissioners and providers. The other point I would make is that, of course, all of this calls for sophisticated and strong commissioning, particularly in terms of extracting probably the more difficult productivity gains from service redesign and change, and that requires activity across acute community services and primary care. It feels often, at the moment, as though a lot of the attention is on commissioners and hospitals rather than on perhaps the broader sector, and there are particular challenges in addressing that part of the QIPP issues.

Q4 Chair: I would like to move on to other members of the Committee, but would it be fair to summarise what you have said so far as being that, at least in year one of this Nicholson challenge, by a range of different measures, the plans, at least probably show how the system might get there, but it is reducing costs in the existing structure of care rather than achieving necessary changes in the care model that is going to deliver it? Is that what flows from what you have just said?

Dr Smith: Yes. It is certainly what flows from what I have just said. Within that as well, it is not only a question of financial transactions and contracts. They are an important part of it, but that change around new models of care and service redesign calls for significant organisational development and cultural change, and the rest of it, and for organisations to work closely with their clinicians, patients and populations. That is difficult to do in any health system at any time and it is more difficult if you are at a time of reorganisation with reduced management costs.

Q5 Andrew George: In the answers you have given so far, if you do not mind me saying so, especially you, Professor Appleby, while in your evidence you have emphasised the very clear distinction between financial savings and productivity gained, you appear to have started conflating the two in some of your answers.

Professor Appleby: Have I? I apologise.

Q6 Andrew George: We will have to go back over the transcript. Could you say a little more about if you had been looking at this from the point of view of productivity gain? You are saying that the NHS was underspent last year. In other words, it made financial savings. In terms of its productivity, was productivity the same or higher or in spite of flatlining or falling spend?

Professor Appleby: From memory, yes, I think activity, if we are going to measure productivity crudely in terms of people through the system, went up last year. I think the NHS managed to maintain its levels of activity. In a crude sense, that measure of productivity went up and the money actually went down slightly. We have seen that in the past with the NHS. It is a big organisation and it steams ahead. One year when the money slows down, quite often the productivity increases. You see that trend. We may see it this year as well. Over time I think there is going to be a problem there. The words are important here and I have used words like “savings” and have criticised others for using that word rather than “productivity gains”. That is what we are talking about. This £20 billion is the monetary expression or value of really important things for patients. In a sense, it is not about money but about better value and care for patients. That is the important thing which has been missing from some of the debate, and I have to say it is missing sometimes in some of the QIPP plans.

Q7 Mr Sharma: Our previous inquiry identified a difficulty in measuring efficiency gains. There are three questions. Are you satisfied with the measures the Government has put in place? How suitable are the indicators proposed by the Government? Finally, what are the risks of inadequate monitoring and measuring of progress?
**Professor Appleby:** I will start to tackle the first one. Measuring efficiency is difficult. The Office for National Statistics have a group called the UK Centre for the Measurement of Government Activity, set up some years ago following a review of measuring efficiency across the whole of the public sector, and one of the things they have focused on is the NHS as it is such a big chunk of the public sector. The NHS has made tremendous progress but still falls short of capturing what it is to be efficient and productive. Now, ONS count most of the activity that goes on in the NHS but not all of it. There are chunks of NHS activity that are not part of the official measures of productivity such as quite a lot of community services. We still do not know for sure how many people see their GP as we do not count that properly. We have to do a survey for that. There is some basic stuff we are missing in terms of simply counting the numbers of the product, if you like. There are problems, but there is a lot of work going into improving it. One of the crucial things that we are lacking is some measure of quality of the product. Counting the numbers of patients that go through hospitals, the number of beds and prescriptions given is a basic measure of activity, but we do not know the quality of those operations. Were those prescriptions correctly given in the right circumstances that improved health? There is a big gap in terms of quality, which is the major complaint that the Department of Health made at your last inquiry into this, that the official measures did not capture what they felt had been improvements in the quality of care which would improve productivity, but the NHS is moving towards that.

**Dr Smith:** May I add to that and reiterate the point John was making about primary and community services? It was a concern for us at the Nuffield Trust—and we published this in a paper called *NHS reforms in England: managing the transition earlier this year*—that, in terms of the operating framework for the NHS this year, the indicators that are being used to monitor performance of NHS organisations are quite heavily skewed towards the acute sector rather than primary and community services. Another issue that is important is to be quite clear about who is going to take the “in the round” view on the performance of a single NHS organisation in terms of both the activity side of efficiency and also, importantly, quality. That is so that we can make sure, at a time when the focus is on productivity, that not only crude productivity but quality is properly taken into account and we do not see the very terrible sort of system failures we know that are possible within a system such as ours.

**Q8 Mr Sharma:** The Department of Health tells us that, so far, the QIPP programme is on track. Do you agree and are savings being made at the level required?

**Professor Appleby:** I do not know whether I agree or disagree because I do not think they know, and I do not know, whether things are on track in that sense. All PCTs and trusts—NHS organisations—have produced plans for this year in going forward about how they are going to make savings—sorry, how they are going to make productivity gains. Those plans have been approved. One of our complaints and our big worries is that we simply do not know where the NHS is at the moment, and I have my doubts that even by the end of the year and beyond whether we will know if the system has achieved what it said it was setting out to achieve. The Department are relying on something that goes back years. In terms of measuring value for money, it is done in an implied way. In a sense, the Treasury give the NHS money and say, “We are going to hold back 3%—that is the efficiency saving—and then we are going to ask you to improve activity and do various things.” If the NHS does those things, and it is assumed that it has done them and made its money-for-value gain, it has made its efficiency gain. That is the sort of tactic now. It is not being measured directly by the Department of Health, so I am not sure how they know that the QIPP plans are on track this year.

**Dr Smith:** This underlines the concern that we absolutely share at the Nuffield about needing the QIPP plans to be in the public domain and easily accessible so that people in local communities can understand what those plans are for their local health services, both in terms of perhaps the savings side of efficiency but also, really importantly, about new models of care and potential changes to services. That is important because what has quite fundamentally been missing a lot of the time from the debate—we talk about QIPP, but that means nothing to the lay person in the street, or indeed a lot of NHS staff, I am sure—is having a strong and convincing narrative for patients, staff and the public as to what this is all about. That is critical because managers and clinical leaders absolutely need that narrative in support of the very difficult and challenging work they have ahead of them to change services and to make the case for that.

**Q9 Chair:** That is very important. Is the implication of that answer that these plans are still confidential in significant parts of the health service?

**Professor Appleby:** I was not aware that they were confidential. When you read them, they are not the most transparent of documents quite often, to be honest.

**Dr Smith:** My sense is that they are not gathered together in one place that is easily accessible. Again, I am getting a sense that it is often through PCT cluster board papers and mechanisms such as those that people are becoming aware of what is happening. There seems to be, to us, a need for greater transparency as to what this is all about, the challenge, and how that is playing out for local health economies.

**Chair:** A better narrative.

**Dr Smith:** Definitely.

**Q10 Rosie Cooper:** I would like to join up some of those things with the world as it exists outside this place. I understand savings being equivalent to efficiency gains, but how does that measure quality? You said a couple of seconds ago that it did not really and then Dr Smith talked about the narrative. How would you explain these efficiency gains to the people...
we are asking to deliver quality—good care and productivity to the patient outside—when what they see is the waiting times for operations growing steadily longer now? But, for example, as for the PCTs, the very people who you talked about regarding strong commissioning required now, that is hollow. You have the shadow commissioning groups forming. How can that in any way be seen as strong commissioning at a time you need it to be in hospitals—I will take that for an example and it will apply right across the system—where employees are finding that efficiency gains need to be made? We are asking them to deliver quality, be efficient and get productivity, but we are saying, “By the way, we will regrade your jobs and you will now take home less pay than you did a short while ago.” The very people we need to deliver good commissioning are demoralised, are not there or are planning their next job, having been made redundant, and will no doubt come back and do the same thing. A lot of the time clinicians are being regraded. How do you see a system that is being so attacked being delivered? The managers and the people who are supposed to deliver all this are being so attacked. How can it be delivered without some very crude slash and burn?

Professor Appleby: This was the point Judith was making earlier. The Nicholson challenge is difficult enough as it is, but it comes at a time of huge upheaval, especially in management, and it is not only the reforms. It is the parallel savings in management costs and reorganisation that are extremely difficult. The people who are working now in PCTs should be congratulated for still doing their job, to be honest. It is very difficult to work in an organisation that will be axed—that you know is going to be disappearing. You have to carry on and help prepare the ground for, in a sense, the next wave of organisations and commissioning groups. On top of that you have to grapple with a difficult problem. Simply saving money is not difficult. We used to do it in the NHS by simply closing a ward. You put the padlocks on the doors, the people do not come in and you save the money. That is not the task now, as you are saying. It is a more complicated job, which needs to galvanise the staff to feel enthused to search out new ways of working and new ways of delivering healthcare to patients.

Q11 Rosie Cooper: Do you think reducing their pay and grading is the way to do it?

Dr Smith: Given that commissioning is under significant strain at the moment, as you have quite rightly said, and it has affected the PCT clusters to whom lots of this important work is falling, one thing that is needed is significant help and guidance, whether from the Department of Health or the nascent NHS Commissioning Board. Clear guidance and evidence is needed about what works and can be helpful in terms of improving productivity in providing services. The work I mentioned that we are going to be publishing in this area has quite powerful messages about some of the things we have known for a long time, like reducing length of stay and making sure that things happen, such as day cases when they should be. Tackling variation in performance is a significant issue for us and there is still quite a lot more to do across the service in that area.

To pick up your point about skill mix and so forth, again the review of the evidence that we are going to publish has some interesting messages about the fact that, when you are looking for greater productivity, you might need a richer skill mix in the organisation. You may need fewer staff, but you need to be cautious about watering down skill mix because there is fairly convincing evidence internationally that that may well have an impact on care and quality. What we are saying here is that it is a complex mix. There is some good evidence we can draw upon that, yes, things can become more productive, but we have to be cautious as we make progress on that, particularly—as the earlier question was implying—in measuring quality at the same time.

Q12 Rosie Cooper: Finally, how do you do that with caution while you are on a steam train heading towards what is 6% gains and things getting more and more difficult year on year?

Dr Smith: It is important that they are not denigrated but that they are supported, both the managers and the clinical leaders, in trusts, and also those in the new commissioning groups and those who have been working for many years in PCTs. It is to that community that much of this will fall. They need appropriate guidance and evidence, and indeed the narrative from above, but they also need space and support to do that work within their health economies.

Q14 Rosie Cooper: It is clear that the Government narrative on this so far has been “Managers are bureaucracy and they are a drain on the system”, when the reality is that—and I know from being chair of a hospital—you cannot run it without them.

Dr Smith: The King’s Fund’s recent commission on management in the health service absolutely underlined the importance of management to the challenge we face. The Nuffield Trust would absolutely support the findings of that commission.

Professor Appleby: I am slightly diverting here, but as to management the crucial question is how many managers do you need to run the system effectively? Nobody really knows the answer to that, unfortunately. A view has been taken by the Government that the NHS could be run as or more efficiently with fewer staff—fewer managers. It is interesting that the impact assessment on the Health Bill, which came out last week, has reduced the baseline spend that they thought PCTs were spending on management by quite a lot and yet the one-third cut in management is still going ahead, even on its reduced baseline. Therefore, obviously the target is a third rather than starting with the question, “How many managers do we really need to run a health service?” It sounds a bit like, “How many managers
Q15 Dr Poulter: Going back to something Professor Appleby said earlier, you touched upon the fact that the Government is set to make efficiency savings—sort of levers—of 40% through provider productivity gains and reductions in input costs and 20% through service redesign and change. From your answer, I have gathered that it is much more complicated than putting these arbitrary percentages on things. Is the structure of the NHS well placed to deliver these efficiency savings? Certainly, the feel I get from what you are saying is perhaps it is structural issues that are more important and the issue around service redesign and change is perhaps the key one of those drivers. Do you think that, currently, the way the NHS is set out, regardless of what the tariff may be and what is paid to hospitals, the incentives and rewards in the NHS, QOF payments for GPs and the tariffs for hospitals, will help to deliver the service redesign and change that is perhaps one of the key drivers to how they are going to improve services?

Professor Appleby: That is a big question. First of all, there are a whole variety of incentives in the system. The tariff is an obvious one, but that is not the only way that we move money around, if you see what I mean, from government to people’s pockets to pay for things. Roughly a third of the amount of money spent on the NHS goes through the tariff. That has some pretty strong incentives. When the Government is squashing down on the price, you presume, in theory at least, that that would have a big pressure on hospitals to examine their costs and think of better ways of providing care for the money they are getting. It could also mean, of course, you can have some perverse effects coming out of something like that. If you squeeze down too much on price, trusts may think, “Is it worth us supplying this high-cost service?” I think the approach, whether about put on some of the price, trusts may think, “What does that imply for changes in the budget? Millions of pounds is it and how do we squeeze that out of our system?” I think the approach might be something like a conversion. Recently, we have seen, in the QIPP plans, quite often that the approach taken is, “What is our share of the £20 billion as an organisation? How many millions is it and how do we squeeze that out of our budgets in, almost, cash terms?” I think the approach should have been, “How can we improve care for patients? What is it that they value that we can do more of?” What does that imply for changes in the service? It may imply doing more hips, more day cases, or it may imply, “Let us keep some patients out of hospital. They should not be there. They should be treated in some other location.” It is working through plans in that way rather than from the financial end. Traditionally, the NHS’s approach to efficiency gains has been to lop the money off the top, that is not give it to the system in the first place and then ask questions later, as it were, and exhort the system to do as much as it can with slightly less money. I have to say, to an extent, that tactic is still being pursued.

Q16 Dr Poulter: You made the point earlier that the easy way to make savings is to say, “We are not going to provide this service. If we shut that ward or that community hospital, that may be a short-term fix”, but, in the long term, that is not necessarily thinking about the overall service redesign that may be required, particularly with regard to care of the elderly, and also in terms of providing a greater focus on improving integrated care. We know, for example, that A and E admissions are increasing in most hospitals year on year for a whole variety of reasons. A lot of those admissions are elderly people with multiple medical comorbidities. Are there the drivers in the system to encourage a focus on better preventing those admissions, which would hopefully save costs as well and provide that sort of integration?

Professor Appleby: It is hard to know whether the system itself is structured in such a way as to encourage that thinking. I am not particularly sure it is.

Q17 Chair: I think you would find it quite easy to know.

Professor Appleby: I am trying to think what they are and, within organisations, what is encouraging PCTs to think about how they put together new types of service. For all this talk about commissioning, I have a suspicion that in fact most of the innovation in the system is going to come from the provider side. They are the ones who provide the service. It is going to come from GPs in their practices, not as GPs in their commissioning roles so much, as far as I am concerned. It is also hospitals. If you talk to hospital managers and people who work in hospitals, that is where a lot of the innovation will come from. It seems to me.

Q18 Chair: Will that innovation include redundancy of hospital service as a result of opportunities for service redesign?

Professor Appleby: Possibly. Hospitals have a remarkable tenacity, over history, in terms of survival as institutions, so I am not sure about that.

Dr Smith: Rather than redundancy of hospitals, it might be something like a conversion. Recently, we had a group of Canadian politicians, clinicians and managers over at Nuffield talking about their experience in the 1990s of having to change their health system at a time of significant economic constraint. They talked about converting hospitals and the way the they are used. That picks up on the point that was being made, and, to follow on from it, yes, the central measures, whether about pay or tariff, clearly give both headroom, to a certain extent, to local commissioners and providers and also make the seriousness of the challenge evident to managers and health communities.

Picking up on your point about developing integrated care and different approaches of care for people with long-term conditions, I am not sure that always does feature as significantly as it should, either at local or indeed national level, and it is easy and
understandable that we go back to looking at waiting times for elective carers because it is relatively easy to measure. But, going into this next period, compared with times in the past, we are better at measuring quality than we were. It is still not as good as it could be. Tracking where care is fragmented and does not deliver properly for people is important. Indeed, picking up on John’s point about, “Is it commissioners or providers?”, in the work I am involved in around the country I am often seeing that, at the moment, perhaps partly because of the pressures commissioners are under, it is often providers now who are taking the lead for looking at the whole health economy with their partners about what should happen, how care could be better integrated. Some of those efforts need to be supported by clusters and centrally, because we could have some interesting—back to where I started—conversion of how services are provided. It is not getting rid of the buildings and staff necessarily but they might be working quite differently to deliver the much better integrated care that all of us want for ourselves and our families.

Q19 Dr Wollaston: Following on from those points, do you think we are going to see greater innovation in integration if we move more towards a capitation-based commissioning and allow a less rigid separation between purchasers and providers? Professor Appleby: Yes. What can confine people to thinking and acting in a certain way is who holds the budget, for example. A hospital can make decisions which could be in the best interests of their patients but is not in the best interests of the hospital as a whole, and they may not be so incentivised to do that. This is a problematic trade-off in the health service: do you have the separation of purchasers and providers or do you put them together in some way? There are costs and benefits to either system. There is certainly room to explore ways of, in a sense, having budgets which cross boundaries and setting up new budgets, so it is partly hospital care, partly primary care and partly something else. That could encourage people to think in different ways about how care is provided.

Dr Smith: There is potential in trying out some different approaches here, particularly in allocating a capitated budget perhaps to a group of general practitioners, if you align them in a certain way. What you are aligning the incentives for them to deliver that more integrated care and perhaps help to tackle the avoidable emergency admissions that we know are such a pressure on the system, particularly at the moment. However, a slight caution there is that it is not, in a sense, the magic bullet, because international research evidence on payment methods in health would say that you need a mix. Capitation has its place, but either some fee-for-service or other targeted payments will be needed as well. The trick is to be shifting those approaches to try and ensure you are delivering the right outcome. Indeed, services for people with long-term conditions may need a different approach to that payment structure from, for example, elective care. But there is certainly room for more experimentation—experimentation which I know is being thought about by the Future Forum and others in the work they are doing about integrated care. It is work on which The King’s Fund and ourselves are providing some support to the Department of Health. There is definitely more to explore there, yes.

Q20 Dr Wollaston: Traditionally, the NHS has not been very good at sharing best practice. Do you think there is hope for the future that this will get better under the new arrangements, with some areas of being innovative and showing real gains, and that will then be adopted elsewhere?

Professor Appleby: That sort of diffusion of new technologies throughout organisations and industries is difficult. One of the things that can help—and it is something the Department can help with and can be a central function—is something like the Modernisation Agency, which has now been abolished. It helped the NHS tremendously in grappling with things like reducing waiting times. It is a big system and there are people doing good things in certain bits and they should be telling other people, but they don’t. There is a role centrally there for doing that.

Dr Smith: We need to remember as well that we have the NHS Institute for Innovation and Improvement, and also NICE is there. Other health systems often look enviously at us in terms of the resources we have. There is the work the Institute has done on “The Productive Ward”, productive departments. They have looked at what the productivity gains are to be made if all organisations operated as do the best. Again, NICE have very clear guidance on things that should not be done and also technologies that should be taken up because they offer real gains in terms of quality and, indeed, productivity overall. We have a lot of resources there, but putting those into practice, both in our system and indeed health systems internationally, is always more difficult and takes us back to what we were talking about as to management and local organisational development, managers working with clinicians and communities and so forth.

Q21 Andrew George: I want to look in a little more detail at the 40% productivity gained by providers, and to a certain extent you have touched on some of it. We have been talking so far rather conceptually about systems reorganisation, or systems redesign, which is supposed to be related to about 20% of the efficiency gain. If we are looking at the providers, which sectors or which procedures are achieving the most, if you look at it from the productivity gain, or bearing the brunt of the cuts most? Is there a pattern emerging so far as to where those gains are being made at the provider front?

Professor Appleby: I am not sure there is. There may be a pattern, but we do not know what it is yet. Again, this goes back to the issue, the problem, the worry that we have that we are not sure what is going on, and certainly there is no central monitoring of what is going on at the level of individual organisations. As I said in my opening remarks, in aggregate the NHS this year will do okay. It will broadly achieve its 4%, or so, efficiency gain as much as we can tell. It is very hard to answer because we do not have data going right down to organisations and it is certainly not collected centrally.

You talked about cuts. There may be some service reductions. In our small panel survey of finance
directors, they produced a number of them. We asked them how they were putting together their QIPP plans and what constitutes the efficiency gains. They talked about a whole range of different things in general. They talked about reductions in the amount of time patients were staying in hospital, for example, which saves some money and frees up some resource for doing other things; changes in the work force; reducing agency staff, who tend to cost more than employing other staff; reducing head counts; redesigning and reconfiguring some services. Some things are going on and, interestingly, there were also back-office efficiencies. In a sense—I hate to say this—it is the usual list of the things that the NHS does and has traditionally done, and it has to do a hell of a lot more of it and very quickly.

Q22 Andrew George: Are you suggesting that what is going on is that the service is not cutting, if you like, fat from the system but perhaps taking risks by discharging early? The same is happening in my own area. Apparently, there is going to be a move to discharge all mastectomy patients within 24 hours, for example. Is that a risk, or is it that they have been staying in too long? There is an indication and some anecdotal evidence that waiting times and waiting lists are lifting upwards slightly in some areas. Is that something that you have noticed?

Professor Appleby: Certainly, it is very hard to pick out what is really going on with waiting times, I have to say, and there are possibly 10 or more different statistics that you can quote about the same bit of data on waiting times. It can get very confusing. There has been a slight indication that in some areas waiting times have crept up a bit in total. There has also been a noticeable change in the numbers of organisations not meeting their targets on waiting times, whereas, in the aggregate, those things tend to get smoothed out a bit at a national level and you do not see those. We will see more of that, and I think we will see individual hospitals, and then within hospitals it will be certain specialties, notably orthopaedics probably, which will be failing to keep their waiting times low. So, yes, there is some trend there.

Q23 Andrew George: Are there technical gains? You were talking earlier about new technologies coming in which could achieve greater efficiencies. Obviously, disseminating that amongst clinicians is important, but, within routine elective work, is that going to be a sector in which there can be greater efficiencies achieved simply by exhorting the service itself to reduce the number of staff in theatres supporting the clinician operating, or whatever, or just asking them to work faster? What can be done in those circumstances?

Professor Appleby: Traditionally, there is a whole series of things. With medicine, over time, the technology has changed so that patients simply do not have to stay in hospital so long. New techniques are invented, recovery times become much quicker and you can get patients in and out in a day. For example, the day case rate in the NHS, as in many systems, is now touching 80% of patients.

Q24 Andrew George: Is that on the surgical side?

Professor Appleby: Yes, but there is an obvious ceiling to that, which is 100%. You are not going to get above 100%. As you get closer to that, it gets harder, and we are reliant on new inventions, as I say, and new technologies for treating patients. That is what has really driven the reductions in length of stay and the fall in beds.

Q25 Chair: If I can interrupt, are we not reliant on better early intervention in order to avoid those patients needing to arrive in hospital in the first place?

Professor Appleby: There is that as well.

Dr Smith: Given the scale of the challenge ahead of us at the moment, this is where the Department of Health, QIPP people or, increasingly, the NHS Commissioning Board can help local commissioners and providers. They can provide a clear steer on what it is that should or should not be done, things that should not be anything other than a day case or certain technologies that must be taken up now because they both deliver quality and efficiency. One reason I mention that is because we have talked about some of the signs we are seeing of waiting times starting to move out, but we are also hearing reports of PCTs restricting certain care, perhaps IVF, or raising thresholds for surgical treatment and so forth. Those decisions are very difficult for local commissioners to make and cause, understandably, lots of concern. We are publishing research this Thursday looking at how PCTs have made those difficult decisions and it suggests that they have tended to look at services at the margin, not at the core spend. I mention that because it is going to be hard for new commissioning groups that are just getting off the ground if they have to start with those difficult decisions. Some steering guidance from the centre about what it is that the people should rightly expect or not from the services could help to set the framework for those new commissioners, because otherwise we may find there will be more reverting back to exactly those patterns and behaviour that you have alluded to and that John has described.

Professor Appleby: I want to say something about day cases. We have known what types of cases are suitable for day cases for decades. The Audit Commission, going back to the middle of the last century or something, had published—

Dr Smith: It was 1955, I think.

Professor Appleby: The Audit Commission had its 20 procedures which absolutely should be done as day cases. That was not, obviously, regardless of the condition of the patient, but, by and large, “These are the sorts of things you should do as day cases.” We looked at these again recently, along with some other interventions, and you still see quite a lot of variation across the country in terms of these operations, so there is still some way to go. All I would say is that, in that area, there is an obvious limit, which is 100%.

You can keep patients out of hospital, yes, but quite often that is the best place for certain types of people with certain types of conditions.
Q26 Andrew George: Finally, I have a question on the issue of international comparisons. You have done some work, Professor Appleby, in terms of outcomes, on the international comparator. To what extent, in terms of the efficiency of the NHS presently in comparison with its equivalent European health systems, are we hopelessly inefficient in the UK?

Professor Appleby: It is a good question and lots of people ask, “How does this system compare with other systems?” It is an incredibly difficult question to answer. Broadly and on fairly crude measures of productivity, almost dividing the activity by the amounts of money going in, the NHS is not too bad. That disguises a whole lot of variation within the system, different sectors and different geographical areas. Broadly, the NHS is seen as reasonably efficient, but, as I say, that disguises a lot of variation and also disguises the fact that the whole system itself could become more efficient.

Q27 Chair: It disguises variation within the system, never mind variation of different types of outcome.

Professor Appleby: Yes.

Dr Smith: To add to that, there is fairly recent work from the OECD showing that, when you compare us even with systems that have broadly the same sort of structure of primary and secondary care, in areas such as length of stay we still could do better. There are countries such as Denmark, which is one example, where they are quite significantly better than us on that, so there is more for us to—

Q28 Andrew George: A shorter stay, do you mean?

Dr Smith: Yes.

Professor Appleby: But they have a higher mortality in the population.

Dr Smith: There you go.

Professor Appleby: But they love their system.

Dr Smith: More research is needed.

Andrew George: Better means shorter, does it?

Chair: We need to move on.

Q29 Chris Skidmore: I would like to come on to social care, in particular integration of health and social care. We mentioned in our previous report back in December that it would be mission-critical to the successful delivery of the Nicholson challenge and that we need a quantum leap in this particular area. I notice, Professor Appleby, from your evidence on point 32, you say “despite notable successes, progress has been limited with less than 5% of NHS and social care budgets subject to joint arrangements with wide variations across different parts of the country”. You go on to say that we need a more ambitious approach in this respect. How have you found, in particular, any efficiency gains that can be made in health affecting social care and how would you set out that we should address this integration? If it is simply not happening, who pulls the levers to make sure it does happen?

Professor Appleby: There are two questions there, one about the impact of what the NHS is doing on social care. I am going to be a bit boring now, but, again, this is an area that needs to be monitored more closely.

The Fund does what it can in that area in terms of talking to people, but there is no routine monitoring of that impact. It is very hard to say. In terms of integration, which has risen to the top of the pile of buzz words, what we are trying to point out here is that, in a way, both systems have been trying to integrate and have been looking at ways of working together because it is just so obvious that that has to happen. Joint budgets go back a long time, and it was trying to encourage both social care and healthcare to think about useful, interesting and valuable areas to co-operate. It goes back to the budget point I was making earlier that you have separate budgets. You can pool them together and you get both services working together on that. It has moved things a little bit.

There are examples—and Torbay, of course, is often quoted as a key example—of where real effort and focus have gone in over a number of years to try and think of what services can be integrated and how they can work. It is not a simple job to do. Changing the budgetary arrangements and pooling things together can help, but it does not instantly change professional attitudes, for example. It does not necessarily generate ideas of itself. We have parts of the system. Northern Ireland has notionally integrated health and social care. I am not necessarily sure that we see remarkably new innovative things coming from that, so there is obviously more that has to go into the mix apart from budgets and so on.

Q30 Chris Skidmore: With the £1 billion that was released from the NHS specifically to be spent on social care in the previous budget, what signs have you seen that that money is not quite ring-fenced but is dedicated toward improving integration between the two services and that the money itself is almost the purse strings drawing, where it is spent, health and social care together?

Professor Appleby: What local authorities seem to be saying, and the messages we pick up, is that that money is extremely welcome indeed, but it has not prevented tightening on the sort of service arrangements, charges, for example, in social care. Some of the eligibility criteria have also become tougher across the system.

Q31 Chris Skidmore: I see in your evidence that you mention about productivity and social care and productivity and healthcare. Obviously, if you look at the flat figures, it seems that since 1997 productivity in social care has fallen by 15%. But that is nonsense, because, if you are looking at certain community-based services upon which social care is far more dependent, it is not being realised in those figures. Is a mismatch between how productivity is measured in social care and healthcare in itself going to mean that health and social care are always going to remain two separate lines of the track, because, with the way that they are measured, you have two entirely different systems?

Professor Appleby: The way we measure productivity within the NHS is a composite of a whole range of measures in different services. There is a measure for secondary care, a measure for primary care and a
separate measure for drugs, and all these get added together in some way. Social care is providing a different service, so it is measured in a slightly different way. I think there is a problem, though.

**Dr Smith:** May I add to that? The point about what is going on with health and social care is very important as both address the efficiency challenge. My colleague at Nuffield, Dr Martin Bardsley, has been doing some interesting work with person-level data but linking data between health and social care to try and track what is happening. Early findings from that work suggest that people receiving social care are much more likely, first of all, to receive hospital care. That is probably reasonably intuitive, but also, interestingly, people in care homes are less likely to have a hospital admission or, indeed, to go to outpatients. People having intensive home support in social care are likely to have the hospital care. The point is that this analysis is starting to help us understand that what might seem like an improvement in care, by moving someone from a care home to having intensive care at home, may lead to an unintended consequence of more use of A and E. So there is something in looking at the connections.

**Q32 Chris Skidmore:** Specifically on that point, in terms of the way we look at the QIPP programme, and almost the philosophy behind the QIPP programme, you would probably agree that it focuses on the supply side rather than the demand. Is there not some room for renegotiating towards looking at the demand side, which would then place a greater emphasis on social care as addressing demand in the way that you have raised? It would help lower demand rather than everything that seems to be only focused on sourcing out and finding productivity inefficiencies in the supply.

**Dr Smith:** It is partly back to the issue that was raised earlier about focusing more on people with long-term conditions. The ideal would be to have a situation where there is much more focus on prevention, on predicting who is going to be at risk, whether it is a social care admission or a health admission. We have experience of that and people are trying to do it in local health communities, but it is difficult work to do. It is quite resource-intensive to carry out that careful and more thoughtful work. There is real promise there and that is what sits within the redesign bit of the QIPP—the new service models bit of the QIPP challenge.

**Professor Appleby:** Traditionally, the NHS has been quite a parsimonious system. The most common prescription from GPs, as far as I understand it, is, “Come back in a week if it is still troubling you,” not, “I am going to whip you into hospital immediately.” Or, “I want to load you with lots of drugs.” When you look internationally, the consumption of pharmaceutical products in this country is relatively low compared to many countries. There are lots of efforts going into “manage demand”, that is, reduce demand. How successful they are up to now has been quite questionable. I have certainly talked to hospitals—that is, the suppliers—who said they could make a better job of reducing demand for their own product than the commissioners, ironically.

**Dr Smith:** To follow up on the point, the issue about “managing demand”, yes, tends to be seen as reducing demand, but if we did become cleverer at identifying people’s needs earlier, sometimes it might mean putting in services where they are not seeking or demanding them at the moment. Often it is the people who are not even going to the GP, who may be sat out there with a range of missed long-term conditions, once they tip the balance, that are going to end up straight into A and E, and there can be a whole consequence of services and experiences for them that might have been prevented. There is something much cleverer there that we could focus on.

**Professor Appleby:** Can I clarify that? I was not saying reduce demand in the sense of not give people anything at all. I mean reduce demand for, say, secondary care, and it is more appropriate routing of people too, you know.

**Q33 Chris Skidmore:** There is, obviously, a debate over the demographic change that we will be facing over the next 20 years, ever since Wanless, and we do not seem to have followed that up properly since 2004. There is obviously debate on whether demand will inevitably rise or whether demand can be managed and sustained at a careful level. I can remember David Nicholson coming to us and saying, “Demand will not be an issue. Demand is tailing off.” I do not know if you have any thoughts about projection. We make these savings now, but that is till 2015, and then we will have a whole new challenge ahead of ourselves after 2015 because—

**Chair:** We have quite a challenge between now and 2015.

**Chris Skidmore:** Is that just a stand-still, and then—

**Professor Appleby:** The tricky thing for an economist about supply and demand in healthcare is that they are not independent. It is not as if there is a lump of demand out there waiting to be satisfied. Supply in healthcare, as in a lot of industries, generates its own demand. New drugs are invented, and what was not treatable and what was not demanded before becomes a demand. You see it all the time. It is a tricky one. It is almost a policy decision as to whether demand will go up, down or stay the same. So I can see where David Nicholson was coming from on that one. You have to make certain assumptions. As to the future, in terms of demographic change, that is not going to happen instantly. It is quite a long, slow process of change in the population. We can see it coming. It is not a time bomb, or anything like that, that is going to go off in our faces without us knowing. We can see it coming over the horizon. The population will grow in England; it will get larger, and we know there will be more people in it who will probably need healthcare. Whether they get that healthcare or what type of healthcare they get is a separate decision, it seems to me, made by government, the NHS and so on.

**Q34 Chris Skidmore:** I have one final question. Last year, Professor Appleby, you mentioned about productivity and efficiency savings possibly being negated by a rise in healthcare inflation. Inflation has hit 4.5% today. Do you have any updates on where
health inflation is relative to that and whether that is going to affect these savings and completely negate them?

**Professor Appleby:** We do not have any hard data on that. As to inflation as experienced by the NHS, in terms of its costs, the big chunk is still essentially frozen—pay costs—this year and next. What happens after that is anybody’s guess because by that time GPs will have had a pay freeze for about four years and consultants for three years. There is going to be a lot of pressure in the system to pay more. At the moment there is a lid on health service-related inflation.

**Q35 Rosie Cooper:** I would like to try and pull the strands of this together. In our 2010 report we noticed that significant efficiency gains could be realised on both sides if only health and social care could be made to work more effectively together. You have just described change as a long slow process. I keep hearing people talk about £1 billion, but I understand it is only about £650 million. How confident are you that those additional funds being made available for social care are being spent in a way that improves the quality of care and contributes to the improving integration between services?

**Professor Appleby:** You talked about Torbay and, when we had GPs from Cumbria here talking about redesign of services, they acknowledged that they received quite a significant financial sum, which I believe was something like £26 million, to help them redesign their services and make it happen. In an area where we now have local authorities increasing charges and changing eligibility criteria so that people in fact are out there on their own without having these huge sums of money made available to help that redesign, I am not sure, in the future, how you see the Department of Health, as opposed to the National Commissioning Board, playing into the strategic future. In this climate, do you see those changes, the service redesign, delivering while we are going at it not long and slow and getting it right but going at it hard and fast to get the result?

**Professor Appleby:** It depends what the service redesign is. We need to be specific about it. Some changes are clearly going to take some time to see through and take some thinking about. With others, it seems to me, there is no reason to see why they have not happened already in certain places. It is tricky identifying why things have not changed sometimes. What are the factors which bring about some change? It could be that incentives are all wrong and misaligned. It could be that there is simply not the management will to change things or there are professional problems. Some of these things are easier to solve than others, so it depends what the change is specifically and what the barriers are. I cannot be more specific than that myself.

**Q36 Rosie Cooper:** Are you confident that the money that is being made available to health and social care will improve the lot of the disabled and/or elderly population who rely on those services? What we are seeing now is that they are paying a lot more for it and on the eligibility they are getting left off.

**Professor Appleby:** I am sure that money will do good. It is not going to be thrown down the drain, as far as I am aware. The question is, is it enough, I guess.

**Q37 Chair:** That is it precisely, is it not, whether the levers are such as to drive through the necessary change in the care model?

**Professor Appleby:** Yes.

**Dr Smith:** That is combined with what were the pre-existing relationships like between health and social care beforehand, between local government and health. If there are strong relationships and there is a high degree of trust between the senior managers, the clinicians and the members of the local authorities, if that is all in place, and also if there is some clarity of vision for the sort of services wanted for local people, they stand a much more fighting chance of using that money to good effect and seeing the results fairly soon. Money of itself will not necessarily solve those relationship problems if they were not great to start with.

**Q38 Rosie Cooper:** If you were to guess and look at the country as a whole, how many local authority health service interfaces do you think look like that that will deliver?

**Dr Smith:** I genuinely do not have a sense of what that would be. It goes back to the point that we need a few but really clever indicators that show us if things are either improving or getting worse for the clients in those areas. I sometimes think of it like the canary falling off its perch in the mine. We need some indicators that can almost be that critical to show us if things are going wrong. Do you see what I mean? It is very hard to tell, by looking only at money and organisations, to try and make comparisons, but some clever indicators are needed that show us what is happening particularly to frail, older people with complex conditions. Again, there is good work that is being done in that area, but we need to be bringing that work and, as I say, some clarity of indicators very much to the fore.

**Professor Appleby:** I can give you a number on that, if you want one, although it has health warnings. In our little panel survey of finance directors of roughly 30, around eight noted that, in terms of barriers to improving productivity, working with local partners, which included social care and social services, was a problem, but it is difficult to say how much store to put by that.

**Q39 Rosie Cooper:** Could you go over those numbers again for me as I did not quite hear them?

**Professor Appleby:** In our panel survey of NHS finance directors, when we asked them, “What are some of the barriers to you achieving productivity improvements?”, eight out of about 30 said it was a problem.

**Chair:** At that point, we need to move on. Thank you very much for coming this morning. You have given us a great start in looking at what is going on in the famous Nicholson challenge.
Examination of Witnesses

Witnesses: Mike Farrar, Chief Executive, and Jo Webber, Deputy Policy Director, NHS Confederation, and Councillor David Rogers OBE, Chair, Community Wellbeing Board, and Andrew Cozens, Strategic Adviser, Children, Adults and Health Services, Local Government Group, gave evidence.

Q40 Chair: Thank you very much for coming. I am sorry we have kept you waiting for 10 minutes. Welcome back to Councillor Rogers, and, I think, Andrew Cozens as well. Welcome for the first time to Mike Farrar, the first time wearing this hat anyway. Would you briefly introduce yourselves so that the Committee knows where you are coming from, starting with Mr Cozens?

Andrew Cozens: I am Andrew Cozens, the Strategic Adviser for Adult Social Care and Health for the Local Government Group.

Councillor Rogers: I am Councillor David Rogers. I chair the Community Wellbeing Board of the Local Government Group.

Mike Farrar: I am Mike Farrar, Chief Executive of the NHS Confederation.

Jo Webber: I am Jo Webber, Deputy Policy Director and Director of the Ambulance Service Network at the NHS Confederation.

Q41 Chair: Thank you very much. As I think you all know, the Committee in various reports and statements over the last 12 months has drawn attention to the scale of what we dub the Nicholson challenge. This is the requirement to deliver a scale of efficiency gain that is unprecedented in the history of the NHS, and indeed in the social care system, if we are going to meet the demands for health and social care that arise in the population. The core question we are focused on in these inquiries, essentially, is whether that challenge is deliverable, and are the plans that have been prepared in this first year of that four-year period demonstrating both that it is going to be delivered in the first year and that there is a realistic prospect of it being delivered over the lifetime of the Government spending programme between now and 2015. I would like to start by asking you for a general statement from both the health and social care perspective of where you feel the system is in terms of responding to that central challenge.

Mike Farrar: The answer is that, yes, it is deliverable but only if significant improvements are made in terms of the way we are going about it at the moment. The “if” bit relates to, first, the scale of the challenge and, secondly, the fact that in order to deliver this there needs to be action at a number of levels, which all have to come off, and I will say a bit about that. Individual organisations need to be as efficient as they possibly can and deliver savings within their boundaries. The care pathways need to be redesigned and commissioners and providers need to work together to get the most effective use of resource. There needs to be more intelligent configuration of services between acute services in order to take out capacity, which we probably cannot afford to keep if we are going to release that to deal with the extra demand. Finally, the NHS overall needs to use its ability to orchestrate at scale those areas like management of supply chain and things like that in order to deliver benefits. To make all that happen is a Herculean task, and I have not even mentioned our relationship with partners in social care. Our concern has been that we have started slowly, in part because our members would say they have been distracted by thinking about the consequences of health reform, and that is one of the issues that they face. In a nutshell, with regard to some of those major transformational changes such as taking capacity out of bits of the system that we need to do, the scale and the time frame that those have been happening in the past would effectively mean that we would not be making the savings early enough over the four years to get to the end point where we would like to be. That makes the catch-up nature of what we are having to do, as well as that Herculean task, quite a significant challenge. But I am an optimist and I believe that we should be doing better than we are at the moment. We can do better collectively and need some help, but it is doable if we get our act together, but we are running out of road to do that.

Councillor Rogers: I agree with that but would add some other points as well. The challenge, of course, is not simply a financial one through the spending review in the case of all public services or some specific challenges for aspects of that. It is also a demographic one—growing demand—and I think we both agree that that is of the scale of 4% a year simply because of our ageing population and all the other factors which I am sure you are well aware of. There is an aspect of this which means, certainly in relation to social care, that there is an urgent need to ensure that the current system is maintained or can be kept going before any of the proposed changes come into effect, which inevitably will be over a medium-term period rather than in the current year or even next year. I think we have to have all of those things at the back of our mind before we talk about anything that is specific. Inevitably, in a period of turbulence, the relationships at local level come under strain and there are existing good relationships in many places between health and social care. It is envisaged that those should be built on, and no doubt we can talk about that more later, but the actual relationships between individuals holding specific responsibilities, specific posts, inevitably come under strain because some of those will move, change or be different in another way. That is another challenge that faces us all.

In relation to the detail of what is happening this year or might be thought to be happening next year, some of it is of a highly technical nature and varies considerably with different local authorities up and down the country. So if there is anything in your later questions this morning as to which we either do not have the information with us or where there is greater detail required, we would certainly be more than happy to work with our professional colleagues in ADASS to ensure that you get that information within the time scale that you need in order to complete this inquiry.
Q42 Chair: Thank you. The core question has two elements, does it not? First, can the system meet the demands that are going to be placed upon it within the budget available and, secondly, related to that, can it meet the quality standard, or does meeting the financial budget mean there is going to be a quality decline? I would be interested in both your views about what the answer is to those questions, and, again, what is the answer, in the current year? Are we going to meet the budget and is there a quality cost, and what is the answer to that in future years?

Mike Farrar: I think you are right. The progress in which we would measure success could be dealt with in terms of looking at either, “Are we financially solvent but our service standards are slipping?” or, “Are our service standards being maintained but our financial position is slipping?” If you look at the current year, there is evidence that this is variable across the country. If you look at the compliance ratings that Monitor has for foundation trusts, which is a good measure of financial performance in the foundation trust sector, we know that that is slipping backwards and a larger proportion of trusts are falling into categories 1 and 2. Equally, we know that the waiting list position across the country has deteriorated from a high watermark previously. Now it is still within the overall constitutional position, but again you can see deterioration, and there are particular areas of the country where they are failing to meet that. So, in aggregate, what we are seeing is a deterioration on both of those fronts.

Our sense is that 82% of our membership believe that it would be possible to remain financially stable this year, but they are worried about future years. There is a strong sense that most of this year’s position on the money is being dealt with by taking account of reserves or a cushion that was in the system previously.

Q43 Chair: Can you put a number on the extent to which this is using reserves?

Mike Farrar: It is very, very difficult across the country to identify that because what we know on the commissioner side is that the commissioners are in a reasonable shape, but we are not as clear on the provider side because foundation trusts are not obliged to say what was in their reserves and what they are committing into their financial position. They just declare their financial position. It is not easy to put a number on that specifically. We could, again in light of David’s comments, try to make sure you have something of an approximation, but it is quite difficult and it is fairly variable across the country in different places.

Q44 Chair: It would be very interesting to know, split between the providers and commissioners, the extent to which they are using reserves to deliver financial balance this year.

Jo Webber: It is not just the reserves either. It is non-recurrent savings. It is savings that you will not be able to make again next year. So, although our members did feel, when we surveyed them, that they would be able to make it this year, it gets increasingly tough. Although this year the vast majority of them also recognise that they could keep quality going at the same time as making those savings, again, if you take that out over the three-year horizon, then it gets increasingly tough or they perceive that it will get increasingly tougher to do that.

Q45 Chair: In quoting this evidence, you are drawing on a survey you have done.

Jo Webber: It was a survey of our membership earlier in June this year.

Q46 Chair: That is published material, is it?

Jo Webber: Yes.

Andrew Cozens: May I say a little on social care? Our position draws heavily on the survey of the Association of Directors in May. As in previous evidence we have given to this Committee, there are the additional complexities of the local government settlement versus the settlement for social care itself. The headline is that, in general, local government has protected adult social care from the expected level of savings, but there still remains a reduction overall, we estimate, of about £1 billion, or about 6.9%, in overall terms. It is too early to say what the impact will be on quality, but it certainly continues the trend of services being maintained for those inside the tent but with greater difficulties for those with lesser need in getting access to service. That is reflected both in the changes to eligibility criteria but also in the intention, for example, to reduce expenditure on care home placements and to try and cap fee levels and other issues of this kind.

The position next year is much more difficult to predict, and it is also difficult to predict whether councils will be in a position to continue to protect adult social care in the second year of the settlement. Again, we do not have the specifics of that but can provide you with some more detail in due course.

Q47 Mr Sharma: Everybody is talking about savings and using different phrases, but in the end it comes down to how we save. Could you tell me where most of the savings are made? I will follow that with two very small questions so that you can answer them together. To what extent is the first year of QIPP about tackling the “low hanging fruit”? Are you confident that QIPP plans are initiating early the actions needed to release efficiency gains over the long term?

Councillor Rogers: As you say, there are a number of terms used to talk about essentially the same thing, but a key point to make here is that local government is recognised as being the most efficient part of the public sector already. A number of commentators have said that and the evidence is available to prove the point. If we are looking specifically at the current year, I have some figures which show that further efficiency savings—this is on top of what has already happened in previous years—represent something like 69% of the total. Additional income represents 8%. Service reductions represent something like just under a quarter of the total amounts that we are all talking about. I hope that gives you a flavour for the balance between different terms and also how they might be interpreted in different places and by different people.
Mike Farrar: Given the nature of the health service costs, the vast majority of costs relate to staffing levels and the price of labour, if I can put it like that. One of the major areas in which savings can be found is in managing the overall costs, not just in terms of individual costs for a staff member but also the amount of staff that are employed. While people will invariably talk about the ability to perhaps conduct lean processing, re-engineering of the way in which you provide service or indeed to reorganise where people access care, unless, ultimately, you can take out the fixed cost and the variable costs associated with staff, it is very difficult to get the cashable benefit of that. This is one of the great challenges. If we cannot release that resource, then our ability to meet rising demand—which David, I think very articulately, described in terms of ageing population and burden of disease from things like alcohol consumption over previous years—will outstrip our ability to effectively use that displaced resource, that offset resource, to meet it. My view is that what we have been doing in year one, and it comes back to Jo’s point, is to approach the QIPP challenge in the way that we might have approached efficiencies previously, which is by small salami slicing around some of our costs. A lot of providers are trying to get leaner in the way that they manage their processes. There is some evidence of better management of long-term conditions, which is reflecting some of the care into better places in terms of cost and quality. But, overall, one of our concerns—which is why I talk about us potentially running out of time within this financial envelope—is that we are not taking out the capacity or indeed fixing down our labour costs sufficiently, in those big chunks of expenditure, to be confident that that can be released in the time frame.

Andrew Cozens: Do you want me to comment on the low hanging fruit, because for adult social care the low hanging fruit are the usual ones of charges, eligibility criteria and reducing non-essential expenditure, particularly around some aspects of preventative services? Most councils are now trying to think about longer term investment in things like incentivising and helping to reduce unnecessary admissions to hospital and thinking about supporting people in the community rather than in residential establishments, and also the extent to which they can work more closely with the health service to get benefits for both. So there is a mixture of short-term and longer-term stuff. The longer term stuff has quite a long lead-in period, three to five years, one might argue, so one of the pressures will be next year’s low hanging fruit rather than perhaps in three to five years.

Mike Farrar: Can I make one additional comment, which is hopefully helpful for the Committee? First of all, the tariff deflation is an aggregate position, as we know, but tariff setting is not an exact science. I was looking at some data from a large teaching hospital, and I probably do not have the permission to quote where, but they were looking at variation away from tariff. For example, on their older people’s medicine, they were effectively spending 30% more than the tariff allowed per case, whereas on some of their one-off elective work they were effectively making around 20% over and above tariff. The issue there is that the balance of that is fairly variable, depending on the nature of the hospital and the nature of the local circumstances. Tariff is important in aggregate in terms of driving some productivity, but, if it is not properly calibrated in individual areas to match the real sensitivity, you risk the fact that that will generate an incentive for a provider to get more productive in order to generate more income and then the cost transfers across to the commissioner side in a way, when they have been trying to manage demand, they are finding themselves increasingly having to push people through. This is why, not wanting to make this over-complex, when you look at things in aggregate you can see one story, but, clearly, for individuals who experience health services and the financial and quality standards in their locality, this can be widely variable and tariff and is a rather crude mechanism. At aggregate level, obviously, putting a tariff deflator in to try and drive up productivity is a good thing, but it will impact variably across the country.

Q49 Chair: What proportion of NHS spend do you estimate is covered by tariff currently?

Mike Farrar: It is about 60% of acute activity, but that is about acute activity. If you look outside of that, primary care, for example, social care, it does not have the same kind of—

Jo Webber: One could argue that if our demand is due to long-term conditions and an ageing population, then it does not cover, except for very precise episodes, the vast majority of where the demand is increasing.

Q50 Chair: Sixty per cent. of acute activity would be your answer. We asked the same question of the
previous witnesses and they gave us a slightly different answer.

**Mike Farrar:** Did they say it was 40%?

**Chair:** They said 30%.

**Mike Farrar:** I might have my figures the wrong way round. We will clarify that, but I am fairly certain that it is around the 50% to 60%.

**Q51 Dr Wollaston:** If we are moving to best practice tariffs rather than average quality tariffs, is there not a risk that we will see tariffs going up rather than coming down as we move forward?

**Mike Farrar:** Yes, there would be. I want to give a very practical illustration of a scheme that we were involved with in the north-west which paid a premium above tariff price in return for compliance with best practice and standards in five big procedures. These were hip and knee replacements, acquired pneumonia, myocardial infarction, coronary heart failure and bypass grafts. The evaluation is going to demonstrate, both in terms of cost of overall care, and certainly in terms of quality, including lives saved, that that scheme has delivered better value for the taxpayer and a huge benefit for the patient. As to the notion that in describing tariff price is our biggest lever and consequence of failure to meet demand and also effects on behaviours. But understanding the way in which services respond.

**Q52 Dr Wollaston:** Therefore, it is very important to measure quality as well as price.

**Mike Farrar:** Absolutely.

**Q53 Rosie Cooper:** To draw the opposite analogy, if you are saying tariff plus a little enhancement for best practice gets great results, what is tariff being driven down likely to get us?

**Mike Farrar:** You would have to look in the context of genuine expectations on productivity because we know there is worse in the system, but if tariff starts to reduce in certain areas and therefore providers cannot effectively deliver that, then they will have to offset the loss that they would make on any individual procedure if they could not get their productivity gain somewhere else in the business.

**Rosie Cooper:** In terms of quality?

**Q54 Chair:** I would ask Rosie’s question in slightly different language. If there is not an expectation that in return for paying tariff you get best practice, what is the expectation, because surely what we are seeking to deliver is best practice?

**Mike Farrar:** There is not much evidence around this, except for the north-west work. What we defined as clinical best practice was agreed by NICE in this country and the American Medical Association because we checked the standards and used something similar. At the starting point of that experience we had compliance with best practice—and this is all trusts who are participating in the north-west, so it is a big study—that was sometimes around 60% to 65% for some of the procedures against what you would expect to see in terms of best practice. That is what tariff was buying us.

You asked the question, “What is the relationship between price and performance?” I was saying that I do not think it is as simple as an expectation that if you keep driving tariff down and keep on saying, “You must achieve best practice and standards”, that that will get you the outcomes which, in the long run, give you the best value for money. The interesting experience of the north-west work was that a very small payment—this was not significant and we were not paying huge amounts of resource—incentivising the best performers had an impact on all performers. I cannot quote the study because it has not been published by the university of Manchester, but the emerging findings there are incredibly positive about a statistically significant difference in outcomes for patients and value for money.

**Q55 Chair:** That is from paying the supplement.

**Mike Farrar:** That is from a small incentive scheme over and above tariff. Certainly, now in the north-west there are data published that show that compliance with best practice is way into the 90s on almost all those standards.

**Q56 Dr Wollaston:** To be picky, does that supplement get included in the tariff figures in the end-of-year report, or does it get put somewhere else?

**Mike Farrar:** No, it was a bonus payment specifically paid for and audited as part of the overall advancing quality programme. Tariff was routinely paid on activity, but the way it worked was the bonus went to the top performers and the most improved performers, so there was a psychology of the incentives which meant that we saw this huge improvement in compliance with best practice.

**Q57 Mr Sharma:** Would you then say that these tariffs are working and are useful?

**Mike Farrar:** It is important to be able to price the work well in the world where you have a purchaser-provider split, otherwise you create perverse incentives. Partial coverage of tariff is an interesting concept because it may have skewing effects on behaviours. But understanding the way in which you achieve the best quality for the taxpayer is not as simple as saying, “All you need to do is ratchet down the price of care through using a tariff and all will be well”, because there are potential consequences of failure to meet demand and also simply transferring risk from one part of the NHS to another.

**Q58 Mr Sharma:** Would you recommend it outside the north-west to others?

**Mike Farrar:** I would absolutely recommend that scheme. In my career, it is one of the greatest things that I have been involved in, and I think the clinicians in the north-west would say that too.

**Q59 Chair:** Can I draw this a bit more conceptually because there is a long argument, is there not, going right back to the 1990s about whether there should be competition on price or whether there should be a fixed price determined by a tariff? There was a lot of political discussion about this over the last six to nine
months. What you are arguing, to my ears, is that some price flexibility is in the interests of patients and that excessive rigidity around the tariff leads to a series of perverse incentives.

**Mike Farrar:** Yes, I think that is true.

**Q60 Chair:** It is an important piece of evidence.

**Mike Farrar:** To go back, I do not think the north-west scheme was working on price competition. It was using price, or it was using resources, in a way to incentivise practice. The competition was effectively between organisations.

**Q61 Chair:** The north-west scheme invites trusts to achieve more revenue by delivering better quality.

**Mike Farrar:** Yes.

**Q62 Chair:** That is a benign, arguably, form of competition.

**Mike Farrar:** Again, Carol Propper’s work was showing that, if you look at the opposite effect on it, in the case of the north-west scheme, there was not the ability to drop beneath tariff. The steering group were looking at that over a period of time, if there was failure to comply with at least a minimum level of achievement of compliance with the tariff, but ultimately its driver was not. That is where Carol Propper’s evidence was that you could have a deleterious impact on quality if you effectively allowed a drop. It was effectively from a standard platform.

**Q63 Chair:** The tariff should be a minimum and not a fixed price would be the policy.

**Mike Farrar:** That would be the conclusion that you might draw from the north-west scheme. It is a population of 7 million, with 63 organisations involved on a voluntary basis, so it is a sizeable study.

**Chair:** That is interesting, thank you.

**Q64 Dr Wollaston:** May I follow up with another aspect of tariff that has been affecting community hospitals where they have not been able to split the tariff? Whereas in the past hospitals might have admitted a patient, say, for part of their rehabilitation to great benefit for both, they were prevented from doing that. Do you think there has been any progress on that score?

**Jo Webber:** There were a variety of different things. When we are talking about tariff, the issue always comes down to one of the big conversations about whether you can unbundle or bundle it up sufficiently. For people with long-term conditions, sometimes it is about bundling it up and about any competition being for the market rather than for elements within that market. The other thing that is probably impacting our community hospitals is that it will be, certainly, the 30-day responsibility post-discharge for acute trusts, the development of the rehabilitation tariff depending on where that starts, how that works and how the 30-day post-discharge responsibility impacts on the way in which they work, either with community providers, who are separately providing community hospitals, or developing their own sort of step-down facilities by themselves, or, probably more importantly, with social services colleagues.

**Q65 Rosie Cooper:** I will jump right in and ask whether you agree with the statement made by the BMA that there is no doubt that the need to find savings has compromised access to services and increased waiting times. I draw your attention to Monitor in its 2011 review of foundation trusts, which noted that maintaining and improving quality while delivering the level of savings represents a significant challenge and a potential risk for trusts. I would say that is a risk for patients and the great British public, but I wonder what your view is.

**Mike Farrar:** Let us go on facts rather than opinion. It is clear that waiting times are slipping back, and they are slipping back not just in terms of waiting for elective care but also in terms of the standards around and experience at A and E departments, for example. Clearly that is a material fact. Is it the failure to deliver savings that is at the heart of that? It is inevitable that that has to be linked to a degree of financial pressure. I would argue that it would have been possible that, had we had the opportunity 18 months ago to look at some of the transformation of care, we might have seen a small dip in that, but we would have been perhaps more optimistic that that would recover faster in terms of waiting times standards. There would have to be a link between the waiting list going out and the fact that we are not on top of the resources now available to the health service, either immediately, unallocated, or its ability to redeploy those to meet new demand. We are on the wrong side of it, if I can put it like that, at the moment.

**Q66 Rosie Cooper:** What about the Nicholson challenge and the pressures on hospitals, staff, managers and employees whose terms and conditions have been changed and gradings dropped—all of that? They are now being pressed to continue to deliver savings and more productivity without compromising care. How confident are you that that is the case?

**Jo Webber:** We would come back to what our members were saying to us earlier on this year, which is that this year it feels like you can keep quality up and it would not be compromised by the savings. The vast majority of our members feel confident that they are going to make the savings this year. When you start projecting this two or three years out, then that balance between quality and savings becomes more finely balanced. That is about how much we can extract capacity, look at reconfiguration and change the way in which we deliver services, particularly how we move services—and I know we have been saying this for years—into more appropriate environments for people. This year it is fine, but obviously going out again it becomes more of a problem, more of an issue for people and more of a challenge.

**Q67 Rosie Cooper:** You mentioned reconfiguration. When the Government came to power, the Prime Minister promised that Chase Farm would not be closed. There are a number of MPs, in my view, who may very well have voted for this Bill who think that services are going to be re-established and
disinvestment is going to be corrected, and yet you are talking about further reconfiguration of the system. Would you say that reconfiguration is going to be on the horizon big time?

**Jo Webber:** Absolutely. We have to take capacity out of the system, otherwise we will not make the savings that we need to. That does not mean that we take the care away. It means that we have to find different ways of delivering care that do not involve the overheads that are associated with that care being delivered in acute hospitals.

**Rosie Cooper:** Leaving aside the fact that the Prime Minister has broken yet another promise, what we are saying here is that any Member of Parliament who voted for this thinking that service is going to be re-established and that reconfiguration big time is not going to happen, has made a mistake. I understand that you might not want to comment.

**Q68 Chair:** Can I just ask this? Lord Crisp, former chief executive of the health service—

**Mike Farrar:** I remember him.

**Chair:** You remember him. He was on the record 10 days ago advocating very fundamental change and a shift in the care model away from a hospital towards a more community-based bias. Does the confederation endorse the views of Lord Crisp?

**Mike Farrar:** Yes. We absolutely believe that is the right thing to do if we are going to release resource to manage additional demand that was previously funded through government growth. A lot of the focus gets on reconfiguration of service in respect of taking out fixed capacity in acute hospitals, but there is fixed capacity in other bits of our system. There was a huge LIFT building programme and yet most LIFT facilities are partially used, and we are still spending money on alternatives in other GP practices, for example, and other community settings. There is also the opportunity, in releasing the clinical resource from an acute setting, to get a specialist input, sometimes earlier in a care pathway, which may well have an impact on the lifetime costs of care. It is that transformation of a service which we believe, if done well, with political support—because that is critical, and this is not a party political point, because I think all parties need to break free of this sense to try and understand what good care looks like in the future, and it has to be less dependent on acute care in hospitals—

**Q69 Rosie Cooper:** If I might jump in, I do not demur from that, or the Chairman's comments, one jot. It was simply that it was not the promise made by the Government when it was trying to get elected. With the Chairman's permission, I would like to ask Andrew a question. You talked a little while ago about councils protecting adult social care this year and it being much more difficult next year. I was trying to reflect what it would look like in two or three years' time, because this year, when you say that councils are doing their best to protect it, what that looks like to adults who need social care is that their charges have gone up, the criteria have changed and fewer of them are managing to get help and care. Genuinely, how do you see the picture, without massive injections of perhaps further cash, or how will life look in local authorities for the provision of social care?

**Andrew Cozens:** It has been our position—and David may want to comment on this—for some time that the social care system is close to collapse, if not fundamentally broken, at this stage simply because it is not able to properly respond to the demands on it. Therefore, it is reacting as a crisis service in many respects. That is a trend that I anticipate will continue. The more positive signs associated with adult social care, which is quite a contrast to that overall gloom and doom message, are the extent to which it is becoming more personalised for those within the system and that there are efficiencies associated with that. People are taking up the services they need rather than, in a sense, over-getting services because they do not have the confidence they will be there in the future when they might need them. Also, there is evidence in some places, and considerable further scope, for looking again at the interfaces between social care, housing and other community services and the extent to which people can be supported early in different models of care, which means they do not make expensive demands, and also, as I said before, around re-ablement. The difficulty for social care is the very substantial numbers of people currently in the system, particularly younger people with complex needs for whom there is very little scope to make savings, and where the costs need to be met because they have an established current entitlement. Inevitably, under those circumstances, those that suffer, as I said before, are those with lower needs outside the system. The other side of the coin, of course, is the very substantial and growing proportion of people who pay for the full costs of care for themselves. That is steadily rising too. As you will know, we very much accept the analysis of Andrew Dilnot in general terms but also in specific terms that we need a fundamental rethink about how resources come into the adult social care system, both its overall priority in terms of public spending but also in terms of people's expectations of the service.

**Q70 Rosie Cooper:** Absolutely. The problem I see is that you will be talking about it and trying to implement it, but you are not going to have that in two or three years. So do you foresee a crisis in years two and three?

**Councillor Rogers:** I made the point in my introductory remarks that there is a significant risk with the current system and, whatever one might think of the proposals of the Dilnot Commission and the time scale for any implementation of those, there is going to be a very significant gap. There already is a very significant gap, and that will grow in terms of the gap between demand and the resources available to meet it. That is a position that we in the Local Government Group have been saying for a number of years. Whether that will result in what you have termed “a crisis” is hard to predict. None of us has a crystal ball, but those pressures are definitely going to increase. Whatever further efficiency savings are made, those pressures will still be there.
Q71 Rosie Cooper: Do you have any idea of any numbers to back that up, because we talk about you getting £1 billion this year but I understand that that translates into less than £650 million? If we are going to have a third gap at least, how are you going to deal with it?
Councillor Rogers: The figure is £1 billion at the end of the current spending review period and it builds up to that. Again, we have said very consistently that, were there to have been a steady state in local government finance, that would have been extremely helpful and extremely useful. In the context of the overall funding settlement for local government through CLG, that is clearly not the case and it does not bridge the current gap, and, even at the end of the spending review period, will not do so. There will still be a gap. We are very clear about that, and £6.5 billion is the figure that we have put on the gap that is likely to exist.

Q72 Rosie Cooper: I have a great fear—and I will stop now—in the current climate that what we are getting is a statement of what will be, a place which is not. I keep thinking that people will shine a light on it and say, for example, “Operation waiting lists are growing,” or whatever, “and that is the fault of the manager, or when there is a problem in local government social care, that is because of your management of the budgets.” This whole thing is always going to be somebody else’s fault, somebody else’s management of a budget, a process or a pathway of care, or whatever it is, but it is never, ever going to be the responsibility of the Secretary of State, for example, be it for Health or for Community and Local Government.
Councillor Rogers: In social care, the responsibility is shared because the service is not free at the point of need necessarily. It is subject to various forms of means testing and always has been. This issue of where the responsibility lies is one that we need to recognise. If, for instance, the Dilnot Commission proposals were to be implemented—we hope they will be, and we are arguing that the Government needs to make significant and rapid progress on that and are disappointed with the slightly delayed time scale—you are quite right to say that that would not be an impact next year or the year after but would be a slightly longer time scale. Nevertheless, it would give people the certainty and the clarity of what they might expect from the system and they would then be able to make alternative provision—those who can afford it, of course—to build up to that over a period of time. Our fundamental message is that there is no time for delay on this because of the predicament that the current system finds itself in. We really do need to act on it.

Q73 David Tredinnick: I have one question going back to something that was said earlier on. If there is going to be less emphasis on acute care and more on localised services, can you provide as good a service at a more local level as you would with a more formidable acute sector?
Mike Farrar: The evidence would be from patients’ experiences, which is that if you can avoid hospital admission, that is, generally speaking, better for individual patients, and certainly families in terms of managing care. We also know that, where you have boundaries in care between primary and secondary, or hospital and social care, for example, there are sometimes difficulties in the individual cases because of crossing that boundary. It is a sort of conventional wisdom, and I am not going to quote anyone but, generally speaking, if you can manage your problem largely through your own resources, that is best. If you can manage your problem, properly diagnosed and supported in primary care, then again that seems to be preferable from a patient perspective. What we need to do is use our hospital capacity where it is the right thing to do and you need the expertise at a critical mass. I have already said that some of that is about location. Some of that we could be more creative on by releasing the expertise in hospital to work in and with partnership in primary and secondary care.

Q74 David Tredinnick: I understand that. By implication, there must be quite a lot of acute capacity around that is not being used, and that is not being used because people are being dispatched, if you like, to the right level of facility for their need, because there is some evidence that once you turn up at A and E you are obviously more likely...
to end up in a hospital bed than if you turn up at, say, a walk-in centre and get care from a specialist nurse. It is about the totality of the local offer, I think, and sometimes getting focused on the A and E department misses some of the other opportunities there are to make sure that patients get the care in the most appropriate setting.

**Q76 Dr Wollaston:** Can I change to how we are going to manage the Nicholson challenge alongside the wider reforms? Many commentators have felt that that will act as a barrier to achieving the efficiency gains. David Nicholson told us last year that he saw that they were mutually reinforcing processes. I am wondering what your view is on that.

**Mike Farrar:** Clearly, when David was talking last year he might not have anticipated quite the delay and hiatus we have had. One of the things that people generally, and quite rightly, are concerned about is the lack of certainty in the system for themselves and the structures in which they are operating. I do not think any industry performs particularly well where people taking decisions do not know if they are going to be around to see the consequences of those decisions. That is certainly one thing which has been a significant problem.

While the situation is in flux, people have to develop, effectively, new arrangements and they are trying to do their day job and manage the budgets and quality at the same time as creating the facilities for new people to take on the work. Clearly that is going to divert them from spending their full attention on the specific challenges. It is also true to say that a large number of the reforms would not materially impact on the financial challenge over the spending period that the Chair has indicated. There are a number of areas where I am suggesting there are gaps between complete synergy between the reforms and this particular challenge.

The other, which we have commented on, and it would be good to comment on again, is that over the course of that period, as part of the transition but also wider government commitments, we are massively reducing the amount of general management that is in the system now. We all believe there are efficiencies, but there is a level of expenditure on general management, whether you are a clinician or an administrator in general management, that is needed to oversee substantial change and to make the organisation of care sufficiently good to enable the quality of delivery of clinical care optimal. We are very concerned that, over that period, we have seen a significant reduction, with a lot of people leaving. It is not only the finances but also the experience that they have that is now lost and which needs to transfer to clinicians as they come on stream and take over the responsibility again, which we support. That is another particular feature of the last 18 months which worries us in terms of delivering this challenge.

**Q77 Dr Poulter:** Focusing in on a couple of issues, the Department of Health tells the Committee that budgets for social care across England are only £200 million lower this year than they were in 2010–11, which is a 1.5% reduction. Is that in accordance with what you understand?

**Councillor Rogers:** Andrew is probably best placed to comment on specific figures, but I have already made the point that we believe there is a very significant gap between need and the resources available. That is not a new issue this year. Pressures may be greater this year than they have been in previous years, but it is something that local authorities have been struggling and coping with for a decade at least, probably longer. We feel that is an underestimate, but you may have the specific figures on that, Andrew.

**Andrew Cozens:** Yes. I think it is their estimate of the impact, but we feel it denies, as I said before, the reality of the wider local government context in which this is set. It makes a number of assumptions about the ability of councils to make efficiency savings on an equal basis across the country, and some councils are already more efficient than others and there is no mechanism for redistributing the savings that one council can make which are greater than another to that other council. We also question some of the assumptions that underlie demographic demand and cost pressures within the system, the level of care inflation, for example, or other factors in that respect. It is our evidence that, in fact, councils, even with a degree of protection for adult social care, as I have said before, are taking £1 billion out of the system; that is the reality, rather than £200,000. However you get to that, the reality is that a substantially higher amount is being taken out.

**Q78 Dr Poulter:** I have one point of clarification. You did make the point that some councils are in a better financial position to make savings than others. There is clearly an issue that obviously the greatest expenditure on adult social care is going to be in councils that have a larger older population. That is clearly going to be the case. A lot of those councils, in my understanding, are in parts of the country that have had less generous financial settlements in the past so those councils perhaps are less well placed to meet the challenge than perhaps they need to be. Is that a fair comment, as a generalisation?

**Councillor Rogers:** Yes. The financial pressures are not only the older population that you have just referred to. Andrew mentioned a few minutes ago the needs of younger people with life-long conditions that would require support from a very early age or—

**Q79 Dr Poulter:** Yes, but the significant driver of adult social care is clearly the ageing population.

**Councillor Rogers:** One of them, yes.

**Q80 Dr Poulter:** But the most significant driver.

**Councillor Rogers:** People with learning disabilities and those with other life-long conditions that require support are also a significant driver, but you are quite right that the ageing population is very clearly one of those.

On the point about local authorities being in different positions, this is a complex picture and of course it is not only the way that taxpayers’ money is spent when it comes from national taxes. It is also from local
Dr Poulter: The point I was making was a general point and I accept that, but the generic point that I am making is that areas with ageing populations, as I think everyone has said—and there are obviously other drivers of adult social care—are undoubtedly the biggest challenge facing the NHS and adult social care, and those areas have traditionally received less good financial packages from central Government over the last few years. That was the point I was trying to make.

Andrew Cozens: This settlement is slightly different from previous years, and our headline position would be that the north is facing a tougher time than the south this time round in relation to settlement, so it does not follow where older people are. That is not only the distribution issues in relation to the grant but it is also the ability to raise charges, because your population is, in general—and this is a generalisation—less well off. Also, the council tax take is different and, therefore, it takes a substantial increase, and that is itself capped in the council tax in some areas. The gearing is such that the scope to deal with this is more problematic. So it is slightly more complex than just where older people are.

Dr Poulter: Yes, but you would accept that as a general point, as you said earlier.

Andrew Cozens: Demography is a very significant pressure on both social care and the NHS. It is the same people, basically.

Dr Poulter: The other point I wanted to make was that clearly this issue—the big, big challenge of dealing with the ageing population—has to be the main driver of both local policies and central Government policy over the next few years. The concern, obviously, is that efficiency savings that are being made at the moment are short-term efficiency savings, but are they going to help? Are local authorities meeting the challenge of dealing with the structural changes of delivering that community-focused care that you have talked about? Are they gearing themselves up to deal with that, because that, obviously, is a key question? Efficiency savings, as you have said, can only happen effectively for a few years. Eventually, there needs to be a new way of working. Are local authorities in a position that you feel they can deliver that improved way of working? Integration is a bit of a buzz word, but that is what we are talking about.

Councillor Rogers: Yes, on that, we recognise that working between local authorities and the health service is something that is not a new concept, but we think that the proposals in the current Bill, with the intention that there should be Health and Wellbeing Boards, which, in effect, would have that as their remit, is likely to encourage that further, and quite rightly so. One of the most important issues in that respect is that it brings a new sense of place, a sense of locality, to those commissioning processes and those decision-making processes. We all know that the funding streams are very different between local government, social care and the NHS, but, having said that, there is still a great deal of scope, in my view, for greater integration. Indeed, in setting up the mechanisms, local authorities are getting on with it. The vast majority have Health and Wellbeing Boards in some kind of preparation or shadow form ready to come into reality subject to the legislation being passed.

Mike Farrar: A supplementary on that would be that one of the short-term risks, which we will have to get over very quickly, is the issue of where PCTs were coterminous with a local authority and had a number of joint posts. Of course, with clustering of PCTs and operating on a bigger footprint, it is very important that the commissioning group relationship with local authorities is picked up quickly, and we have lost some ground in respect of joint appointments.

Dr Poulter: The general view is that the Health and Wellbeing Boards are going to be a great facilitator of providing an improved service delivery in the service reconfiguration that is required to meet this big demographic challenge.

Councillor Rogers: I think so. Time will tell, obviously, how that works out in practice, as with any other change, but the potential is there because it will bring the relevant decision makers and professional advisers across the whole of a relevant local area together in one place to make those decisions for the future.

Chair: Can I bring us back? There is a straight discrepancy in the numbers which I do not understand. This is the total council allocations for social care in the year 2011–12 compared with 2010–11. As I understand it, the LGA is saying that that number is £1 billion smaller in the current year than it was last year and the Government is saying that that number is £200 million lower. There is a discrepancy of £800 million. Why is that?

Andrew Cozens: I have confused the issue by talking about the impact of the decision councils have made as opposed to the Department of Health’s assessment of how much councils would have to save. The Department of Health’s estimate, based on the net savings councils would have to make in an otherwise straightforward position, is £200 million. What I am quoting is the reality, taking account of those other factors that I described, that councils have had to identify £1 billion, and that £1 billion, with some protection—that is, other services being cut rather than adult social care—has enabled them to achieve that. I do not think we dispute the raw figures the Department of Health put into the equation, but it is further complicated by the transfers from the NHS and the extent to which that is directed towards additionality or towards replacing spend.
Chair: I am sure you have taken every other member of the Committee with you, but I am afraid you have lost me in the complexity. It would be very helpful to have those numbers in a note setting out the LGA’s view of the impact in the current year of the councils’ anticipated level of spend on social care reconciled with what the Department has had to say about that.

Q86 Rosie Cooper: I was going to cover those two points in that the Department of Health says the social care budget is only £200 million lower, but then I was also going to say that the Department is saying that the local authorities’ average reduction in spending power on social care is 4.4%. Do you accept those figures in their totality? You may now want to reflect that further question in the comments that the Chairman has asked you for.

Councillor Rogers: It is probably best if we deal with it all in one further submission, which we will do as soon as possible.

Q87 Rosie Cooper: With the Chairman’s permission, at the end I would like to ask a general question, which I will not ask now. We are told that ADASS says that 82% of councils only provide services where the level of need is significant or higher. Do you see local authorities now needing to restrict eligibility in this way right through to the end of the spending review period? Do you see increased council charges going the same way, continuing to increase apace? What can people who depend on you expect?

Councillor Rogers: As always, the picture is more complex, and whichever aspect you look at there are always other things that can be said. The trend in eligibility criteria under the current Fair Access to Care arrangements has been upwards, but not as rapidly as you might expect given the demographic pressures and the spending pressures that we have already talked about. That demonstrates the relative commitment of local authorities to protecting adult social care. That does not mean that it happens in every case in every area, but it does demonstrate an overall picture. Having said that, we have all acknowledged the demographic and financial challenges, and that only points in one direction. That is why we are saying that the need for reform of the system as a whole is more urgent than it has ever been before and that remains our key message to the Government. The time to act is now, otherwise, there are opportunities. They will be very good if the joint strategic needs assessment works across the whole of the local community and that is the basis of some very joined-up planning. When you look at the reforms, there is not anywhere else locally where that planning is going to take place. It has to take place at the Health and Wellbeing Board level. There is a lot yet to play for. When we did a survey jointly with ADASS last year around what made locally-integrated organisations work well, it was about local relationships, local cultures and a local shared vision. If Health and Wellbeing Boards take up that challenge and start making themselves a place where that strategic planning is done locally, it will be helpful, particularly strategic planning that takes us, as Councillor Rogers said, upstream so that we are beginning to invest small amounts of money in pump priming some things that will help in the future to divert people from higher cost care environments. However, it is all still to play for and it will be interesting to see how the pilots develop to make sure that this does not become what I do not think anybody on this side of the table wants, which is a talking shop.

Q88 Rosie Cooper: Can I ask the panel as a whole how you think Health and Wellbeing Boards will make a change? I understand the dynamics, where people with authority will be round the table, but they have to go back to their boards or their councils and get agreement. How do you think it will actually make a difference? Other than transfer and exchange of information, how will it make a difference?

Andrew Cozens: Can I add a related point to the Fair Access to Care criteria because it is only part of the picture? It is a guarantee of service to those with the greatest need, but councils are still investing in services that are aimed at preventing demand in the long run, re-ablement and other services. It is a slightly misleading picture to say it is only that bit that there is investment in. The key issue for Health and Wellbeing Boards is planning for further upstream intervention on a health and social care basis that will tackle the really wicked issues of unnecessary unplanned hospital admissions, better hospital discharge arrangements—making sure people are not accelerated into more expensive options, so care closer to home—but also issues around long-term conditions and end-of-life care. It is in those areas that continued joint investment in Health and Wellbeing Boards may bring considerable advantage. We have not talked at all about children’s services, but we do feel there are similar issues to be addressed in relation to children’s services by Health and Wellbeing Boards.

Q89 Rosie Cooper: Do the Confederation have any view?

Jo Webber: At the moment there is a lot to be played for in terms of how Health and Wellbeing Boards turn out. The agenda is still being developed and, therefore, there are opportunities. They will be very good if the joint strategic needs assessment works across the whole of the local community and that is the basis of some very joined-up planning. When you look at the reforms, there is not anywhere else locally where that planning is going to take place. It has to take place at the Health and Wellbeing Board level. There is a lot yet to play for. When we did a survey jointly with ADASS last year around what made locally-integrated organisations work well, it was about local relationships, local cultures and a local shared vision. If Health and Wellbeing Boards take up that challenge and start making themselves a place where that strategic planning is done locally, it will be helpful, particularly strategic planning that takes us, as Councillor Rogers said, upstream so that we are beginning to invest small amounts of money in pump priming some things that will help in the future to divert people from higher cost care environments. However, it is all still to play for and it will be interesting to see how the pilots develop to make sure that this does not become what I do not think anybody on this side of the table wants, which is a talking shop.

Rosie Cooper: Nor this side.

Mike Farrar: The last thing to add, of course, is that Michael Marmot’s work would suggest that it is important that you look at prevention of ill health in the context of both local government expenditure and health service expenditure. They have been separate silos and there is an opportunity, yet to be grasped, to be very creative in terms of using resource around housing, community environments and things like that to do what people are hoping to do.

Councillor Rogers: I have one sentence on that. The return of public health to local government will enhance the process that you have heard from Mike.
Q90 Dr Wollaston: I want to follow up on that because I understand that £648 million has been allocated to transfer from PCTs to local authorities. Is that where it is being spent, in Health and Wellbeing Boards, do you think, in the future to move this forward?

Jo Webber: This is the money for re-ablement and rehabilitation so that it can be spent on social care activities that also help to improve the healthcare of people at the same time.

Q91 Dr Wollaston: This is the £300 million that the NHS is going to spend on re-ablement because there are two separate funding streams. Do you think the £648 million transferred from PCTs is genuinely driving and improving integration and change in the service redesign?

Jo Webber: If you look at some of the figures from the local authority survey, which you already have from ADASS, the one area where there was increased investment was in rehabilitation. One of the points made in there was that this was probably as a result of the fact that the money is in the pot between health and social services in this particular area.

Q92 Dr Wollaston: Has it been well spent, do you think?

Jo Webber: I could not say, hand on heart, that every single penny of it has been well spent, but you can see some evidence here that rehabilitation is the one part of the joint services which is continuing to develop probably as a result of that extra spending.

Councillor Rogers: In some ways, it is too early to say because this is a transfer in the current year. Therefore, some of what is happening has not happened yet, if I can put it that way, but it is certainly a driver for the sort of investment in re-ablement and other similar services to which Jo has just referred. It is a help in the integration process.

Q93 Chair: One of the results of the NHS Future Forum exercise is an elevation of the commitment to integration and, indeed, the placing of statutory responsibilities on various parts of the NHS structures to promote integration. Do you feel that these changes, coupled with the budgetary changes we have just been talking about, represent a change of gear? Are you confident that it will deliver significantly enhanced integration or do you think this is another round of aspiration?

Councillor Rogers: My view, Chairman, on that is that it has the potential to do exactly as you have said, but we are still too early in the process to be certain that that will be the case. I certainly hope it will be because that greater integration of services is based on not only what is best for the individual—and we have not talked much about individuals today—but for an individual experiencing the need for healthcare or social care they do not want to have to give the same information to a whole range of different people. They want an integrated service that meets those needs. It has the capacity, the potential, to do that. I very much hope that it will be. Certainly from a Local Government Group point of view, we shall be encouraging our member authorities to take whatever steps they feel appropriate in that direction.

Q94 Chair: We have heard various people explain to the Committee how you can have integration of health and social care without integration of budgets. Do you think that is possible?

Mike Farrar: That worries me enormously, because we are going for integrated provision but we have a disintegration in terms of commissioning spend. Clearly, if you are dealing with a number of different commissioners, all of whom might have to operate within a contractual framework, a lot of the primary care spend currently spent by the PCTs, alongside their spend on acute care, and jointly commissioned through local authorities, may well be split into a number of different places. That is not least because of the geographies of the organisations as well as the fact that some of those, structurally, now are spent by different people. It would be a sensible thing, in my view, if you were pursuing integrated care, to have integrated commissioning.

Jo Webber: Can I also make the point that I made before about relationships and culture and developing things locally that work with the grain of a local partnership or a local integrated service? That means you need some stability in the system, which is why, at the moment, it feels so fragile. What would help integration most, in my view, over the next 10 years would be to make sure we were not reorganising every couple of years, which throws the relationships up in the air. We have already had PCTs now clustering and that changes the relationships already. We have CCGs developing and that changes the relationships. Although I think people on the ground understand that this is the way to go and will keep working at it, it will be fragile for a while because of those ever-changing relationships.
Chair: I am anxious to draw to a conclusion. Rosie has a concluding question and Chris wants to come in.

Q95 Chris Skidmore: The efficiency savings simply are not always about cutting and finding those savings. They are also about making sure there is productivity in the system. The ONS figures show that productivity in adult social care fell by about 15.5% between 1997 and 2008. Obviously, one of the key criteria for achieving productivity is through innovation and best practice. What is the Local Government Group doing in order to try and disseminate that across your organisation for your members?

Councillor Rogers: I am not familiar with the statistic you quote, but the principle, of course, is very important. We do have a programme that seeks to take that forward and are working very hard with a number of authorities to pursue it. Andrew can give you more detail, but the principle of bringing in innovative ways of providing services relates very closely to the personalisation that Andrew mentioned earlier, because we need to shape the spending not only to meet the needs of the individuals in our communities but also their preferences as to how they would like those needs to be met. Would you like to say more about the programme itself?

Andrew Cozens: I will add perhaps three aspects on where there is further scope. One is the assessment process itself, which is very expensive and needs review—the basis on which decisions are made. Secondly, the unit cost of services for people in similar circumstances varies considerably from authority to authority. There is scope for looking at that, and I am sure that is true in the health service too. Thirdly, there are inefficiencies in the way that local government deals with the large and complex market that we operate in, with so many providers in terms of the processes, both at their end, in terms of the way they relate to 152 authorities, but also the way that we pay them and other issues that could generate further efficiencies. We accept that there is considerable further scope for efficiency, but, as I said before, that is not consistent across every authority. Some are further advanced than others. While it helps us to help some authorities deal with their issues over the next couple of years, it does not help the overall crisis that we talked about before. It does provide some councils with some respite if they approach these issues.

Q96 Chris Skidmore: Also very quickly on the unit costs that you talked about, the Committee itself has done a survey of local authorities, of which you might be aware. It roughly shows that around a third of local authorities are planning to make efficiencies by reducing the unit costs that private providers provide. Do you think that is the way forward? To the extent that those could be squeezed any further, are we going to get to a stage where the unit costs will go down so far and then that will adversely affect services? How far can unit costs still be squeezed before we reach the floor?

Andrew Cozens: Markets vary considerably across the country. It is an imperfect market and there are different marketplaces. Where there is a lot of provision, there may be further scope, but there are some areas—and this is a view very much shared with the trade associations themselves—where we need to step back from the process of salami slicing and look at the actual costs of provision and the extent to which we can address, as indeed colleagues in the health service are doing, what is the realistic cost of this but also how you can build in quality premiums that encourage better staffing ratios, better facilities and those sorts of issues. There is a limit to how far we can have crude squeezing on the basis of the prices we pay.

Chair: Rosie has a concluding question.

Rosie Cooper: It is slightly loaded.

Chair: No, I do not believe that.

Q97 Rosie Cooper: With the Health and Social Care Bill, I do not believe it is too late to save the NHS from this absolutely radical change and we could create a plan, anything such as establishing 50 GP-led PCTs, that type of organisation. I would like you to comment on how you see the impact on your organisations if the legislation is held up in the Lords for some time or, as I would hope, it is binned.

Councillor Rogers: Mike has already made reference to the uncertainties created by the pause earlier this year. On balance, that was a pause that was worth waiting for the outcome. You are asking me, or indeed all of us, to speculate about what might happen in the House of Lords—

Q98 Rosie Cooper: No. It is about the uncertainty and the impact on your organisations should the Bill be held up. How far can you keep on trying to implement structures and organisations which have no validity in law and have not been agreed by the people out there or the people in here?

Councillor Rogers: A further delay would obviously lead to greater uncertainties or reintroduce the uncertainties that you have already heard about, but it is unwise to speculate on that, quite honestly. Local government has a great tradition of coping with whatever legislation finally emerges from the place where we are now and we shall continue to do that, whatever it might be.

Mike Farrar: Clarity and certainty are very important to our members and, therefore, any delay in getting that clarity, subject to due parliamentary process, will make it more difficult for us to achieve what we are trying to achieve over the next one to two years. We have some issues which we have raised in our material to MPs as the Bill is debated through both the Commons and the Lords. The question is that there are some practicalities in the current Bill as it stands that we believe, if we were going to get the benefits over a longer term and indeed be able to do something in the short term, need to be amended. The delay in itself does not help, at least in the short term, because that uncertainty is a problem, but we believe that for the long-term aspiration of the health service there are things that could be done to the Bill as it currently stands that would be in the long-term interest as well.
Therefore, we would want the process of parliamentary scrutiny to be done properly and some of the concerns that we have raised in other material on other occasions to be addressed. **Chair:** That is a subject to be pursued in other material and on other occasions. Thank you very much for coming this morning.
Tuesday 11 October 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Grahame M Morris
Dr Daniel Poulter

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses
Witnesses: Rt Hon Andrew Lansley CBE MP, Secretary of State for Health, Una O’Brien CB, Permanent Secretary, Department of Health, Sir David Nicholson KCB CBE, Chief Executive of the National Health Service, and Richard Douglas CB, Director General of Policy, Strategy and Finance, Department of Health, gave evidence.

Q99 Chair: Can I begin by welcoming, in particular, Una O’Brien—it is your first visit to the Committee—and your three colleagues, including the Secretary of State, all of whom are old hands of the Committee? You are all very welcome.

The relatively brief inquiry we are conducting to seek guidance on where the NHS is getting to in the delivery of what we call the Nicholson challenge for reasons that are familiar to everyone present. To set the scene, I would like to begin by asking where you feel you have got to if you look at the plans being prepared within the Health Service to meet demand to deliver the desired quality standard within the significantly tighter resource framework we are now living in, and, in particular, to react to the sense, reported to us in evidence, that, while there is reasonable confidence the Health Service will be able to deliver its objectives through the current financial year, that is being achieved by taking some non-recurrent savings which will have the effect of making it more difficult in later years. That is the sense we have been offered by the NHS Confederation and by other witnesses and we would be interested to hear where you feel you are against that starting point.

Mr Lansley: Thank you very much, Chair, and thank you for the opportunity to be here. It is rather a good moment to do so because the regular publication, The Quarter—which the Deputy Chief Executive of the NHS publishes on a regular basis—a few weeks ago gave the Service a good opportunity to look at what had already been achieved and where primary care trusts, in particular, in that context were in terms of the preparation of their QIPP plans for this year.

I will not go back—you know the history—but it is fair to say there is a tendency to treat these as major financial challenges since the election. In fact, they were major financial challenges anticipated before the election. David Nicholson, to my left here, first, was clear to the Service about the need to deliver efficiency savings up to £20 billion in May 2009. That was in the context of doing so by 2013–14 and, potentially, of a cash freeze. We are not in that position. We have real terms growth in the NHS in each year through to 2014–15 and the efficiency savings through the QIPP programme are intended to be achieved by 2014–15. We have been working together with QIPP, essentially. The QIPP support from the centre is in terms of understanding the nature of the support that can come from central budgets—the reduction of central budgets and the reduction of administration—but also a series of work streams that help people to understand what is possible in terms of things like better prescribing management, better procurement, redesign of services, management of long-term conditions and so on. The bringing together of all of that to see what it means in terms of efficiency savings in any single health economy is the responsibility of the NHS organisations themselves.

The strategic health authorities have carried out that process overall and, essentially, what they have been telling us in different places is that the composition of those savings differs. The Quarter, published a few weeks ago, showed that significant progress had already been made. The QIPP programme, technically speaking, began on 1 April 2011 but, in truth, people in the Service have been working for this right through last year. That has delivered administrative savings in 2010–11 of £240 million beyond what was originally expected. The Audit Commission reported efficiency savings over the Service as a whole in 2010–11 of £4.3 billion and primary care trusts have reported to the chief executive planned efficiency savings in 2011–12 of £5.9 billion. If those savings are fully achieved in 2011–12, it puts us ahead of schedule.

The total expectation across the Service as a whole is that the strategic health authorities are, themselves, anticipating delivering about £17.5 billion of total efficiency savings and probably £1.5 billion on top of that is deliverable directly through central budgets. So we are looking at anticipated total savings of the order of £18.9 billion. That equates quite closely to what we, ourselves, had estimated—looking at it from the top down—of about £18.7 billion as required to do the job we have to do: delivering improving services in response to rising demand and taking account of changes in costs.

Q100 Chair: Understanding those numbers, is a separate question being asked—because I cannot see it in The Quarter—that identifies what level of those savings are non-recurrent? The problem is going to be, is it not, the delivery of continuing service if we are relying on non-recurrent savings as the means of living within the cash envelope?
Mr Lansley: I was intending to see if David, in particular, wanted to add a bit about that because, at that point, you need to look at what it is the strategic health authorities and primary care trusts are doing in terms of the structure of these savings.

Sir David Nicholson: In The Quarter we do not produce a running total of savings for the NHS as a whole. We will be doing that in the second quarter. We are currently working through it because, as you say, it is quite complex. It is not only a question of saying what is going to be recurring and what is non-recurring. It is where the savings are falling—whether they are falling in community services, acute services, or whatever. Hopefully, in quarter two we will have a better picture of how that is looking. Whether that will give you a definitive picture on recurring and non-recurring, I doubt—partly because people describe things in different ways. It is quite difficult to get the real detail underneath all that.

As to the savings that we need to make overall, we have identified 40% coming from national action, 20% from service change and 40% from operational efficiency. If you look at the first bit, which is the national action, we have achieved all of the things we said we would and they are all recurring. Whether it is the amount of cost savings or the implications of the pay freeze, all that sort of thing is recurring and of benefit—

Q101 Chair: It is only recurring if you assume no bounce-back in the pay in the later period—

Sir David Nicholson: Absolutely, and we have to make assumptions about what that might be in the future. That, in a sense, is much more for years 3 and 4 than for years 1 and 2. In terms of all of those, we think we are in a good position. Operational efficiency is more mixed, though from our experience and the information we have from our reporting system—and obviously you have been taking other judgments and points of view—we think the vast majority of those are recurring. We would have to look at the evidence that people have described around all of that.

The area where we have had least success in year 1—and we always knew this would be the case—is the benefits of service change because it is complicated and difficult and takes a lead time to do it. If you look at the way we worked out the savings profile, we thought that the national action and the operational efficiency would be much more in year 1. However, we have offset some of that because of the savings we have made in management costs. The Secretary of State identified that we have made £250 million more than we imagined. In the NHS, in 2010–11, we reduced the total number of people working in management and senior management jobs by about 15,000, so it has been a substantial set of changes. Some organisations—and London is an example of that—have moved to make all their management cost savings in one year rather than trying to do them over three years. We have offset some of that but, particularly in years 2 and 3, I think service change will increasingly become an issue for us to tackle.

Q102 Chair: It is quite noticeable, as to your description of 40%, 40% and 20%, that when you came before the Committee previously you described the second 40% as being related to movements of the tariff, but today you described it as operational efficiency.

Sir David Nicholson: I am sorry. It is through the tariff I am describing it. We get the effect through changing the tariff. Organisations deliver it through operational efficiency, and they get it by being better at what they do.

Q103 Chair: Changing the price as merely a transfer price does not get you anywhere. You have to actually change what is going on on the ground to achieve a saving.

Sir David Nicholson: Yes. That is right.

Q104 Chair: You believe that that 40% is on track, recurrent.

Sir David Nicholson: Yes, we do.

Q105 Valerie Vaz: Secretary of State, can I start by apologising? I have to leave at 3.30pm because I am moving an amendment to the Public Bodies Bill. In fact, it is an area where, hopefully, I can lobby you now. It is on the Human Tissue Authority and the Human Fertilisation and Embryology Authority. They would like to stay as separate organisations rather than be subsumed into the CQC and they would like to be accountable to you only. Anyway, I am moving the amendment this afternoon.

Mr Lansley: I am sure you will get an excellent reply from Nick Hurd, the Minister from the Cabinet Office.

Q106 Valerie Vaz: Or it may even be David Heath. I thank my Committee colleagues for allowing me to ask you a few questions in the beginning and give my apologies again because I hate leaving early. It is no disrespect to you whatsoever.

The Department of Health is monitoring certain efficiency gains and, clearly, you have some indicators. It would help if you could set out what those indicators are and how you are measuring those efficiency gains.

Mr Lansley: Across the Service, we are setting out not only to be very clear about the need to use resources more effectively and deliver efficiency savings but, at the same time, to strengthen our reporting in terms of the quality and the outcomes we are achieving. For example, we have already published—indeed for the second time now—data on accident and emergency quality indicators. It takes us beyond the four-hour wait to include such issues as whether patients have arrived at the emergency department and left without being seen, how long it took before they were seen by a qualified professional and so on. It was interesting on the latest data to see, on a couple of those measures, the reduction in numbers of people leaving without being seen. For example, from memory, it went from 3.4% down to 3%. So we are starting to measure quality at the same time.
From my point of view, we are aiming to make sure everybody in the Service is constantly focused on those two things side by side: delivering within budgets through greater efficiencies, which obviously includes managing within tariff and managing against issues of redesign of services, and, at the same time, looking at the quality to ensure that these financial objectives are not being achieved by eroding quality of services.

Q107 Valerie Vaz: Where is that information coming back to? Who, specifically, is the accounting officer for that?
Mr Lansley: Inside the NHS, that information comes back to David. It comes back both on the financial side and on the quality and reporting side, and The Quarter, as a document, captures and reflects precisely those two sets of information.

Q108 Valerie Vaz: What about in terms of the Department of Health as a whole?
Una O’Brien: You asked who the accounting officer is for the NHS side. That, clearly, is David and that has been the convention for some years now. My responsibilities are for everything that is not the NHS. If you are asking me specifically about the Department of Health as an organisation, we obviously track our own efficiency. We are a relatively small organisation compared with other Government Departments, and we have measures to track keeping within our budgets and so on.

In terms of the changes that we have made in the recent 12 to 18 months, the most significant has been the reduction in the number of staff following the close-down of many of our programmes. As we have sought to put more money into the frontline and to reduce what is being led from the centre, that has led to a reduction of about 1,800 staff within the Department itself. Clearly, we also have a responsibility for the efficiencies in our arm’s length bodies. You mentioned two of them earlier. That is why we have undertaken a comprehensive review of all the arm’s length bodies. In fact, there are now proposals on the table to see what we can do to get better alignment of the purpose of those bodies, on the one hand, and enable us to manage within their overall running cost objectives, on the other.

Q109 Valerie Vaz: What sort of programmes are you closing down?
Una O’Brien: Most of them have been completed, but they were programmes run centrally to do with national initiatives. Richard can perhaps help with examples, but they relate to public health, social care and the NHS across the whole piece. They were often things for which we would set up an action team in the centre to provide support on a particular initiative. Perhaps Richard can help with some examples.

Richard Douglas: They were mainly national support teams that helped people in the NHS and in the public health system. A lot of them were set up originally as task-and-finish-type programmes but they tended not to finish. What we really focused on was—

Una O’Brien:—finishing.

Q110 Valerie Vaz: Does anything finish in health—unless you are dead?
Richard Douglas: You get to a point where you should have transferred that learning across to local organisations for them to take forward themselves. Most of them were in that area. There has also been some reduction in administration staff and back-office staff in the Department.

On the information side overall on the tracking of efficiency, David has his direct routes reporting from each organisation about what they are doing against their efficiency and QIPP plans. What we can also do at the Department is track, at a macro level, what is happening with things like unit costs in the system, productivity, activity and the prices we pay. We can triangulate what comes up from David’s bottom-up reporting from looking at the aggregate numbers. Looking at the level of activity in the hospital and community health system and the numbers of staff there, we can say we are running at a rate of about 2% to 2.5% improvement in labour productivity over the last year or so. We can look at the prices that we are paying for nationally and locally-procured goods and how that compares with the overall inflation figure to see what saving we are getting from that. There is quite a lot of aggregate-level information we can use to not second-guess what is coming up from the Service but triangulate it and make sure this really makes sense as a whole.

Q111 Valerie Vaz: We have all been through the Health and Social Care Bill—you more than anyone else—but there has been a lot of uncertainty around that and staff have left. To a certain extent, there has been some chaos in the whole system. In terms of the reorganisation costs, the QIPP costs and the £20 billion saving, how are you measuring where you have made all the efficiency savings among those three areas in particular? There may be other areas, but how are you measuring your efficiency savings in relation to those three different things?
Mr Lansley: First, I would not characterise any of it as chaos—on the contrary. What has been important to do and has been done, both for reasons of securing efficiency and a reduction in administration costs, is to manage with fewer management staff. That is true right across Government. It is not, in any sense, being done in the NHS in a way other than is common right across Government. As David said, since the election, we are at a total of 13,000 fewer administrative staff. For managers and senior managers, that is in excess of a 5,000 reduction. Of course, that is in the context of the primary care trusts coming together into a clustering process, which is now essentially complete, creating reduced demand for managers and senior management staff. In fact, that is part of what has already delivered the £240 million reduction in administration costs in 2010–11 which we were not anticipating. There are further administration costs. After the election we established direct control in relation to the running costs of these organisations across the whole of the NHS. So we control that directly, which did not happen previously.
As far as efficiency savings are concerned, as Richard was explaining, that is done on a bottom-up basis. Primary care trusts, together with their developing clinical commissioning groups, have their own PCT-led plans, and strategic health authorities bring those together at an SHA level—now clustered together as well—but Richard and his colleagues are able sometimes, in some of these respects, to look at them from data available from a top-down basis to cross-check against that. So we can look at the level of savings directly in administration costs and impact on that, we can look directly at central budgets and—

Q112 Valerie Vaz: I am sorry to interrupt, but my question was how you allocate the costs between the three distinct areas. You have lots of people leaving the Service because they are not quite sure what is happening—you know that in PCTs people are leaving—so you have costs associated with the reorganisation, with QIPP, and with the £20 billion. My question is: how do you know which bit you are getting the costs from?

Mr Lansley: Where administration costs are concerned, clearly there have been managed programmes for people who are leaving the Service. We did that through the mutually-agreed resignation scheme. We have had redundancy costs, if memory serves me right, of £225 million in total in 2010–11 across the Service.

Sir David Nicholson: I will have to check.

Mr Lansley: But we directly manage the administration costs. You are making a distinction between QIPP and efficiency savings, which is not a distinction I would make. As far as I am concerned, the Quality, Innovation, Productivity and Prevention programme incorporates within it the necessary level of efficiency savings to deliver improving quality through innovation, productivity and performance enhancements.

Q113 Valerie Vaz: Is that part of the £20 billion?

Mr Lansley: It is one programme. The “up to £20 billion”—I should say that because it is “up to £20 billion” and not necessarily £20 billion—efficiency savings is an integral part of the QIPP programme. It is a measure of what the QIPP programme needs to achieve allied to the £12.5 billion increase in cash resources for the NHS in order to deliver improving quality by these various routes.

Sir David Nicholson: When we set out on this road in May 2009, it was pretty clear that administration and management would have to take its fair share of reductions during this period. In fact, we said we would reduce it by a third. It went up a little. Our target went to 40%, largely because we had a big increase in management costs in 2008–09. What we did not know, when we said we were going to make that change, is how we were going to do it. But what was clear to us at the time was that it was going to be quite difficult to do in terms of the existing organisational shape of the NHS, sustaining 10 SHAs and 152 PCTs and reducing management costs. Was there a better way of doing it? As we were thinking that through, we had the election, the new Government came in and they answered for us how we were going to do it.

What we have tried to do since then is shape the reductions, pointing in the direction of the new world. That is why we have clustered PCTs, but it is also why we have assigned quite a lot of staff to clinical commissioning groups. People are associated now with clinical commissioning groups—not that they have jobs permanently there, because they will not have until legislation is passed and organisations are formed, but, in a sense, pointing them in the direction. That is what we have tried to do with the way we are organising ourselves at the moment.

Q114 Valerie Vaz: I have one final question. You mentioned management and administrative costs. Are you employing any consultants from McKinsey? If so, how much are they costing?

Mr Lansley: I hesitate to say we are not because we probably are somewhere, but I am not sure where. Are we?

Sir David Nicholson: Do I have any McKinsey contracts at the moment?

Mr Lansley: When you say “we”, do you mean the Department of Health or the NHS?

Q115 Valerie Vaz: The Department. I didn’t mean you. I meant anyone.

Mr Lansley: Clearly, the NHS will be doing so in some respects in some places, but since we are not directly—

Q116 Valerie Vaz: You must know whether you have management consultants or not. You must know that.

Richard Douglas: McKinsey were engaged in some work around the foundation trusts pipeline. That is the most recent piece of work.

Mr Lansley: Yes, they were.

Q117 Valerie Vaz: Are you sure that is all they are involved in? Could you find out and write to me, perhaps, and give me a figure for how much you are paying them?

Mr Lansley: McKinsey and the Department.

Valerie Vaz: Yes, all the work they are doing for you.

Mr Lansley: Yes.

Rosie Cooper: Is it only McKinsey or all consultants, Valerie?

Q118 Valerie Vaz: Let us extend it to all private consultants.

Sir David Nicholson: I am happy to. It is very little. I cannot think that it is very much at all that we have engaged in.

Mr Lansley: I know that, since the election, we have reduced the management consultancy expenditure at the Department by more than 50%.

Una O’Brien: We can let you have the figures, but it would be a difficult task to do it. There are a whole separate body of work to do with that which the Committee is very familiar with. We are very happy to share all the information with you, but I can assure you that the
expenditure on management consultants has come down dramatically since the election.

If I may add one point on this, the management of costs, it might help to illuminate the general approach we are taking to this. Whereas, in the past, prior to the election, the running costs of the Department of Health itself were under very specific controls—and they were dealt with separately from the running costs of the NHS—what is different about this spending review is that it is all together in one pot. We are looking at the totality of the running costs of the Department and its arm’s length bodies now and in the future. When we think about how we are going to reduce the management costs, we are also bearing in mind the journey from PCTs and SHAs to the new Department and its arm’s length bodies. That is the four-year journey that frames the management costs reduction as a whole rather than looking at the Civil Service bit separately. This is obviously a different thing for us because we have to approach it managerially, but when it comes to the discussions about where work should be done between the Department and its arm’s length bodies, it also enables us to have a more sensible discussion to ensure that we are not duplicating work and that each organisation is properly focused on its own objective. By that change we have a much stronger opportunity to use our resources effectively.

Q119 Valerie Vaz: May I have that information—the work they are currently engaged in now as well.

Una O’Brien: Yes.

Chair: We need to speed up a bit.

Q120 Dr Poulter: Secretary of State, you outlined at the beginning that there are very big financial challenges facing the NHS just to stand still, regardless and so the new arm’s length bodies may take place—obviously, tackling the increased healthcare demands of an ageing population and increased demands from all patients from the NHS are all key part drivers of that—and that there needed to be 20% efficiency savings over a period of five years, by 2014, I think. A number of organisations have told us that they are looking at a figure and its arm’s length bodies. That enables us to have a more sensible discussion to ensure that we are not duplicating work and that each organisation is properly focused on its own objective. By that change we have a much stronger opportunity to use our resources effectively.

You are quite right that, over the Service as a whole, we are looking for what is, broadly speaking, a 4% efficiency saving. We have always expected that, for some organisations, there would be impacts derived from the tariff of that order, but that, in addition, in so far as there are changes associated with the redesign of clinical services, there may be impacts on the budgets of organisations that go beyond that 4%. From what I have seen, over hospital trusts across the country, the efficiency savings being looked for are in excess of 4% but not greatly in excess of 4%. I suspect they will sometimes be in excess of that if they are the subject of acute services being managed to a greater extent in the community. However, if they, as organisations, are themselves also responsible for the provision of community services and hospital services—delivering pathways of care—they may well be in a situation where, in budgetary terms, the overall scale of the budgetary impacts on that are not necessarily as great.

Q121 Dr Poulter: On that theme, changing the tariff and obviously quite a crude mechanism in terms of dealing with things. You have spoken about managing services in the community in perhaps a more cost-effective way and a more patient-centred way as well. But if you are looking at changing the tariff on an annual basis, is that not going to force short-term thinking from organisations and private providers in adult social care rather than necessarily encouraging the redevelopment of services that we all would want?

Mr Lansley: That would be true if we were not, at the same time, developing the tariff and the way in which the tariff itself is structured. For example, we were expecting increasingly to extend into best-practice tariffs which, in themselves, incentivise, through the structure of the tariff, the ability of providers to be able to provide more high-quality services and hospital services in the community in perhaps a more cost-effective way and a more patient-centred way as well. But if you are looking at changing the tariff on an annual basis, is that not going to force short-term thinking from organisations and private providers in adult social care rather than necessarily encouraging the redevelopment of services that we all would want?

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hospital and community and if the tariff is confined to the hospital sector and is not in the community, it creates a considerable organisational and financial barrier to that happening. The extension of tariffs out into the community is very important. The same will be true for mental health services. We are in a position, I hope, where, by 2012-13, the currencies established for local use will be mandated for contracting for mental health services. That is another £4 billion. We will be taken, across the NHS, from a position where 60% of acute services are subject to the tariff to a position where an increasing proportion of community services are likewise subject to the tariff. If it is best-practice-driven, yes, there is an element of reducing to deliver efficiency below the average cost. In this financial year there is a 1% reduction—am I right, Richard?—below the average calculation.

Sir David Nicholson: Please do not think we underestimate the scale of challenge that people have here. This is a very, very different way of working, particularly for the acute sector. If you think back over the last seven or eight years or so, the business model of the acute sector essentially has been, “We do more, we get paid more.” That has driven a whole set of ways of working and operating. Very successful organisations have done that and worked really well. This is very different. This is looking at an environment where there is no more money anyway, so generating huge amounts of activity will not drive huge amounts for you. We are going to have to focus much more on outcomes and integrated care. If an acute hospital thinks they can carry on as they are and, in a sense, salami-slice their service through efficiencies, it will not work for them. They will have more and more difficulty. They increasingly need to look at how they integrate with health and social care and to think about what sort of organisation they are going to be. They also need to look at the disposition of their services: can every DGH do everything? All those things are what people need to do. A substantial proportion of them are getting into that, but it is tough, absolutely.

Q122 Dr Poulter: In what you have seen so far are you concerned at all—you have mentioned salami-slicing—that in order to make short-term cost savings some—particularly acute trusts, because they are still paid by results, as you indicated—are making frontline cuts rather than looking at the efficiency savings they should be making in the back office and in terms of administrative savings?

Sir David Nicholson: Can I explain what we have tried to do with all this, because the potential—

Q123 Dr Poulter: I want a simple answer, the answer “Yes” or “No” really.

Sir David Nicholson: I understand the need for a simple answer.

Dr Poulter: There is no need to be elaborate.

Sir David Nicholson: I will not be elaborate. One of the things we have tried to do, right from the beginning, is to build some kind of assurance system into the cost improvement programmes that people carry out. We have set out, very clearly, that we expect the chief doctor or the chief nurse in every organisation to sign off their cash-releasing cost improvement programme, so you have, in a sense, clinical oversight for that. We have also asked SHAs to quality assure those. Even when you have done that, there is the potential—and we are very alert to that, and as we get examples of people doing it, we want to intervene, help and support—

Q124 Dr Poulter: You are safeguarding against that sort of thing happening.

Sir David Nicholson: We are absolutely trying to do it, but even if you safeguard for it sometimes it will happen. Hence, we meet every month with the Royal College of Nursing through their Frontline First system for them to alert us to things that are going wrong or other issues. There is no benefit to the system to do that. We want people to make proper efficiency gains.

Dr Poulter: That is very helpful. Thank you.

Q125 Dr Wollaston: Sir David, can I draw your attention to an item on page 13 of The Quarter which could be an example of that? In figure 10 is the “Diagnostic waiting times” and it refers to the “over six week waiters and median waiting time April 2008 to June 2011.” Looking at the graph for the six-plus-week waiters, there does seem to have been just such a drift upwards. Do you feel that is an example of where people could be salami-slicing services rather than taking another approach?

Sir David Nicholson: What I would say about waiting times generally is that the NHS continues to deliver the operating standards.

Dr Wollaston: Indeed, absolutely.

Sir David Nicholson: There is no doubt that, in diagnostic terms, there has been a huge increase in the number of diagnostic tests done. It has gone up significantly more than certainly anyone planned for, as we went through. Bearing that in mind, we have seen the increase in six weeks. It is an indicator. It is an alert for us to go back to organisations and see what is actually happening. That is the way we would deal with it.

Q126 Dr Wollaston: That is an assurance you can give the Committee today, that you are now aware that this is an issue—the six-week waiters.

Sir David Nicholson: Yes, and we will go back to organisations.

Dr Wollaston: Thank you.

Q127 Rosie Cooper: I have three substantial questions to ask. Initially, the huge cost to the Health Service is in staff costs. Many trusts currently, in a bid to reducing costs, are re-grading staff downwards and therefore reducing the pay bill. Pay is going to be a huge consideration in future years. Do the Government intend to do a national pay deal and, if
not, what will your attitude be to local pay deals and potential industrial action?

Mr Lansley: I am not aware—my colleagues may be—of what you describe, that is, trusts who are seeking to manage their costs by the downgrading of existing staff. If you are aware of that, then, by all means, tell us, but I was not aware.

Q128 Rosie Cooper: Secretary of State, speak to any of the national organisations and speak to the nurses. All of them will tell you. The hospital of which I was formerly chair was an FT and has just gone through a massive programme and re-graded all its staff. Any hospital I know of seems to have either done it or are doing it currently.

Mr Lansley: I will gladly, by all means. David will know better than I do, but I have talked to the Royal College of Nursing and this is not an issue for the Royal College of Nursing. I talk to them regularly.

Q129 Rosie Cooper: They spoke to me about it at the conference.

Mr Lansley: They have not raised it with me. The whole purpose of Agenda for Change was to try to ensure that there was accuracy in terms of the grade of staff in different places across the country. Previously, the grading of staff had been very much the product of pay and related pressures in different places so you arrived at the position—and you will recall this very well—where there were anomalies in grading for members of staff doing the same work in different places across the country who had quite different grades because that was the only way in which they could respond to recruitment and retention pressures.

Q130 Rosie Cooper: That was all supposed to be sorted and now they are re-grading.

Mr Lansley: Agenda for Change was designed to deal with that and to deliver greater consistency. If there is inconsistency emerging for that reason, then I am not aware of it, but I will take that away and certainly find out if we know to what extent that is true. As far as I am concerned, the legal position is unchanged and we have no plans to change it. Each of the NHS trusts and foundation trusts are their own employers. They have the legal right to establish their pay, but across the NHS there is an expectation that people will pay in relation to what are, effectively, collectively-negotiated structures of pay advised by the pay review bodies for professional staff groups. That, as far as we are concerned, is still true. The exception to that is a position where the Government, for reasons of broader public finance, has established a pay freeze. That began on 1 April this year and lasts for two years. It applies to staff earning above £15,000 per year and, for a salary below £15,000 per year, there is an across-the-board £250 pay increase. That is the position. We have no plans to change that position.

Q131 Rosie Cooper: There will be no national pay deal.

Mr Lansley: Do you mean in this year or next year? The pay freeze is as we have described it.

Q132 Rosie Cooper: Thereafter.

Mr Lansley: In so far as the question below £15,000 is concerned, we asked the review bodies’ advice—

Q133 Rosie Cooper: When that comes to an end.

Mr Lansley: We asked the review bodies last year to advise on that and they endorsed the £250. That applies this year. Clearly, I am not in a position to talk beyond 2013.

Q134 Rosie Cooper: That is fine. Thank you. Secretary of State and Sir David, I have listened as carefully as I can, because the answers are long and sometimes you get lost in those answers, and brief answers would help me. When you speak, everything sounds wonderful; everyone supports the current Bill; everyone supports all the changes; the doctor and everybody is on board; everything is fine; everything is on target; QIPP is fine and the majority of savings are being met recurrently. But you don’t quite have the details yet, so okay.

Let me suggest to you that the majority of the Service would not recognise that. I am sitting here with a letter from a chief executive of a hospital—and, Secretary of State, a little while ago I think you said that QIPP included its own efficiency elements—which I will read to you. Remember that QIPP is all going fine: “Experience of QIPP has been fairly negative to date, with delays to the pathology centralisation and when schemes have delivered savings to the North Mersey economy, as in the Capita bid for HR and payroll services, we would have lost a million pounds had we joined. QIPP is unlikely at present to deliver major contributions to our CIP”. Their cost improvement programme currently—and they are an integrated care organisation—is 5% as against the national 6%. Monitor, if they become a foundation trust, would expect them also to make a profit each year of 1%, which is very nearly £2 million. They are going to find it really difficult to do.

My questions to you are about the reality out there. It is not quite the pretty picture you are painting. Take non-recurring savings. You may not be able to tell me exactly now, and I understand that—although you will have a feel for it—and be able to let us know—but, for example, in foundation trusts how many of them have used their reserves to prop up the Service to get through this year? Also, an element of that is that Monitor’s risk rating is falling backwards. It is clear that services are being affected. It is not as simple as saying, “Oh, dear, hospitals are just cutting the frontline because that is the easiest thing to do when they do not cut back service operations.” You have heard what a chief executive said to me. People do not cut frontline services if they do not have to.

Also, what evidence do you have that trusts have kept in financial balance at the expense of waiting times? We have heard that from another member of the Committee. The Service is desperately trying to keep its head above water and you sit in front of us telling us it is all okay and everything is marvellous.

Mr Lansley: Clearly, Monitor will want to report in due course about the extent to which foundation trusts are meeting their financial objectives and how they
are doing so. It may be that some—I do not know—will use their reserves to help them to do so because I do not think any of us are under any illusions about the extent of the financial challenge. David said that a few moments ago. We recognise this is a very considerable financial challenge and the challenge is greatest in the acute sector because of the combination of a need to make efficiencies driven through best-practice tariff development and the redesign of services in the course of the QIPP programme which is clearly going to have an impact in terms of delivering more care closer to home. The cumulative impact of that is to create unprecedented pressures inside the acute sector. Where foundation trusts are concerned, many of them are in a good financial position to do so. I make no bones about it. Of course, there has been a shift in some of the risk ratings in some foundation trusts because the financial pressures are considerable, but we are doing it against a background of a £12.5 billion increase.

I might say: what do people think about QIPP across the Service? I noted in the staff attitude survey—published in June of this year—that 62% of NHS staff felt that QIPP would have a positive impact on the quality of care patients receive overall.

Q138 Rosie Cooper: The alternative is to do it in a measured way, to do it taking the people in the Health Service with you. The way to do it—

Mr Lansley: That is exactly what we are doing.

Q139 Rosie Cooper: But you are not. Secretary of State, you have got to be demented if you believe that the people in the Health Service are behind you—absolutely demented. You have got to be. I understand that might be towards £1 billion. Would that be right? If it is right, can you tell me—

Mr Lansley: It is nothing to do with whether people agree with me or not. When you talk about QIPP, the whole point is that it is measured. That is why it is not about me and it is not even about this Government. It was about a recognition, in May 2009—

Q140 Rosie Cooper: So it loses a bit of the impact that they had lost £1 million.

Mr Lansley: No. You said have brief answers. You then had a six-minute question.

Rosie Cooper: Okay.

Mr Lansley: David and his colleagues were very clear in May 2009 that there were going to be unprecedented financial challenges whatever the situation. That is why I think from May 2009 to April 2011 is a considerable period of time over which to have supported the NHS to do that. The National Audit Office—talk about measured—on this issue said to your Committee about the Department, the NHS and David and his colleagues, that most strategic health authorities told them that the model the Department had put in place to support the development of QIPP plans and integrated plans had been very helpful and effective, that they considered it had brought a necessary discipline to the process and that they received an appropriate level of follow-up, feedback and challenge. It is a measured process. It is absolutely not as has happened in the past. You will remember when the NHS fell into a loss of financial control in 2005–06. One of the things David and his colleagues did was to restore financial control after that period. At that time there were short-term expedients, salami slicing and budgets being cut without regard to the impact on quality. We are not contemplating any of that. We are working across the Service to our utmost to ensure that we deliver against these financial and other efficiency challenges while continuing to improve the quality of the service provided to patients.

Q141 Rosie Cooper: Can we go to the other end of it then?

Chair: You can have one more go, Rosie.

Rosie Cooper: Absolutely. The Department’s report and accounts show an underspend of £695 million on the capital budget. The initial question is: are you satisfied with that and are you disappointed that that budget was not used? I do not have the exact figure here. How much did you save on the revenue budgets?

I understand that might be towards £1 billion. Would that be right? If it is right, can you tell me—
Mr Lansley: Hang on a minute and he will tell you the answer.

Q142 Rosie Cooper: Yes, if you just say the figure. Is it £1 billion?
Richard Douglas: The revenue underspend was just under £1 billion. It was £970 million.

Q143 Rosie Cooper: Are you happy that you managed to save £1 billion out of your revenue budget that could have been used in social care, that could have been used in the Health Service and that could have been used to fund operations? Is that money going to be carried over so that money is not lost to the Health Service? People out there will be really incensed. They have not perhaps been able to get the operations, the waiting lists have become longer and you have saved all that revenue. You have not used it.

Chair: It is a technical question, I think, Rosie, if I may help. Is there year-end flexibility around that?
Richard Douglas: There is not year-end flexibility from last year into this year.

Q144 Chair: On either the capital or the—
Richard Douglas: That is on either the capital or the revenue. There has not been for at least four or five years. This is not new. What there will be is a degree of flexibility from this year into next year. There is a new scheme that will allow flexibility from one year to the next. On the revenue side for last year—to be clear on it—about £0.5 billion of that was savings from the Department’s own spending around the efficiency controls, the efficiency measures that were put in, so about £0.5 billion of that was the Department itself. There was about £400 million from the NHS, in that we ended up in a slightly better position than had been planned. There will always be some degree of underspend. That is inevitable in the system we have. You cannot overspend at the end of the year. If you cannot overspend and you have a £100 billion budget, none of us can manage it to three and sixpence. There will always be a degree of underspend and most of that came from the Department. The NHS element was probably not dissimilar to previous years.

On the capital side—

Sir David Nicholson: I am sorry, but it is worth saying that when we realised the potential for the underspend we made £162 million available in January this year to support local governments through winter.

Richard Douglas: We did.

Q145 Rosie Cooper: Could you have made more available? This is the question. You have £1 billion sitting there.

Sir David Nicholson: They could not have spent it.
Richard Douglas: They could not have spent it sensibly at that point in the year.

Q146 Rosie Cooper: I don’t mean just to them, but there would be stuff in hospitals. There will be people right round this country that were not able to get the services they desperately needed and you were sitting on it. You were not intending to make that saving, but it was there for you to spend and you did not spend it on them.

Richard Douglas: We were not sitting on it. Some of the saving emerged quite late in the year and at that point you cannot use money sensibly. What we do not want to do is push money into a system where we know it could not be used well. If you get to the point that late in the year, there is not—

Q147 Rosie Cooper: Could you not have negotiated, because the Health Service—

Richard Douglas: There were no negotiations around carrying forward underspends. As I say, there have not been for the last four or five years, at least, to my knowledge.

Q148 Chair: To be clear, there is year-end flexibility around the end of the financial year.
Richard Douglas: There is. It is a different form. It has to be declared earlier on in the year and you have to surrender money in-year. There is a system now running for this spending review period, but it was not going to run from one spending review period to another.

Q149 Rosie Cooper: Can somebody write and explain that to us because I find it really difficult?
Chair: Is there a simple formulation of how the rules will work?
Richard Douglas: We will provide a simple formulation but—

Chair: If not simple, preferably comprehensible.

Richard Douglas: We can give you a copy of that. On the capital side, the bulk of that capital underspend was around the national programme for IT, where it was based on the fact that things had not been delivered and we were not going to pay for things that had not been delivered. If you strip out the national programme for IT, the other elements were relatively small on the capital side.

Q150 Dr Wollaston: I have a follow-up question on the issue of capital budgets, an issue to do with capital that several people have raised with me. It is around the position of community hospitals. I have been hearing some concerns that we are going to see a decoupling of the ownership of community hospitals from local control. Formerly, of course, they were owned by PCTs, but if, in future, the NHS provider loses a service contract or vacates or ceases to exist for any reason, the outgoing organisation, I understand, could dispose of the property with the Secretary of State having half the proceeds for that. Could you please clarify that for community hospitals?
Mr Lansley: I will go first and my colleagues might want to add to that. The first step is, as we set out a few months ago, that our expectation is that in community services—you will recall the Transforming Community Services programme, which is now effectively complete—if there were property assets integral to the delivery of those community services and essential for doing so, they should be transferred with those community services.
The way it works is that if, at any time in the future, that organisation were not in a position to deliver those community services, the ownership of those property assets would revert to the NHS—to the Secretary of State—for all intents and purposes.

Where there are community assets that have been owned by the primary care trust, we are still considering and consulting on the question of where those additional assets should be housed, but the intention is that they will continue to be NHS assets. There is no process involved where these assets will transfer out of NHS ownership.

Q151 Dr Wollaston: Do you understand the concern that local communities have that they would have less say through, for example, clinical commissioning groups about the ownership of that and that it could potentially transfer out of NHS control?

Mr Lansley: Strictly speaking, it gets us into the vexed question of whether people had any say about what primary care trusts did with the assets they owned in the past—

Q152 Dr Wollaston: Indeed, but we are supposed to be improving things with these reforms.

Mr Lansley:—where very often people felt they had no such say. Yes, we are looking at what the best route is and we have not reached a conclusion yet about that. In so far as they are managed by community services and are integral to the delivery of those community services, the expectation of any public locally would be—in the same way as they would expect a hospital trust, in effect, to own the hospital from which they provide their services—that their community services will own the clinics and the community hospitals from which they provide their services. There is no change where that is concerned. People should not regard that as, in any sense, disturbing their current expectation. For the rest of the property assets, many of which will not be needed directly necessarily to provide clinical services—they may well be office accommodation and the like—if they are NHS owned, then we are looking for an NHS mechanism by which they will be owned in the future.

Q153 Dr Wollaston: One crucial difference is, of course, that many local communities have put a great deal of funding themselves into community hospitals and, naturally, feel rather threatened by the prospect of losing ownership and control locally.

Mr Lansley: Yes. In a sense, they should not feel that because it will continue to be NHS owned.

Q154 Dr Wollaston: Thank you for clarifying that.

Mr Lansley: In particular, for example, if it is owned by a community trust and it becomes a community foundation trust in a very real sense, it will be a locally-owned community hospital.

Q155 Dr Wollaston: It would be helpful for them if you were able to clarify what degree of local control would be enhanced under the new arrangements.

Mr Lansley: It will vary from place to place, depending upon the nature of the community services organisation that runs community services in that area.

It might be a hospital trust or it might be a community services trust.

Dr Wollaston: Thank you.

Q156 Andrew George: When does a cut become an efficiency gain?

Mr Lansley: The question should probably be the other way round: when does an efficiency gain become a cut?

Q157 Andrew George: I am happy for you to answer either way.

Mr Lansley: The answer is, in my view, in circumstances in which there is prejudice to the quality of the service you are providing, which is why we are very fixed upon the two things. QIPP is not an efficiency programme. It is a quality and innovation and performance and productivity programme. The title is absolutely deliberate. To put it in simple terms, if we are spending £100 now and in four years’ time we would expect to be spending £130 but we managed to only be spending £112, yes, the amount we spent has gone up. It is not a cut in the sense that the budget has been cut, but if we can continue to deliver better services, I am not sure there is any cut there at all. If the service is being provided and the budget has increased, where is the cut?

Q158 Andrew George: In our previous evidence session—and I am going to characterise, which I know is probably unfair, the views of the King’s Fund, the NHS Confederation and the Nuffield Trust—the theme was that this is largely a budget-driven process, that the Department is exhorting the local NHS to ensure that there is not total carnage and that is what the QIPP programme is about. If we take it to the particular, where, for example, we have an out-of-hours GP service which is erring on the side of using nurse-led telephone triage rather than hands-on doctor visits, resulting in perhaps taking risks in certain circumstances, the question is—this could apply across a range of services where we see in The Quarter that the number of hospital beds has clearly been cut by earlier discharge of patients, which I know is desirable in many ways but there is also greater re-admission in certain trusts—to what extent are you content that what you are achieving in terms of budget savings at this stage, the low-hanging fruit, as it were, will be sustainable through subsequent quarters?

Mr Lansley: You took evidence from the King’s Fund and Nuffield Trust, among others. I would be surprised if they would recognise that characterisation as saying this is a purely budget-driven process. Of course we live within a budget, but this is an unprecedented focus on how we can deliver quality in the long term through the clinical redesign of services. I know, in particular, that the Nuffield Trust has done a great deal of work on issues such as a development of tariff to develop quality and efficiency side by side, and the King’s Fund are working with us on how we can integrate services more effectively in order to deliver improvements in quality and efficiency, as I say, as both sides of the same coin. I would be
surprised if they, themselves, would characterise it that way. None the less, we do live within a budget and we have to deliver the best possible quality we can within that budget.

In the past, talking about competition—for example, with out-of-hours services, and we have all been there and seen it—in truth what happened in the NHS very often was that primary care trusts went out to competitive tender and it was cost and volume. It was, “Are we going to give the contract to somebody who is going to charge us £10.20 per head or somebody who charges us £9.40 a head?” Sometimes quality suffered under those circumstances. That is why we absolutely are looking to make sure that we have a clear understanding of the quality of services that are being provided and are developing quality indicators to make that happen. We cannot do that for everything from the centre. Much of that must be locally led and locally driven but, in the particular example you describe, my personal view is that there is a tremendous opportunity in the redesign of urgent care. When David and his colleagues are looking towards the latter stages of the QIPP programme from 2013 onwards, their expectation is that the redesign of urgent care services will be one of those areas where that will be achieved. It will be achieved by integrating the out-of-hours GP service with things like walk-in centres, NHS Direct and some of the aspects of the ambulance response in a way that should get us to a place that is safe and with higher quality from the public’s point of view. It need not at all be anything other than financially cost-effective as well.

Q159 Andrew George: We will come on in a moment to whether that desired and—I entirely agree with you—desirable integration will be possible under the reforms. That is another question. It is very early stages, as you say. QIPP only started in April this year. Therefore, it is a question of how you are measuring the quality and whether you are satisfied at the moment that what you are getting from David Flory’s work so far is likely to be sustained—whether you have the measurements in place. The example I have of given of urgent care being provided on possibly a greater risk basis is one which obviously needs to be watched. Early discharge needs to be watched. The extent to which that might result in increasing cases of early death or increasing re-admission and so on is clearly going to be part of the measurement process as to whether you are achieving the quality we all desire.

Mr Lansley: You can see in The Quarter, as you know, there is a continuing programme of reporting on a number of quality measures. We have extended those. We are reporting on accident and emergency quality indicators that are wider than we reported on before. You will be familiar with the introduction of the National Outcomes Framework at the end of last year. Our purpose is continuously to improve and report on that as time goes on so that we will have a much stronger basis for measuring the quality and the outcomes that it achieved. Some of the things you describe would immediately be evident if the response to pressures in the service was to try and change that.

For example, through the tariff we are working to ensure that hospitals take a greater responsibility for rehabilitation and re-ablement following discharge. It would become obvious if they do not but, in particular, if you look at the Outcomes Framework, people’s recovery following treatment is one of the central domains for that. As it happened, yesterday I did not so much launch as receive the winners of a competition looking at what the indicators should be in relation to the National Outcomes Framework. Where stroke is concerned, it is a modified ranking scale, looking at what level of disability people have six months after a stroke. That has not been measured in the past. From a patient’s point of view, measuring this makes an enormous difference because not only are we going to be saying, “Do patients survive a stroke?” which, to an extent, has been measured previously—mortality—but, also, we are looking at the worry that patients always had, that they left hospital and fell off the cliff edge and there were not enough services in the community. Looking six months out at people’s recovery following treatment is a very valid measure of that. Collectively, we are moving to a world where there is much better information. If you were to ask me what I think, when we look at all of this data, financial and otherwise, is likely to make the biggest positive impact for patients, it is the availability of good information to clinicians that shows them how well they are doing and takes things like this—the NHS Atlas of Variation. This was the first one we published at the end of November last year, and we will publish it again later this year. In a sense, you might say that this is not a management performance tool. Managers in the NHS are not necessarily using this to bash clinicians around the head. It is clinicians who look at this and say, “Why are we doing worse than somebody else on this measure?” The more we do that, the more we will see improvement for patients.

Q160 Andrew George: Providing, of course, that those statistics are robust and fair in their representation.

Mr Lansley: Yes.

Q161 Andrew George: That is very helpful and you will obviously be pleased to know that we intend to repeat this inquiry on an annual basis, so we will be monitoring the process. Finally, I wondered—Chair: They have broad smiles on their faces.

Andrew George:—to what extent you would agree with the BMA when they told us there is no doubt that, as a result of these changes, the need for hospitals to find savings has resulted in an adverse impact on access to hospitals? Are they, therefore, out of kilter with the general direction of services?

Mr Lansley: I do find this slightly surprising. There was some talk over the summer about people not having access to things like knee surgery and cataract surgery, and so on. When I look at the data, the numbers of patients being treated in the last year has gone up in some of these respects. Our objective is not to increase activity, but there is no evidence from the data that tells you people are getting less access.
We are continuing, as David said, to meet the operational standard for more than 90% of patients having access to treatment within 18 weeks. The average wait to treatment on the last measure that was published was 8.2 weeks between referral and treatment. At the time of the last election, the average was 8.4 weeks. Not for the first time we have encountered circumstances where, for financial reasons, some primary care trusts were looking at setting minimum waiting times. There is a particular example which the Co-operation and Competition Panel saw in Wiltshire recently where the primary care trust was setting a minimum waiting time, I think, at 15 weeks because, of course, the only target they were meeting was the NHS number, which had the 18-week deadline. The Co-operation and Competition Panel have said—and we have made clear, including David and his colleagues—that that is not acceptable. The objective is to use our resources to deliver to patients the best service we can, not to make them wait under circumstances where the capacity is available.

Q162 Rosie Cooper: I am confused at that because it is a continuation of what I was saying before. Secretary of State, I have heard what you said about various operations that technically, we hear, are not being done on the NHS and yet they are going up—cataracts you mentioned.

Mr Lansley: Of course cataracts are being done on the NHS.

Q163 Rosie Cooper: In my own area, for example—and you mentioned cataracts—the PCTs do not now do varicose veins and various operations. Where I am at a loss is with the story, which you must have read in national newspapers last week, of a practice, in the Midlands I think, which had been taken over where they wrote to the patients and said, “You require X operation or X clinical help and this is no longer being agreed on the NHS. Therefore, here are three or four providers and one is us.” How can you sit there and say that everybody is doing everything when it is quite clear that with the NHS there are certain categories of operation or treatment—whatever that is—that people are not doing? You cannot sit there and say that the numbers are going up and therefore it is not happening. It may be different in different parts of the country, but it is a reality. It was in the newspapers—or didn’t you read any?

Mr Lansley: I do not necessarily believe what I see in the newspapers. I tend to look, as I said, to clinical discussion, to look at where, in their view, on a clinical basis, treatments are of very poor clinical value and cannot encompass excluding from treatment whole categories of patients and all patients. Even under those circumstances patients must be considered on their individual merits. The story you are referring to is the Haxby surgery in North Yorkshire, not in the West Midlands. The North Yorkshire and York Primary Care Trust made it clear that, in their view, they were not accurate in their description of access to services in their area. If they wrote to patients in the way described we would have our concerns about whether they did so using patients’ information which was provided to the NHS for NHS purposes and should not be used for other purposes. From our point of view, the NHS continues to provide a comprehensive health service and that will be true in North Yorkshire as well.

Q165 Chair: May I come back, Secretary of State, to something you said 10 minutes ago? You said there was a big opportunity to improve urgent care and that you were working with Sir David on plans to do this from April 2013 onwards. If that is going to deliver better care and do it more efficiently and all of the good things in the QIPP programme, why do we have to wait until April 2013?

Mr Lansley: Please me. I should have explained. I do not mean that we should not do it, and in many places they are doing it now, but, at the moment, we have four pilot schemes for the 111 telephone system. I say April 2013 because our intention is that by April 2013, across the whole of England, telephone and online access to the NHS for urgent care will be able to be achieved through the 111 system.

Q166 Chair: The reason I raise that question is that it is symptomatic of a concern that has been expressed to us—the proposition that Sir David put to us—that we can only achieve the £15 billion to £20 billion, the QIPP challenge, however we want to characterise it, by substantial service redesign. It is service reorganisation, whether it is classified in the 20% or the 40% operational. It is a substantial service redesign. Your comment about “This will happen from 2013” sparked in my mind a sense that those real service reorganisations are being left relatively late in this process rather than being brought forward in order to embrace the need for service redesign now. First, is that an accurate characterisation? Second, if it is, is it to some extent reflecting a degree of political support for necessary service reorganisation? I would be interested in Sir David’s view of the extent to which managers in the Health Service are comfortable with the level of political support they have for the service reorganisation which is implicit in the QIPP challenge.

Mr Lansley: David can obviously add to that but, from my point of view, where urgent care is concerned—and the case in point is a particular example—we are making rapid progress. Individual localities are able to make progress themselves on the redesign of urgent care, but in order to link it to the 111 telephone system, quite reasonably, many people are looking for a clear evaluation of a number of pilots which are using things such as the clinical assessment software of different characters and telephone response systems that have different characteristics. They want to see that evaluation before they make
final decisions about how they structure an urgent care service. They are working in many places, because I have had these conversations with quite a number of clinical commissioning groups. They have, themselves, work streams looking at the proposition that they will have a more co-ordinated access—a gateway, as it were—and they are redesigning themselves urgent care behind that gateway to see how it best works for their area. It will vary from place to place because we are not creating a top-down, one-size-fits-all design for urgent care.

Q167 Chair: But whether the driver for change comes nationally or from the clinical groups, surely the position we are in is one where we should be encouraging that change programme to speed up rather than slow down.

Mr Lansley: We are encouraging it to speed up and the QIPP programme does that. It is a very good illustration—and there are others—of how, in effect, you need a combination of a national approach and a local approach in order to make it work. It is very difficult for individual organisations all over the country to be trying to design an urgent care telephone triage system. You cannot do it. We want to arrive at a place where we have a 111 system and the public everywhere in England feel confident that, for access to the NHS, they can call 111 and it can be achieved. What the NHS offers in each area in terms of the structure of the relationship between general practice, the ambulance service and the hospital services is going to vary from place to place.

Do managers feel they have political support? I would say this before I hand over to David. It is not only about political support. It is about those four tests that give management great confidence. I have already seen, since the election, places where reconfigurations that in the past were thought to be intensely difficult to achieve have been achieved more readily, more successfully and more quickly because they have literally gone through the process of saying, “Are our GPs supportive as commissioners? Are our local authorities supportive on the public’s behalf? Are our patients supportive, even if reluctantly, but recognising that it delivers them the choices they are looking for? Is it clinically safe? Do we have a clinical evidence base for what we are setting out to do?” Meeting those four tests pretty much gets you to a very good place in terms of delivering service redesign.

Sir David Nicholson: Service change is very difficult but it happens all the time. Virtually every month an overview and scrutiny committee somewhere in this country is agreeing to a set of service redesign and changes going on in the system. There is quite a lot that goes off on a day-to-day basis which never makes the national newspapers or whatever. Nevertheless, particularly for a manager, service change can be very difficult because it is often you who has to stand up in the village hall or the town hall and explain something to a whole set of people. No matter how many clinicians you have with you, it still is a very difficult thing to do. What managers want to know is if, in those circumstances, you are prepared to take that forward will you get the political backing to make it happen? That is the question they often ask. I have to say that this does, in my experience, depend on where you are in the electoral cycle as well. This is a general point I am making, by the way, not a specific point. That does matter in all of this. That is the position managers find themselves in.

We have been through the QIPP programme and certainly there are things Andrew and I have been saying over the last six or seven months or so in particular—we have been encouraging and supporting people in service change—because we want to improve the quality of service for patients. That has been well received by people. The fundamental issue is that you have to get your local politicians on side because, in a sense, if you do, it never gets to the national position. Getting that local agreement is going to be very important, and I think that is a really big challenge for local government as we go forward in all of this. Not only is the NHS transferring substantial portions of resource over to the local government at the moment, but we are also trying to develop Health and Wellbeing Boards and a much better way of working with local government. In that sense, the challenge for local government and politicians in local government is to stand up to that and to say, “Okay, how can we best organise services locally?” That is a big challenge. There is evidence around the country that that is happening.

Q168 Rosie Cooper: But it is not managers who are going to make those decisions; it is doctors. That is what this is all about. Doctors are going to design the system. Doctors are going to be the people who cause that—

Sir David Nicholson: You are absolutely right. I was asked a question about managers.

Rosie Cooper: But it is not managers who are going to make those decisions; it is doctors. That is what this is all about. Doctors are going to design the system. Doctors are going to be the people who cause that—

Chair: Let me bring a doctor in.

Q170 Dr Poulter: We can park that point for a second and talk about the local authorities’ issue,
which is key in this. Putting acute service reorganisation to one side for a minute, people obviously absorb a lot of healthcare in the last years of their lives. The challenge of our ageing population is the essential and crucial issue we have to tackle, the tie-in between adult social services and the NHS and how, at the moment, there are very arbitrary lines between what is social services and what is NHS care. Actually, we are dealing with a person or a patient. What, at the moment, is really incentivising local authorities to spend their social services budget, which is a different budget to the NHS budget, in any way that will make savings for the NHS?

Mr Lansley: Let us start with what we know—and I will ask Una perhaps to add a little on this—about the way in which local authorities are responding on their social care budgets. We know they are under pressure. We recognise that, which is why, from the NHS point of view, we are working together with local authorities with the transfer of resources that David was talking about. In this financial year it represents not only £150 million for reablement but £648 million for support for health and social care. That is money available through the Formula Grant Distribution from the Department for Communities and Local Government as well. We know, against that background, you have some evidence from your survey, and the ADASS report gives us survey evidence and so on, that local authorities, relative to the rest of their budgets, where there is, overall, an average of 4.4% reduction in spending power this year, are reducing their social care budgets less. I think on average it is a 1.1% reduction. They are making decisions which are clearly prioritising, relatively speaking, social care, but that does not mean it is anything other than very challenging in terms of the efficiency gains they are having to make.

Q171 Dr Poulter: It is a very good thing that local authorities are doing that, but, nevertheless, what we all want is integrated services, particularly around those elderly care issues. What I am driving at is how we are going to get that if we have separate budgets. There is nothing to incentivise, at the moment, local authorities to spend money on preventative measures, preventing elderly people getting into hospital when they do not need to, people with dementia, mental health problems and those sorts of things. There is nothing that incentivises local authorities to spend money on those things in an effective way. There is no mechanism to join up that care because of the separate budgets. What I am trying to drive at is: how are we going to make this work?

Mr Lansley: Let me trespass a moment on Una’s answer. There is an incentive. The NHS financial support to local authorities is a direct incentive to do that. It is focused on trying to deliver that kind of joint preventative approach. We make it very clear and the legislation—in fact, the Bill—makes it clear that we are not only sustaining the legal mechanisms by which local authorities with social care responsibilities and clinical commissioning groups with NHS responsibilities can go down the route of pooled budgets or joint commissioning. We are creating in the legislation a statutory duty to promote integrated care between health and social care which was not previously there. We are creating a statutory incentive and we have a financial incentive. To be fair to local authorities, many have shown themselves willing to take a preventative approach, and they do so because they can internalise the financial benefits. In the past it has often been the case either of the NHS doing prevention and having to measure the benefits themselves without reference to social care, or social care doing so and not being able to internalise the benefits from the NHS. I do hope we will be able to bring these things together. A great example would be the whole system’s demonstrator pilots for telehealth where we are able to see how joint investment into telehealth systems will be able to reduce local authorities’ subsequent social care costs and NHS subsequent medical costs.

Q172 Dr Poulter: What you are saying is that, as things stand, there are one or two very good examples round the country, and I think Sarah may mention those later on, but I did not get a feeling that there are any real mechanisms to force this to happen. There is quite a lot of silo working that goes on but what we are saying is that down the line, Health and Wellbeing Boards will enhance co-operation.

Mr Lansley: They should, yes.

Q173 Dr Poulter: If you feel the way forward is probably towards pooling budgets and pooling resources, and because that is much more patient focused—

Mr Lansley: There is quite a chance of that. I should not leave out of account, because I made it clear, our intention, alongside the extension of access to personal budgets in social care by 2015—it is a slightly longer timescale, and I think it runs through to 2014—for patients who receive NHS continuing care to have the offer of personal health budgets as well. We are all in a situation where we have perhaps met people who are able, through a social care budget, to determine the shape of the care provided to them and who it is provided by, and then the NHS continuing care steps in and that degree of empowerment and control simply disappears. We do not want that to happen. So there is a range of mechanisms. Do I think that they are uniform across the country? No, they are not uniform and will not be uniform across the country. Are they able to be? Yes, we can get joint commissioning and pooled budgets, but we are not in a position where we can ignore the simple fact that they are separately funded. One is local authority funded, subject to a means test, and the other is NHS funded, not subject to any means test and free. The management of bringing those things together is inevitably going to be a co-ordination mechanism rather than a simple integration.

Q174 Chair: We have half an hour left. If Grahame will forgive me, we need to move on to social care. I know he wanted to raise a question. Hopefully there will be time at the end to come back to tariff, but Una O’Brien was going to come in on this pooled budget.
Una O’Brien: Not so much that necessarily, but to add to what the Secretary of State has said about this question of; is the incentive there sufficient for local authority social services departments and the local health service to come together? What has been significant about the arrangement made in the spending review is the decision to route some money for social care through the NHS. We have supplemented the support grant and the money has gone into that big pool for local government. In addition to that, we have made these two additional strands of money available, this year £800 million, through the NHS to social care. The conversations happen at a local level around local needs. Obviously there is the £150 million for reability which is spent by the NHS. Then there is the second portion, which this year is £648 million, for a transfer from local PCTs to local authorities around an agreed programme of spending on social care support that will help people and, in the doing of that, help them to stay out of hospital.

Q175 David Tredinnick: It is very helpful to hear that and I am sure we welcome the £648 million that is coming across to social care. The Secretary of State touched on the importance of getting local politicians on board. As we look at the social care and efficiency savings, I would like to draw your attention to the fact that the Local Government Group has told this Committee that the social care system is close to collapse simply because it is not able to properly respond to the demands on it and that it is “reacting as a crisis service in many respects.” How do you react to that statement?

Mr Lansley: The first thing I would say is that one of the reasons why we recognised the pressures on local authorities was one of the reasons why, in the spending review, we made the two additional supports to social care that I mentioned previously. The evidence that has come forward, as a result, is that local authorities have, in the great majority of cases, not had to reduce their eligibility. Some may have but, generally speaking, they have not had to reduce their eligibility. There was a process previously, and we know that there has been a movement away from access to social care for those with moderate care needs towards substantial care needs. The truth of the matter is that we always knew, and we made clear in response to the Dilnot report through the spending review, that what we were setting out to do was to give local authorities, effectively, a bridge to a long-term structure of social care—one that is not only about funding but also about quality, the workforce, the structural regulation and so on and so forth. It is necessarily something which we are looking at through the social care engagement this autumn with a view to all of those aspects, including bringing together their response to the Dilnot Commission for the longer term.

Q176 David Tredinnick: Thank you for that. In your memorandum to the Committee, and certainly in the written submission, you told us that “budgets for social care across England overall are only £200 million lower this year than they were in 2010–11, a reduction of around 1.5%. The Local Government Group and the Association of Directors of Social Services argue that, on top of that reduction in funding, increased demand and other cost pressures mean that local authorities are having to find a further £791 million in efficiencies, almost £1 billion in total.” Notwithstanding that amount, which Una O’Brien spoke about, the £648 million transfer, do you agree with that assessment? Do you think that is a fair assessment?

Mr Lansley: I said earlier that, so far as we can see, the estimates from surveys which have come back suggested that the local authorities’ social care budgets on average are reducing by 1.1% for 2011–12 compared to 2010–11. That is, of course, against a background of rising demand. Indeed, what is interesting is that, under those circumstances, there are some pretty challenging gains in terms of efficiency that are required. We know, because we have been working through the Department with ADASS, local authorities and the Treasury on supporting that kind of efficiency gain—I think we saw last year efficiency gains in the order of 3.5% to 4%—that many in local authorities, responding to your own survey, are suggesting they are looking for greater efficiency gains than that in the year ahead. That is pretty challenging, and I make no bones about that.

Q177 David Tredinnick: I accept that it is challenging. I think we all do. The Department has argued—developing this—that there is enough funding available to protect people’s access to care without tightening eligibility. On the other hand, the Association of Directors of Social Services—ADASS—has told us that 13% of councils raised their eligibility thresholds this year and that 82% of councils now only provide services where the level of need is significant or higher. Are you disappointed by this?
Mr Lansley: If I may, I will ask Una to add a word about changes in the eligibility because my recollection was not that figure.

Q178 David Tredinnick: We have been told that 13% of councils raised their eligibility thresholds this year and that 82% of councils now only provide services where the level of need is significant or higher. These are very large figures.

Una O’Brien: Clearly, we are disappointed where local authorities have made those decisions. It is also the case that a lot of local authorities have not made those decisions, so the decisions about how to distribute resources across a local authority are obviously something that is handled within those individual organisations.

If I may go back for a moment on the overall point you have made about the scale of the efficiency assumption, the ADASS construction is based around an assumption on pay and prices and on demographic pressure. Our understanding—our judgment—is that it is not as large as that. We would not agree with the scale of what they set out because that is their interpretation of the demand pressure with pay and prices. Our view of pay and prices is more conservative than the one they have taken, so we would not share the scale of the efficiency challenge that they have set out. Notwithstanding that, it still is challenging. Those decisions, then, are for local authorities in the distribution of their resources to come to a view about how they are going to manage it.

The point you are making about the eligibility criteria does go to this much broader and more challenging problem that we have as a country, which is to work out a new and different funding system for social care.

What we have done is put an arrangement in place in this spending review, as best can be done, to hold the position steady. The starting position is one that is already challenged, and finding that new arrangement between the individual and the state around how we should fund social care going forward is very, very important. I would not want to take away from the significance of the work that is being done around establishing a new way forward because that is really the answer to addressing the question about eligibility, in addition to which, of course, we have had the Law Commission’s report on that.

Q179 David Tredinnick: I am sure my colleagues want to come in on this, so I will ask you only one more question on eligibility. How would you expect local authorities to cope with reduced funding and increased demand without tightening eligibility? Is it not trying to square a circle? Is it possible to do that? How can local authorities cope with this reduced funding and increased demand without tightening eligibility? Surely that is the valve, is it not? The safety valve is eligibility. How can you do it any other way?

Una O’Brien: I hope the Committee has seen the Demos report which was done with Scope, the organisation for people with disabilities, which is already demonstrating that, certainly for services for people with disabilities, there is not a direct correlation between pressure on resources and the type of service that is made available to people. Their report bears scrutiny and is very compelling in some of the stories that it tells about personal budgets and direct payments, where they exist. Of course, they do not cover the totality of social care by any means. Nevertheless, they can have a very significant impact on the way in which services are delivered. Only the other day I was talking to, for example, a different local authority in Westminster. The way they are approaching this is a fundamental redesign of how they deliver their services where they are absolutely focused around maintaining quality but doing it in a different way. The model that they have had, the conventional model, is being challenged and they are having to rethink that. It is not a case of everything stays steady and then the changes are simply made to money. Rather, as David was saying earlier on with the model around the acute hospital services, these financial challenges pose a fundamental redesign question around the way in which services are delivered.

Q180 Chair: Do they not, in particular, pose a requirement to redesign services across the health/social care divide, and is that not where more effective joint commissioning processes provide the opportunity for better use of resources in both social care and in the healthcare system?

Una O’Brien: I think that is right. Mr Lansley: That is true. In her earlier answer Una made clear that that relationship between the NHS and local authorities is giving rise precisely to that kind of joint planning in order to do joint work.

Q181 Chair: Is there evidence that it is happening quickly enough to relieve the demands that are being placed upon the system?

Mr Lansley: Yes, in part, in response to what David was asking in terms of “Is eligibility the only route through which you then respond to these financial pressures?” It is interesting, looking at the data we have about the structure of the transfer from the NHS to support social care of £642 million in this financial year, for which the data has been returned, it is about how this money is to be used, that nearly £116 million is for maintaining eligibility criteria, so there is an issue in terms of that. When you begin to look at all the other things that are being done, it is about community equipment and adaptation, £32 million, £28 million plus for telecare—I was mentioning those opportunities—integrated crisis and rapid response services are £50 million, and both in South Birmingham and Kirklees, where I have been, that makes an enormous difference. It is free for those who are getting access to that service but it is doing an enormous amount to establish people in a preventative way rather than simply letting them fall into care need and then providing them with an expensive package over a long period of time. There is £117 million for reablement services, £50 million plus for early supported hospital discharge schemes, and bed-based intermediate care services at £61 million. There is a range of different responses which are meshing the
NHS and social care together. That is why we are doing this and it is demonstrating that kind of joint working in a way that was not present before. There were good examples in the past, especially where there were care trusts bringing people together, but they were far too few. This is in 151 primary care trusts—all over the country.

David Tredinnick: I am not saying it is all bad, but I attended the Hinckley and Bosworth Health and Wellbeing Partnership briefing meetings, and I am going back. There is no doubt there is a lot of work going on between our local doctors, the council and other organisations to make things happen. I merely wanted to alert you to what I see as pressure points and points that the Committee are concerned about.

Q182 Chair: Can I be clear about the facts and what these numbers mean to us. When it is said that the expected budgets of social care authorities are down by 1.5%, is that after taking account or before taking account of the NHS transfer money?

Una O’Brien: I do not think it does take account.

Richard Douglas: It does take it into account.

Una O’Brien: I beg your pardon. It does take it into account.

Q183 Chair: The total spend, including NHS money on social care, is still down by 1.5%.

Richard Douglas: It is down by just over 1%. Yes.

Q184 Rosie Cooper: I was going to say those figures, Secretary of State, represent a drop in the ocean. What are you doing to measure, to evaluate and to quantify that huge amount of unmet need that is out there that will be a major part of the Treasury’s requirement for Dilnot? What work are you doing?

Mr Lansley: Local authorities and ADASS themselves are very clear. We have done work collectively, over the spending review period, on what our anticipated demographic pressures lead to in terms of rising demand, and that is of the order of 1.5% additional demand from demographic changes alone. My personal view is that that is an underestimate and I think most social services authorities would tell you it is an underestimate. The reason why is because of the relative morbidity of people, in addition to demographic pressures, when they are older. The extent of co-morbidities and the degree of vulnerability is tending to add to those pressures, but we can offset that. If we offset it through more preventative work, then we may be able to manage those pressures more effectively. Our general calculation—our estimate overall—is that we are looking at least at a 3.5% efficiency gain each year in order to respond to the levels of demand and cost in the service. That is what we are aiming, at least, to achieve.

Q185 Rosie Cooper: So 82% of councils only provide service now to those people who are desperately in need of it. You are only putting in 3% or 3.5%, whatever the figure is. We all know there is a huge unmet need out there. Dilnot requires the Treasury to have a grasp of that before you can take off and deal with the problems that are coming in social care and I would have thought you would be wanting to try and really—and I understand how difficult it is—get a grip on much of that unmet need. Una said before, in a response, and I understand that the question was phrased like that, that she was disappointed if local authorities were changing their criteria basis, but if you are one of those people out there desperately in need of those services, or you have family who are not quite desperately in need but absolutely need help, you would be devastated, never mind disappointed, that you are not getting it.

Chair: Can I stop you there and have an answer to that? Andrew needs to leave and wants to come in but can we have an answer to that question?

Mr Lansley: From my point of view, and I will not repeat all that I said before, it is because we know that there are those pressures—and I make no bones about it—going back to previous spending reviews, and support for social care was very often a residual sum. In the spending review that took place last year social care was at the forefront of the coalition Government’s considerations of where resources should be provided and £2 billion a year additional resources were provided both through the NHS and the Formula Grant Settlement. We know that is a bridge for the future. We know that it does not escape from the fact there are considerable pressures. We know that the social services authorities have delivered something over a 3% or 3.5% efficiency gain last year but will need to do so in further years in order for the loss of eligibility to social care not to continue. In fact, the loss of eligibility for social care this year compared to last year is limited. The extent to which we are investing in prevention and other routes not only to respond to need but to try and offset rising need is considerable. This is not, in the way that the NHS is, a service which is provided with a comprehensive service in all parts of the country, that is free. It is a local authority-delivered service and it is a local authority-led service. There will be differences in different places about the decisions that are made, the nature of the services provided, how they are provided and indeed the extent to which they are provided. But we do keep track, as we have said, of the way in which they are provided. Our objective is to work with the local authorities and ADASS, understanding the nature of the service they are providing and making sure that the support we give, as central Government, through the Formula Grant and the NHS, enables them to respond more effectively in the future.

Chair: I am sorry I did not get Grahame in. Andrew has a quick question.

Q186 Andrew George: On the big question which you were alluding to earlier, Secretary of State, Sir David said in previous evidence to us that health reform, reorganisation and the efficiency gain were not merely parallel but mutually reinforcing. While we are impressed by the elegance of the language, the question is: how? A lot of people are very sceptical that they are going to be mutually reinforcing, and in fact they may be quite the opposite. The costs of
change, commissioning, achieving integration, which you mentioned earlier, the costs of recreating supra-local and sub-national strategic tiers, and so on, are going to be big challenges.

I will add the second question now rather than come in later. Secretary of State, you earlier talked—and I think with the agreement of everyone, I am sure—about the desirability of the integration, for example, of urgent care between out-of-hours GPs, telephone triage and the ambulance service. How is this going to be achieved in such a circumstance? One can see the budgetary efficiencies that are achieved by doing so, but how is that going to be achieved under the reorganisation?

Mr Lansley: On the latter point, it is perfectly clear that we are going to be looking to clinical commissioning groups themselves to provide leadership in this area, but that does not mean that clinical commissioning groups are in any sense bound to their own geography. In any case, they will be working together on a range of commissioning tasks. One of those commissioning tasks will be in relation to emergency and urgent care, and very often they would look beyond their own boundaries to make that happen. When you look at urgent care, the sensible thing to do, as in many of these areas, is for them to work together through the Health and Wellbeing Boards. For example, in Cornwall that would be the Cornwall County Council, a Health and Wellbeing Board, clinical commissioning groups—I forget how many there are in Cornwall, but there will be a number.

Andrew George: They should work together to see that. They may have local solutions, because the geography of Cornwall is quite challenging in terms of provision of urgent care, but they might well co-operate together in saying, “We want to work with the local authority and the ambulance service and others and the hospitals trust” because, to that extent, they have a combined single hospitals trust, to all intents and purposes. They might work together in order to try and devise what an urgent care structure looks like.

Can I talk about the mutually reinforcing? We published a revised impact assessment when the Health and Social Care Bill entered the Lords. The costs of the transition are estimated at between £1.2 billion and £1.3 billion. The long-term annual savings will be £1.5 billion in due course. The savings per annum over this Parliament rise from £643 million this year to £1.5 billion by 2014–15, so they are mutually reinforcing in the sense that the development of clinical commissioning groups and the abolition in due course of primary care trusts and strategic health authorities assist us in the process of delivering these administrative savings. That is the lesser part of this. The greater part is the fostering of clinical leadership and when we are talking, for example, about delivering operational efficiencies and about delivering clinical redesign of services, it is the bringing forward in the modernisation process of clinical leadership across the service, not least in the clinical commissioning groups, clinical networks and the like, that is most likely to enable us to achieve these secular changes in the structure of services.

Q187 Andrew George: Why are those who gave evidence last time—we referred to them earlier—so sceptical and what have you failed to do to persuade them?

Mr Lansley: In my experience, most people are sceptical, especially where change is concerned. That does not mean that all change is wrong—let us be clear—if the principles are right. From my point of view, it is my job to be clear about the strategy. We have been very flexible about the implementation, listened hard and changed quite a number of things. As the Future Forum and the listening exercise made clear, people support the strategy. They want to see a patient focus. They want to see clinical leadership and devolved responsibility close to patients in the hands of clinicians and they want to see a focus on outcomes. As it happens, they also, I think, want to support the fostering of a stronger public health structure with local government leadership for health improvement. They want all those things so let us keep our eyes firmly fixed on that strategy. In this context, where QIPP is concerned, the strategy helps us to deliver that. If we did not have that strategy, we would still be sitting here discussing exactly the same financial challenge. We would still be living with exactly the same kind of challenge and you would be asking us a lot of questions about why we are not engaging clinicians more in the process of redesigning services in order to benefit patients. The fact is we are doing that.

Chair: We have been at it now two and a half hours. It is two hours. Although it may seem like two and a half, it is two hours. Unless any of my colleagues have any—

Q188 Dr Wollaston: I want to follow up very briefly on a couple of points. You twice referred to accident and emergency and emergency quality indicators, which I agree are very important, and also outcomes. Could you clarify for us what proportion of A&E attendances are currently related to alcohol, particularly on Friday and Saturday evenings, what proportion of ambulance call-outs—I know I am rather tedious on this issue—how much this costs accident and emergency departments; the impact it has on the patient experience and whether you would commit to introducing a requirement for staff in A&E to record how many there are in Cornwall, but there will be a number.

Andrew George: Three.

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Mr Lansley: I am pretty sure we have. I do not have it immediately in front of me. Strictly speaking, the answer to your first question, “How many A&E attendances are associated with alcohol on a Friday and Saturday evening?” is “A lot.” “Does it cost a great deal?” I think it does. Across the NHS as a whole, we are certainly looking at in excess of £2 billion, from memory, as directly associated costs of alcohol-related admissions. Across the NHS as a whole, alcohol-related admissions and treatments have seen very large increases. That is a combination. The
The interesting thing is that that has continued to be true, and that increase has continued, regardless of the fact that the overall consumption of alcohol in this country rose but then plateaued and has slightly fallen in recent years. It is because the character of alcohol abuse is still a major problem for us. We have a minority of younger people who engage in binge drinking and a minority of older adults who engage in chronic alcohol abuse, but those are giving rise to immense pressures on medical and other services. A lot of public services are suffering from that. It is why, from our point of view, as part of our broader cross-Government approach to public health issues, following up *Healthy lives, healthy people* last November, we undertook to publish an alcohol strategy and will do so soon.

**Q189 Rosie Cooper:** Could I ask the Secretary of State a very short question? Will providers be squeezed to give clinical commissioning groups a healthier start than they might have?

**Mr Lansley:** I do not understand the question. How do you mean?

**Q190 Rosie Cooper:** We heard from Cumbria, for example, that they were given a huge wad of cash to enable them to redesign services. We are asking clinical commissioning groups to implement this brand new vision, and some of them will have cash problems. Will there be any injections of cash in there? Where will you get the cash, or are you going to put any extra money in there?

**Mr Lansley:** What you have to understand is that from 1 April 2013, subject, of course, to them having been authorised, the clinical commissioning groups will get all the money for the NHS in their area. That is how the money will be distributed, so the idea that they will somehow have an extra bit of money, the money will be allocated to the CCGs—

**Q191 Rosie Cooper:** What will happen to the deficits they now have?

**Mr Lansley:** We have said— I have told the Committee previously—and have made clear to the clinical commissioning groups and primary care trusts that, if they do not incur deficits this financial year and next financial year, we will make sure, on 1 April 2013, they do not start with deficits that were incurred prior to 1 April 2011.

**Q192 Rosie Cooper:** Where will the Department—you—get the money for that bit? Is that where you are going to squeeze it out of acute hospitals?

**Mr Lansley:** No.

**Q193 Rosie Cooper:** No?

**Mr Lansley:** No.

**Rosie Cooper:** Fine, thank you.

**Chair:** That was three minutes of extra time. Thank you very much indeed.
Written evidence

Written evidence from the Department of Health (PE 01)

1. NHS Efficiency Challenge

1.1.1 The plans being made by NHS bodies to enable them to meet the Nicholson Challenge

1. The NHS will receive cash funding growth of £12.5 billion by 2014–15 compared with 2010–11. However, over the same period the NHS will also experience additional demand for services arising from demographic change, medical advances, increased public expectations and lifestyle of the population.

2. The Department estimates this increase in cost, demand and relative cost of treatments as adding up to £30 billion to total NHS spending over this four-year period if no action were taken to mitigate these increases. To meet this additional demand, as well as the cash funding, the NHS has been asked to make up to £20 billion of efficiency savings by 2014–15 to reinvest in services, simultaneously making services more productive, driving up the quality of services it provides and the outcomes it achieves. These savings will be delivered through the Quality, Innovation, Productivity and Prevention (QIPP) programme.

Local and Regional Plans

3. The local NHS is best placed to develop plans for meeting this challenge in line with local needs and circumstances. This has included identifying areas which require early action to support the longer-term transformational change necessary to deliver efficiency savings in future years. In areas where the NHS has requested support, or where national action is required, the Department of Health has developed national work streams to aid the service to meet this challenge.

4. These local and regional proposals are part of the integrated plans submitted to the Department of Health in March 2011, as required by The Operating Framework for the NHS in England 2011–12. The integrated planning process brings together the key activities to meet the QIPP challenge the NHS faces, the transition to new structures under current reforms and operational delivery. All strategic health authority (SHA) integrated plans are subject to an assurance process to ensure they take suitable account of maintaining or improving quality and resources. Following this process the plans were signed off at the end of July 2011.

5. All the proposed local and regional responses to the efficiency challenge are based on four year plans held by individual organisations outlining their strategy over that period and demonstrating how quality will be improved whilst efficiency savings are released. These plans are not static but will continue to develop over time, as more evidence of good practice on QIPP becomes available and the NHS responds to national requirements set, for instance, through the Operating Framework or Outcomes Framework, as well as in response to local requirements and operational pressures in year.

6. National analysis of the potential opportunity within the NHS suggests that three broad areas of action will deliver the overall efficiency challenge. Early action through national levers has the potential to contribute around 40% of the overall challenge through reducing administrative spend in PCTs, SHAs, arm’s length bodies and the Department, reducing central programme spend and national pay restraint.

7. The remaining savings are likely to be achieved through productivity gains and service change. Provider productivity gains and reductions in input costs—through improving in areas such as staff productivity, drugs management and use, and procurement—have the potential to deliver 40% of the overall challenge. The strategy over the four years has an early emphasis on achieving productivity improvements, supported by action on pay, to deliver the majority of the efficiency savings. Later years will increasingly focus on the service redesign and change, which is expected to deliver around 20% of the overall challenge through changing how and where services are delivered, for example through transforming care for long-term conditions and increasingly providing services away from acute settings and in the community or primary care.

8. Successful delivery of plans for 2011–12 will ensure that financial balance is achieved across the NHS with quality of care being maintained or improved. The headline measures on quality, resources and reform set out in the NHS Operating Framework for 2011–12 cover key quality measures for issues such as waiting times, healthcare-associated infections, mixed-sex accommodation and patient experience. The measures also include key areas of reform, such as progress on the foundation trust pipeline and the development of clinical commissioning groups, as well as resource indicators such as activity levels, which help create an understanding of how the NHS is building a sustainable service.

9. This comprehensive set of indicators will be regularly published in The Quarter, ensuring a clear and transparent account of progress is publicly available. The Department will hold the NHS to account across this range of indicators, not focusing on one area at the expense of any other. The first edition of The Quarter covering the headline measures will be published in September 2011.

National Assurance

10. As part of the spending review process the Department estimated around £30 billion of forecast pressures over the period to 2014–15; pressures include pay, prices, drugs, costs of additional policy objectives and
growth in underlying demand. The combination of £12.5 billion of additional funding available plus £18.5 billion in efficiencies met these funding pressures without any dilution of quality and/or reduction in access. The delivery of “up to £20 billion” of efficiency savings by 2014–15 therefore formed a key component of this analysis.

11. The Department has developed a monthly reporting system designed to give early warning of whether the NHS and Department remain on target against this plan. The reporting system has been in place since April 2011 and shows that performance is on track. This system is largely based on a subset of the headline and supporting measures set out in the Operating Framework for 2011–12. Regular reports on NHS progress against the Operating Framework measures are published in The Quarter.

1.1.2 Where changes are being proposed, and whether the NHS is succeeding in making efficiency gains rather than cuts

12. The NHS has been developing plans in response to local needs and circumstances to meet the efficiency challenge since May 2009. As set out at the beginning of the process, there is strong evidence and experience that a sustained focus on quality can deliver more productive and efficient services. This is clearly better for patients and for the service. The planning process has built on the development of the Next Stage Review, building on the quality improvement ambitions set out through that process. The role of quality as the organising principle of the development of QIPP proposals is maintained and continued through the quality improvement requirements in the Health and Social Care Bill. The ability to deliver on quality and productivity has been a central message in the support provided to the NHS, and is something which runs strongly through the local proposals.

13. The ambition in responding to the efficiency challenge is to significantly slow the rate of activity growth, or even reduce activity in some areas, where this is consistent with improving quality of care and in driving improved outcomes. Changing demographics, such as an ageing and growing population, mean that the overall volume of activity across the NHS is likely to continue to rise. In future, success will not necessarily be measured by what activity levels are, but whether activity is focused on delivering real improvements and benefits to patients in cost-effective and sustainable ways.

14. There are a number of areas where certain high or rapidly increasing levels of activity are directly linked to high expenditure, worse healthcare outcomes or poor patient experience, for example emergency admissions connected to long-term conditions. Better management of individual care can reduce the overall cost of the system by preventing unnecessary admissions whilst improving patient experience. There are further allocative efficiency gains to be achieved through exploring what interventions or procedures offer lower clinical value compared to alternatives to support a refocusing of activity away from lower value procedures and towards those areas which provide better outcomes.

15. The Department has been clear that delivering service change is not an excuse for performance dip. NHS organisations are expected to at least maintain or improve quality in a number of areas, such as waiting times or reducing infections. Progress against these areas will be reported through The Quarter to provide assurance that the quality of care is not being compromised. A critical aspect of quality is patient safety, where services are changing or measures to improve productivity are introduced these will need to happen in a safe way and maintain the right levels of appropriately skilled staff. The Department is working with SHAs to develop a quality assurance framework for workforce to ensure quality and safety are not compromised. To support understanding of responsibilities in the future structure the intention is that the framework will be available in time to support the development of operational plans for 2012–13.

16. Each local plan identifies a unique set of actions in response to their situation. The Department has been working closely with the NHS on the development of these plans and has gone through an assurance process with each SHA. The Department is confident that the plans provide a credible basis for the NHS to deliver maintained or improved quality whilst improving productivity.

17. The period prior to 2011–12 focused on the development of robust plans, with 2011–12 being the first year in which the efficiency gains from QIPP are due to start developing. In many areas this first year is also being used to undertake the transformational change that will be necessary to ensure services are correctly organised to deliver long-term sustainability. Measurement of progress against the delivery of QIPP will take place throughout the QIPP period providing assurance that process is driving transformational change to deliver more efficient quality care and not cuts. Progress will be regularly published through The Quarter, alongside the headline measures on quality, resources and reform set out in the NHS Operating Framework, providing a transparent view of how the NHS is performing on quality and efficiency.

18. There are a number of areas where innovative action has already been shown to deliver improvements in quality and productivity, and which are now being taken up more widely in the NHS, for example:

— The End of Life Care Family Liaison service in Birmingham East and North PCT.
— The Antibiotic Stewardship programme at Southampton University Hospitals NHS Trust.
— The reengineering of blood transfusion services at Oxford Radcliffe Hospitals.
— The fractured neck of femur rapid improvement programme at South Tees Hospital NHS Foundation Trust.
— The enhanced recovery programme at Yeovil District Hospital NHS Foundation Trust.

— Improving the community assessment and management of dysphagia in end-of-life care at Sandwell Community Healthcare Services.

19. The NHS Evidence website (http://www2.evidence.nhs.uk/qipp) also provides a range of other evidence-based and peer-reviewed examples of approaches and service changes which could significantly improve the quality and productivity of a range of NHS services. NHS and social care staff can submit examples of best practice which are subject to an external assurance process, providing an independently reviewed and assessed library of case studies and real practice examples of how services and individuals can support the QIPP challenge.

20. Where the NHS has requested additional support the Department of Health has put in place national work streams. The national work streams cover a range of areas across commissioning and pathways, provider efficiency and system enablers, and are:

— Safe Care: supporting the NHS to deliver safer care in hospitals and community settings by reducing hospital and community acquired pressure ulcers, blood clots (deep vein thrombosis (DVT) and pulmonary embolism), urinary tract infections in patients with catheters, and falls in care settings.

— Right Care: providing a range of data and training to help commissioners to aid them in understanding their spending patterns and thresholds and to benchmark themselves against others. The work stream published the NHS Atlas of Variation in November 2010 to support commissioners in identifying unwarranted local variation, and is continuing to work with the clinical community to identify clinical areas where spending variations can be reduced and consider how to use the national standard contract to effect change. It will also roll out patient decision support tools nationally in areas where there is strong evidence that they can improve quality and reduce costs.

— Long-term Conditions: supporting and accelerating the national identification of new models of care for long-term conditions which represent the best evidence and experience from across the NHS, and support a range of exemplars across the country. This work will transform care, for example, for patients with diabetes and chronic obstructive pulmonary disease (COPD) as well as frail, elderly patients and those with multiple conditions.

— Urgent Care: supporting and accelerating the national roll-out of the NHS 111 telephone service. In addition, the work stream will provide support and best practice information to support the commissioning of high quality and productive urgent care services.

— End of Life Care: accelerating implementation of the existing national strategy to increase patient choice and reduce unplanned admissions.

— Back-office efficiency and optimal management: has successfully delivered its products to help enable trusts to make changes to their back-office functions which will enable improved quality and drive out efficiencies, releasing money which can be reinvested in patient care. The work stream published its national report on Back Office Efficiency and Management Optimisation jointly commissioned by the Foundation Trust Network (FTN) and the Department of Health in November 2010. It outlines ways to simplify core functions, drive out unnecessary work and activities; standardise process and maximise opportunities for sharing services and cost bases. The report can be found at: http://www.nhsconfed.org/Networks/FoundationTrust/Workstreams/QIPPBackoffice/Pages/QIPPBackoffice.aspx#compendium

— Procurement: reviewing the current architecture and incentives to identify and address the barriers to more collaborative procurement of non-clinical products.

— Supporting staff productivity: rolling out the “Productive” series across the NHS to give staff more time for front-line patient care and to maximise efficiency. In addition, the work stream is providing support to organisations to reduce temporary staffing costs, and to improve staff health and well-being in order to reduce sickness absence rates.

— Medicines use and procurement: offers a range of advice and support to reduce variation and waste in prescribing, including ways in which the NHS can make better use of low-cost generic medicines. In addition, the work stream is looking at ways of supporting patients to make best use of the medicines they are prescribed, and at the case for encouraging increased use of over the counter medicines where these offer greater patient convenience.

— Primary Care Contracting and Commissioning: supporting primary care trusts (PCTs) to commission higher quality and more efficient primary care services.

— Workforce: working with NHS to improve the health and well-being of the workforce whilst increasing productivity.

1.1.3 The impact on NHS plans of decisions currently being made by local authorities

21. Throughout the planning process the importance of effective engagement with the whole local health and care community including local authorities, has been emphasised. Effective partnership working and
integration are key enablers in delivering against the QIPP challenge within the NHS, and supporting improved
efficiency within social care.

22. The Department has put in place practical measures to support social care services, in the context of a
challenging local government settlement, and to encourage improved joint working between PCTs and local
authorities. In 2011–12, £648 million has been allocated to PCTs to transfer to councils for spending on social
care services that also benefit health. The Department has been clear that PCTs and local authorities will need
to work together closely in order to agree appropriate areas of social care investment, taking account of joint
priorities identified by the Joint Strategic Needs Assessment for their local populations.

23. A further £150 million (rising to £300 million in 2012–13) has been allocated to PCTs for the
development of post-discharge support and reabilitation services. There is local discretion over how this money
is to be spent, but in a letter to the service the Department has been clear that: “This funding is intended
specifically to develop current reablement capacity in councils, community health services, the independent
and voluntary sectors, with the objective of ensuring rapid recovery from an acute episode and reducing
people’s dependency on social care services following discharge”.

24. Where appropriate QIPP national workstreams are supporting the NHS, in partnership with social care,
to improve services to support individuals in the community. For example, the Long-term Conditions QIPP
national work stream is focusing on improving the quality and productivity of services to enable patients and
their carers to access higher quality, local and comprehensive community and primary care. The national
support and improvement programme is designed to facilitate and enable local health economies to deliver the
necessary change at pace. A key aspect of this work is the creation of integrated health and social care teams
to provide joined-up and personalised services. Co-ordinated and integrated teams, with individual care led by
a key worker, ensure that appropriate specialised care is available when needed, and services are effectively
co-ordinated to improve outcomes and reduce duplication and costs in the system.

25. The Department has also been very clear that the NHS should seek to maintain and improve current
arrangements for joint working in the reformed system.

26. Where people need to be in hospital, commissioners and providers should work together to ensure that
no one is made to stay there longer than is necessary. The NHS and social care must work together to ensure
people have the support they need on leaving hospital.

27. In the future system, effective integration and partnership in provision and commissioning of care will
have a key role in delivering efficiency in the NHS and social care, and improved care outcomes. In future,
health and wellbeing boards are one example of how the modernisation agenda will support integrated processes
in commissioning and, through that, integration of provision. They will encourage close working between
social care, public health and NHS services and aspects of the wider local authority agenda that impact on
health and well-being, such as housing, education and the environment.

Health and wellbeing boards—as a forum for local commissioners across the NHS, public health and social
care, elected representatives and representatives of HealthWatch—will develop an agreed view of the needs
and priorities for their area. Individual commissioning plans will need to have regard for this and the board
will actively promote joint commissioning and integrated provision. Therefore in future any decisions taken by
local authorities that impact on NHS plans will be based on a holistic view of the health and care system
agreed between both partners.

1.1.4 Progress on and implications of changing the tariff structure

28. Over one quarter (around £29 billion in 2010–11) of NHS expenditure is managed through the national
tariff. The tariff operates in a cash-limited system but it is possible to reward providers for quality, not just
activity, while still living within the same envelope.

29. Priorities for the development of the tariff are aligned with the QIPP quality agenda. For example, in
2011–12 the Department has expanded the number of “best practice tariffs”, through which providers are paid
according to the clinical characteristics of excellent care rather than average cost, and commissioners see
improvements in the quality of care that they commission. Best practice tariffs are designed to promote best
practice models of care which are often more efficient, for example incorporating shorter lengths of stay, which
can drive productivity.

30. There is no single measure of quality for best practice tariffs. Instead, there are different models, all
based on widely accepted clinical evidence. Best practice can be lower cost than inefficient practice in many
cases, and can also provide a more sustainable approach to managing some health problems, with lower costs
for commissioners over the longer term. There will be a further expansion in the number of best practice tariffs

31. Furthermore, new approaches for best practice tariffs in 2012–13 will include linking payment to
outcomes for hip and knee replacements—for the first time, Patient Reported Outcomes Measures (PROMs)
scores will be used to determine whether full payment of the tariff for hip and knee replacements should be
made.
32. For some conditions, “pathway” tariffs will be more appropriate and efficient than paying for episodes of care. Importantly, they incentivise a more preventative approach to care with fewer acute episodes. For example, in 2011–12 the Department has introduced a “currency” that the NHS must use when agreeing contracts for cystic fibrosis services which covers a whole year of care, with a view to introducing a national tariff in future years.

33. A national pricing structure can never reflect the reality of the most innovative care occurring locally. Therefore, there needs to be the opportunity for local discretion, so that payment by results (PbR) is not seen as a barrier to providing the best care for patients. For example, innovation payments give the commissioner the flexibility to make an additional payment for the use of new devices, drugs, treatments and technologies. These payments may also have longer-term efficiency benefits, for example by reducing the risk of a procedure having to be repeated.

34. The Department has made changes to the tariff rules this year so that providers are not paid for avoidable readmissions to hospital. This means that providers have a greater incentive to discharge patients at the right time, and with adequate support, with the aim of reducing the numbers of emergency readmissions. These changes are driven by the need to encourage better care planning for patients and drive health and social care integration.

2. Social Care Services

2.1 The impact on the provision of adult social care of the 2010 spending review settlement and the removal of ring-fencing for social care grants

35. In recognition of the pressures on the social care system in a challenging local government settlement, the Spending Review allocated an additional £2 billion per annum by 2014–15 to support the delivery of social care. The Government believes that, if councils push forward with an ambitious programme of efficiency, there is enough funding available to make it possible to protect people’s access to care, without tightening eligibility.

36. This assessment has been corroborated by the King’s Fund. Its publication on social care budgets following the Spending Review showed that the settlement would be sufficient if local authorities made efficiency savings of around 3.5% per annum in adult social care. The Department agrees broadly with this analysis.

37. The Government recognises that the Spending Review set out a challenging settlement for local government. However, the Department has sought to achieve a fair and sustainable outcome by listening to what the local government community has asked for. It has insulated the councils that are most dependent on grant funding by giving more weight to the levels of need within different areas and less weight to per capita distributions. It has also grouped councils into four bands, reflecting their dependence on central Government. More dependent authorities have therefore seen proportionally lower falls than more self-sufficient places.

38. For 2011–12 and 2012–13, no authority will face more than an 8.9% reduction in spending power (including income from council tax and NHS support for social care), with an average reduction in spending power for 2011–12 of 4.4%.

39. The local government settlement includes £530 million of additional grant funding for social care in 2011–12, rising to £930 million in 2012–13. This is on top of previous Department of Health grant funding, which at the time of the Spending Review the Department announced had been maintained and will rise in line with inflation. Previously, grant funding was allocated directly to local authorities by the Department of Health. However, in order to support local flexibility and to reduce administrative burdens, these funding streams now go to authorities through the general local government formula grant. The Government believes this will have a positive impact on front-line services, by removing the lengthy and burdensome central prescription and guidance that is currently tied to funding and giving authorities much greater freedom in how they chose to use their resources to meet local needs and priorities. In its submission to HM Treasury, ahead of the Spending Review, the Local Government Group identified the removal of ring fencing as one of its top five priorities for the local government settlement. The Department agrees that local government should be accountable for the majority of its resources.

40. The Government is also actively supporting better joint working between health and social care and has made available a number of new funding streams to back this up. Some £648 million this year has been allocated to PCTs, to transfer to councils for spending on social care services that also benefit health. A further £150 million has been allocated to PCTs to support reablement.

41. Provisional data on actual adult social care expenditure in 2011–12 will be available in the autumn of 2012. However, in the interim the Department is monitoring budgeted expenditure data. The Department for Communities and Local Government published 2011–12 budgeted expenditure data on 30 June 2011. This showed that budgeted net current expenditure on adult social care was £14,898 million for 2011–12, compared to £14,439 million in 2010–11. These two figures are not directly comparable, as local authorities have taken responsibility for commissioning services for people with learning disability from PCTs, funded through the £1.3 billion Learning Disabilities and Health Reform grant. The 2011–12 figure also does not include the additional income of £648 million received by local authorities from PCTs for spending on social care services that benefit health. Adjusting the data for these two funding streams suggests a like-for-like budgeted net
current expenditure of £14,220 million in 2011–12. This represents a budgeted spending reduction of just over £200 million—or around 1.5%—compared to last year.

42. Reduced spending does not have to mean poorer services or cuts to provision. Currently, some councils are making changes like sharing back-office services, and caring for people in their own homes instead of expensive residential care. By making these types of changes, councils can protect other frontline services whilst reducing costs.

2.1.2 The ability of local authorities to make the necessary efficiency savings

43. The Government believes that central targets and data collection burdens actively stand in the way of local authorities getting the best value for money. Central government needs to free local government from red tape in order to deliver savings. The Department of Health will not, therefore, be requiring authorities to measure progress on delivering efficiency savings. Instead, the Department has been working with the sector to consider what efficiency opportunities exist over the current Spending Review period.

44. In November 2010, the Department published A Vision for Adult Social Care, which set out some of the changes that local authorities should look to take forward in order to maximise value for money. These included:

- Maximising the potential of reablement services. Reablement can help people to regain their independence after a crisis, and can have a significant positive impact on people’s quality of life. The recent study on the impact of reablement, from the Personal Social Services Research Unit and the University of York, showed that reablement is cost effective for local authorities. For the 10 months after a reablement programme, people’s care costs were around 60% lower than a comparison group which had not gone through reablement—which significantly outweighed the initial cost of providing the service.

- Developing an integrated crisis or rapid response service. Evidence from the Care Services Efficiency Delivery programme suggests that a rapid response service, that responds to people who have a crisis within a four hour period, could save an average of £2 million per PCT and £0.5 million per local authority by reducing ambulance call-outs, unnecessary admissions to hospital and unplanned entry to long-term nursing or residential care.

- Rolling out telecare support, which can help people to live at home independently for longer by providing technologies that make their homes more safe and secure. Self-evaluations from three local authorities indicated that they could save around 1.5% per annum of their home and residential care spend by introducing integrated telecare support to people.

- Reducing spending on long-term residential care forreinvestment in other services. Variations in the proportion of local authority spending on nursing and residential care was a key focus of Use of Resources in Adult Social Care, which benchmarked performance across local authorities. In A Vision for Adult Social Care, the Government set out how supported housing and extra care housing can offer flexible support in a community setting, which can provide better outcomes at lower costs than traditional high-cost nursing and residential care models. Better use of community-based services (for example reablement or home improvement and adaptations) can also reduce demand for residential care.

- Minimising spend on back-office administration, sharing services with other parts of the public sector where appropriate.

- Ensuring that the separation of responsibility for commissioning and providing services becomes standard practice. As set out in A Vision for Adult Social Care, the Government believes that local authorities with substantial in-house provision should look to the market, including social enterprises, mutual and voluntary organisations, to replace them as a local service provider.

45. The Local Government Association and the Association of Directors of Adult Social Services both suggested, in their Spending Review submissions to Government, that efficiencies of 3% per annum were achievable in social care. The Department agrees broadly with this analysis.

46. It is the responsibility of local authorities and the local government sector to deliver these savings. The Local Government Group, through its “Local Productivity” programme, is looking at a range of productivity topics, including efficiency in adult social care. This sector-led programme aims to identify best practice and new and innovative ways to support local government and its partners in finding greater efficiencies. The Department has been working with the Local Government Group on adult social care issues.

2.1.3 The use of the additional £1 billion funding for social care made available through the NHS budget

47. In recognition of the pressures on the social care system in a challenging local government settlement, the Spending Review made £1 billion per annum by 2014–15 available within the NHS specifically for measures that support social care and benefit health. Of this £1 billion, up to £300 million per annum has been earmarked for reablement to help reduce demand upon social care services. For 2011–12 and 2012–13, the
Department set out that the remainder of the funding should be transferred from PCTs to local authorities, for spending on social care services which benefit health and improve health outcomes. The funding should be spent in accordance with joint local agreements between the PCT and the local authority. The breakdown is shown in table 1:

| Table 1 |
|------------------|-----------|-----------|-----------|-----------|
| Reablement         | 150      | 300      | 300      | 300      |
| Other health support | 648      | 622      | 759      | 700      |

48. The detail on how this money should be spent was set out in The Operating Framework for the NHS in England 2011–12, which stated that:

“In 2011–12 PCTs will receive allocations totalling £648 million to support social care. Indicative allocations, totalling £622 million, will also be set out for 2012–13. This is in addition to the funding for reablement services that is incorporated within recurrent PCT allocations of £150 million in 2011–12 rising to £300 million from 2012–13.

PCTs will need to transfer this funding to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.

PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment [JSNA] for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms”.

49. As part of our planning and assurance processes for 2011–12, the Department will be holding SHAs to account for ensuring that arrangements are in place between local authorities and PCTs for the funding to be transferred and objectives for the investment agreed. SHA plans have been reviewed and the Department has applied key assurance tests to them to ensure robust arrangements are in place for the social care funding allocations.

50. Information on the two Spending Review social care funding streams is being collected in the quarterly Departmental FIMS (Financial Information Management System) returns. This shows, by individual PCT, the year to date and forecast outturn position of:

— the share of the £150 million allocated in 2011–12 for local reablement services that will be spent on reablement services; and

— the share of the £648 million funding in 2011–12 that has been transferred to local authorities.

51. Quarter 1, 2011–12 data indicates that, by year-end, all of the £150 million will be spent on reablement and the £648 million will be transferred to local authorities.

52. The Government strongly believes that this funding will support improved integrated working between health and social care. PCTs will need to work with local authorities to agree where the money should be invested, with a shared analysis of need and common agreement on what outcomes need to be met. The Department has been clear that the funding should be used to support those interventions where there is mutual benefit for both PCTs and local authorities, whilst providing local flexibility so that PCTs and local authorities can respond to the JSNA for their area. This represents an important mechanism for encouraging PCTs and local authorities to work outside of traditional silos, and to collaborate in order to achieve maximum impact for their investment.

2.1.4 Progress on making efficiencies through the integration of health and social care services

53. The delivery of NHS QIPP and local government efficiency savings cannot be achieved in isolation and will require joint and close partnership working, for example for older people with complex needs and those with long-term conditions.

The Operating Framework for the NHS in England 2011–12

54. The Department of Health has clearly set out its intention to progress delivering efficiencies through the integration of health and social care services in the Operating Framework for the NHS in England. The NHS Operating Framework set out key messages for the role of local government in contributing to the delivery of improving NHS quality, productivity and prevention and meeting significant efficiencies across both sectors.

These allocations are based on the adult social care relative needs formulae, in order to reflect social care need.
55. PCT allocations for 2011–12 include funding of £150 million for reablement and £648 million for transfer to support social care. The NHS Operating Framework spelled out that PCTs must work together with local authorities to jointly agree areas for investment. This can include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services.

56. The NHS Operating Framework states that the Department will create clearer incentives to drive integration between health and social care by giving PCTs responsibility for securing post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge. NHS commissioners need to also demonstrate how they can support the challenges in social care.

Health and Social Care Bill

57. The strong messages on partnership working outlined in the NHS Operating Framework have subsequently been reinforced in the Government’s response to the Future Forum.

58. There will be stronger duties on the NHS Commissioning Board, including responsibility for identifying innovative ways of integrated working. The proposals for how services are commissioned aim to provide a number of important levers and incentives, with the aim of stimulating the NHS to develop new ways of delivering services which meet the needs of individuals and makes effective use of resources across services and partner organisations.

59. The creation of health and wellbeing boards will maximise opportunities for integrating health and social care, and for the NHS and local government to drive improvements in the health and well-being of their local population. They will be a forum for local commissioners across the NHS, public health and social care, elected representatives and representatives of HealthWatch to form an agreed view of the needs and priorities for their area. Individual commissioning plans will need to have regard for this and the board will actively promote joint commissioning and integrated provision. Local authority and clinical commissioning groups will be required to undertake the Joint Strategic Needs Assessment (JSNA) to ensure that each area develops a comprehensive analysis of the current and future needs of their area.

60. The Department will encourage lead commissioning, pooled budgets and integrated provision, through the Government’s mandate to the NHS Commissioning Board and new statutory guidance on joint health and well-being strategies.

61. The Government strongly believes that these legislative changes will provide the national framework to support improved integrated working between health and social care whilst providing local flexibility so that PCTs and local authorities can respond to the JSNA for their area. This represents an important mechanism for encouraging PCTs and local authorities to work outside of traditional silos, and to collaborate in order to achieve maximum impact for their investment.

Commission on Funding of Care and Support and the NHS Future Forum

62. One of the Commission’s key recommendations and tests for social care reform is that, “Government should review the scope for improving the integration of adult social care with other services in the wider care and support system. In particular, we believe it is important that there is improved integration of health and social care in order to deliver better outcomes for individuals and value for money from the state”.

63. The Government’s response to the Commission made clear that any solution on funding has to meet six tests, one of which is to support better integration of health and social care. It recognised the need for greater efficiency, that people should be treated in the most cost-effective settings, and how funding in the two systems can be better aligned. Funding for reablement is regarded as a good example of where a more strategic and integrated approach between the NHS and social care can better support people, and deliver efficiencies. The Department has committed to further engagement on social care reform.

64. The NHS Future Forum has been asked by ministers to work with a full range of health and local government stakeholders. The key issue it has been asked to explore is “how best to exploit the NHS, social care and public health modernisation programmes to accelerate the redesign of care so that it is more integrated around the needs of people who use services”. This work will conclude in December 2011.

65. The Department is currently working with the NHS Future Forum to develop a common approach for engagement on the integration challenge. Discussions between social care and future forum colleagues are ongoing as to how to maximise public engagement.

Performance Management

66. For this Spending Review period (2011–15), the Department is not introducing top-down efficiency targets for local government. However, the Association of Directors of Adult Social Services and the Local Government Association have both said that 3% per annum for adult social care would be challenging but realistic, and the Department agrees that this is achievable.
67. To deliver this ambitious programme of efficiency local authorities are identifying how the integration of health and social care services can contribute to efficiencies by:
   — helping people to stay independent for as long as possible, for example through investment in reablement services;
   — through assistive technology and driving forward with personal (health) budgets and investment in community services;
   — developing an integrated crisis or rapid response service with the NHS; and
   — minimising spend on back-office administration, sharing services with PCT’s where appropriate.

On-going policy development work

68. Early learning from the personal health budgets pilot work to integrate with social care personal budgets shows that there will inevitably be difficulty working at the interface between health and social care largely due to national barriers, legislation and reporting requirements. It is essential to get this right. An over-aggressive central drive towards integration may threaten partnership working, finances and outcomes rather than help drive modernisation and productivity. The Commission on Funding of Care and Support and the NHS Future Forum’s forthcoming engagement on integration will help us better understand the problems and potential solutions.

69. The Department of Health has over the past two years supported 16 integrated care pilots to explore different approaches to integration. A formal independent evaluation is due to report back at the end of 2011, and the Department hopes this will provide a robust evidence base on the benefits and challenges on which the NHS can draw in the future.

70. The Department is monitoring risks at the interface of the two sectors, for example the levels of delayed transfers of care, to ascertain progress on making efficiencies through the integration of health and social care. This forms part of the Department’s wider co-ordination and monitoring of the Spending Review and performance framework.

3. NHS Modernisation

3.1.1 The cost of the continuing reorganisation of NHS structures in line with the provisions of the Health and Social Care Bill

Transition costs

71. The latest cost estimates of transition will be published in the Impact Assessment on 8 September 2011.

September 2011

Written evidence from the Association of Directors of Adult Social Services (PE 05)

1. The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children’s Social Care within their Local Authority.

Summary

2. Adult Social Care makes a vital contribution to our individual communities and society at large, supporting vulnerable people and communities, encouraging and facilitating personalisation and accountability, seeking effective early intervention and prevention solutions and working collaboratively with stakeholders to create a seamless health and wellbeing response and resource.

3. Adult Social Care is facing widely acknowledged unprecedented demands, with estimates of 4% per year cost pressures (fuelled by exponential growth in demographics and rising socio-economic pressures) and despite year-on-year close budgetary management with local councils making savings of more than £3 billion between 2005 and 2008 and a further £1.7 billion in 2008–09 (demonstrating Adult Social Care effective models of delivery and management), the gap between resources and demand are not matched and is widening at a rate of 2% per year (based upon councils making on average 7% savings over the spending period—Kings Fund).

4. The ADASS Budget Survey 2011,\(^4\) based on responses from 148 councils confirmed £1 billion worth of reductions by Adult Social Care Departments for 2011–12, which represented 6.9% of the these budgets, and a follow-up poll survey of Directors by ADASS confirmed that this pace of reductions is expected to continue into 2012–13. These reductions are after taking into account the transfer of NHS funds to adult social care, which do not compensate for the increasing level of demand combined with reductions in the Local Government Formula Grant. This is not sustainable (in either the short, medium or long term).

\(^4\) ADASS Budget Survey Analysis 2011, May 2011
5. As stated in previous consultation responses, ADASS urges the Coalition to seek broad political consensus and to positively respond to the Dilnot Commission recommendations for a sustainable social care funding solution. Any delay in a solution will only exacerbate this gap between demand and resources and inadvertently widen this to the disadvantage of both immediate and future generations.

6. ADASS Directors welcome the increased flexibilities offered within the settlement and the ability to localise commissioning decisions to reflect local priorities and circumstances and ADASS is working closely with partners and Government Departments to maximise this flexibility against a backdrop of increased local accountability, integration and focus upon improved outcomes and personalisation.

7. ADASS also welcomes the policy agenda set out in the Health and Social Care Bill where local accountability and commissioning is embraced and advanced, particularly the proposed enhanced role of the Health and Wellbeing Boards in coordinating local integration around local agreed outcomes as described in health and wellbeing strategies, and the increasing application of personalisation in the health and social care environment.

8. ADASS welcomes the recommendations of the Dilnot Commission in “levering” in resources through advocating the partnership model, in which personal contributions and/or insurance models persist as a counter to the reductions in funding that are adversely combined by increasing demand. ADASS firmly believes that these recommendations will provide a long term sustainable solution, creating real co-production and accountability with local communities.

9. The impact of the spending review has clearly removed the extent of resources available to councils (the LGFG as a whole being reduced by an average of 26% in real terms over the spending review and according to figures from the Office for Budget Responsibility, council budgets will decrease by 14% once projections for council tax are taken into account) and with increased flexibility, councils have taken differing positions as to how to allocate planned reductions across their differing portfolios. Indeed, the ADASS Budget Survey 2011 analysis illustrates this variation, with for example, 17% councils not funding demographic pressures, 42% partially funding and 41% funding in full. However, the critical point remains that Adult Social Care makes up the largest proportion of “discretionary” spending by councils (The Local Government Group estimates that Adult Social Care makes up 25% of council spending) and consequently the extent of impact of reduced resources is disproportionately felt by Adult Social Care where there is little opportunity to make reductions for “planned” reductions over the spending review period being absorbed by “efficiencies” as opposed to service reductions. NB the ADASS Budget Survey 2011 identified that 69% of the 2011/12 reductions were found from efficiencies and the question remains as to how much more can be gained from this area going forward without impacting upon front line services?

10. The ADASS Budget Survey 2011 analysis confirmed the extent of pressures being faced by Adult Social Care, identifying £1 billion worth of reductions from 2011–12 Adult Social Care budgets and a corresponding movement in raising the eligibility threshold, with 13% councils raising eligibility and 82% councils now only providing services at significant or above levels of eligibility. This shift restricts the extent of future headroom for “planned” reductions over the spending review period being absorbed by “efficiencies” as opposed to service reductions. NB the ADASS Budget Survey 2011 identified that 69% of the 2011/12 reductions were found from efficiencies and the question remains as to how much more can be gained from this area going forward without impacting upon front line services?

11. ADASS welcomes and shares the Coalition’s Vision for Adult Social Care and a mainstay of this vision is prevention, early intervention, personalisation and focus on improved outcomes and in this context, these themes are driving the integration agenda with health and other stakeholders.

12. ADASS is proud of its long history of joint working with health and the maturing relationship which has seen integrated commissioning and existence of joint teams becoming common-place and the development of a shared, integrated outcomes framework binding the focus of health, public health and councils together. The attention upon the “patient pathway” and the mix of the health model of treatment alongside the social care environment.

13. The recent transfer of £648 million from Primary Care Trusts (PCTs) to councils (2011–12) is seen as a positive move in this shared understanding, and the ADASS 2011 Budget Survey affirmed that this allocation has been largely transferred across, of which 24% is to be deployed to avoid cuts to services, 10% to cover demographic pressures, 9% to spend on additional services, and 57% yet to be decided. ADASS is aware of the Secretary of State’s recent request for PCT Finance Directors to give account of this allocation and ADASS Directors will be linking up with their PCT colleagues to discuss this analysis.

14. ADASS remains concerned as to the status of the £400 million over four years announced by the Coalition given to PCTs to fund carers breaks. The support of carers is critical to allowing individuals to remain independent in their own homes with minimal state intervention; however the ADASS Budget Survey
2011 was unable to establish amounts held by PCTs from this announcement and commitments to the provision of carers breaks.

15. In terms of integrated working with health, and the principles of inter-dependencies of financial mutual benefit (early intervention, prevention and joint commissioning), ADASS welcomes the proposals in the Health and Social Care Bill in the movement of Public Health to councils, creating greater synergy and opportunity to capitalize upon expertise and access to universal services, however ADASS, alongside Council leaders remain concerned that the extend of the Public Health allocation is still not known, restricting forward planning and commissioning activity.

16. ADASS welcomes the proposed Clinical Commissioning Groups (CCGs) as means of increasing local commissioning, accountability and integration across the health and social care agenda, but within these proposals, ADASS seeks reassurances that there will be a degree of continuity between the “long term” commissioning strategies of the current PCTs and those to be undertaken by the CCGs to ensure effective use of resources, as well continued targeting of marginalised communities dealing with long-term health inequalities. In terms of responding to long-term and often deep-rooted health inequalities, ADASS has strongly advocated for the proposed Health and Wellbeing strategies to focus joint effort to in addressing these inequalities and for the Health and Wellbeing Boards to oversee the transformation of the whole system to maximise resources in responding to mutual local priorities.

17. Finally as previously stated, Directors of Adult Social Care are faced with unprecedented demands whilst having to respond to reductions in funding and this is being played out with potential impacts upon the patient pathway, particularly upon delayed transfers from acute hospitals and admissions to hospitals, although ADASS notes (as reported by ADASS in January 2011) that approximately 70% of delayed transfers by the 2nd quarter of 2010 were the responsibility of PCTs, rather than a consequence of adult social care activities, although ADASS is more concerned about collective working to seek improved outcomes for local people and is pleased to note that the level of collaborative working is high, for example the ADASS 2011 Budget Survey confirmed that of the £70 million allocated for reablement services in 2011, 48% of this agreed with PCTs to be spend directly by councils.

September 2011

APPENDIX

ADASS BUDGET SURVEY 2011

Social Care is such a large part of local government spend that reductions are inevitable, although Councils are working hard to offset cost reductions, meet demographic pressures and integrate funding with the NHS. The reduction in spend by £1 billion adds to the known gaps in social care funding and makes it imperative that this Government delivers on its promise to see through the reform of how we pay for long term care.

**Key Conclusions**

— Councils are reducing their budgets for adult social care by £991 million, representing a 6.9% reduction against a 10% reduction in overall spending by councils.
— Councils are reducing by £169 million their spend on Supporting People.
— 13% of councils are changing their FACS criteria. There are now 78% councils at Substantial in 2011–12 compared to 70% in 2010–11 and 4% at critical only.
— 79% councils have frozen or increased fees to providers.
— The full amount of the reablement resources has been identified with strong levels of agreement with the NHS on areas of spend.
— 95% of the Winter Pressure allocation was identified, with 89% of councils reporting agreement on how this allocation will be spent.
— The full year NHS Transfer is still to be determined with 57% not yet agreed.
— £425 million of demographic pressures were identified with 41% of councils fully funding these pressures.

**Background Notes**

**2010–11 Net Budget**

— Councils are forecasting an under-spend of approx 1.5% of their Adult Social Care Budget.

**Demographic Pressures**

— The survey indicates demographic pressures across all groups totalling £425 million. In 2011–12 demographic pressures have been quantified as £180 million for Older People, £41 million for Physical Disability, and £179 million for Learning Difficulties, £25 million for Mental Health.
— 17% of councils are not funding demographic pressures with 42% partially funding and 41% funding in full.
Council Budget and Planned Savings Levels (excluding School Grant)

— Local Authority budgets for 2011–12 have been set at £39.5 billion which includes savings of £4.4 billion over 2010–11.
— Adult Social Care is a substantial part of the overall budget for Councils across the country, representing 1/3 (34%) of Council’s net budgets for 2011–12.

Adult Social Care Savings

— Adult Social Care will provide a contribution to savings in 2011–12 of £991 million, representing 6.9% of the 2011–12 Adult Social Care budget before savings. ie £991 million of £14.4 billion.
— The £991 million breaks down as follows—Efficiency £681 million (69%), Income £84 million (8%) and Service Reduction £226 million (23%).

Savings from Supporting People Budgets

— The 2011–12 savings break down as: Efficiency £91 million (54%), Income £50,000 (0%), Service Reduction £78 million (46%).

Reablement (£70 million one-off)

— 98% of the allocation has been identified:
— 89% agreement in how this allocation will be spent across Health and Social Care services.
— Joint planning of services has seen 48% (£33.2 million) spent directly on Council services, underpinning the importance of reablement to the Health and Social care economy—20% of councils reported all the allocation was spent on Adult Social Care services provided by the Council.

NHS Transfer (£648 million full year)

— 99% (£646.9 million) of the total allocation was identified by respondents to the survey.
— 24% will be deployed to avoid cuts to services.
— 10% to cover demographic pressures.
— 9% to spend on additional services.
— At the time of the survey, Local Authorities were still planning the use of the remaining funding (57%).

Winter Pressures (£162 million one off)

— £154.3 million identified by councils—some discrepancy with matching this with total allocation given to PCTs, but accounts for 95% of total allocation.
— 87% (£133.9 million) of the identified allocation has been passed to councils from their PCTs.
— 131 councils had reached agreement with their PCT on how to spend this money, the survey identified that £15.8 million (10%) would be spent on NHS services.

Fees (independent sector)

— 61% of councils have frozen their fees and 18% have reduced fees, 18% report an increase in fees with 3% still awaiting final decisions.

Fair Access to Care criteria

— 13% (19) councils changed their eligibility criteria between 2010–11 and 2011–12, of whom 15 councils moved from Moderate to Substantial.
— 78% (116) at Substantial.
— 15% (22) at Moderate.
— 3% (4) at Low.
— 4% (6) at Critical.

May 2011
Written evidence from the Audit Commission (PE 19)

The Audit Commission is a public corporation set up in 1983 to protect the public purse.

The Commission appoints auditors to councils, NHS bodies (excluding NHS Foundation trusts), police authorities and other local public services in England, and oversees their work. The auditors we appoint are either Audit Commission employees (our in-house Audit Practice) or one of the private audit firms. Our Audit Practice also audits NHS foundation trusts under separate arrangements.

We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.

THE AUDIT COMMISSION’S RESPONSE

SUMMARY

1. The Audit Commission welcomes the opportunity to respond to the Health Select Committee’s continuing inquiry into public expenditure. Our submission draws on:

   — local audit work on NHS bodies’ finances and cost improvement programmes, carried out by the Audit Commission’s appointed auditors, and an analysis of the audited NHS accounts for the 2010–11 financial year; and

   — research into value for money in social care, including: an analysis of Personal Social Service Expenditure for 2006–07 to 2009–10; productivity analysis of services for older people and people with learning disabilities, from 2005–06 to 2009–10; and the Care Quality Commission’s efficiency data.

2. The Commission has identified the following key points in response to the Committee’s questions.

THE PLANS MADE BY NHS BODIES TO DELIVER THE NICHOLSON CHALLENGE

— NHS organisations are used to making and delivering annual efficiency plans. However, the efficiency savings required to meet the Nicholson Challenge will have to be delivered during a period of increasing financial pressure. NHS organisations will have to meet the efficiency challenge and continue to deliver high-quality services, without the funding growth of the recent past.

— The Nicholson Challenge is to deliver recurrent efficiency savings of £20 billion by 2015. This means the NHS needs to save an average of £5 billion, or about 5% of its budget, every year to 2015. Every NHS organisation has put plans in place to deliver efficiency savings as part of the Quality, Innovation, Productivity and Prevention (QIPP) programme.

— In 2010–11, NHS foundation trusts, NHS trusts and primary care trusts (PCTs) reported total savings of £4.3 billion, which is approximately 4% of total NHS expenditure. There may be some double counting between NHS organisations and some of the savings were non-recurrent.

— Our research at a sample of NHS trusts and PCTs shows that plans for 2011–12 are more ambitious, particularly so in PCTs. Past levels of achievement against plan suggest that about 80% of planned savings will be achieved.

— Some NHS organisations struggled to achieve planned efficiency savings in 2010–11 and it will require determined effort and strong leadership to make larger savings and continue to do so.

THE CHANGES PROPOSED AND WHETHER THE NHS IS SUCCEEDING IN MAKING EFFICIENCY GAINS RATHER THAN CUTS

— Our research shows that in 2010–11 most of the savings came from increases in clinical productivity and efficiency. Savings were also made in the areas of pay and workforce.

— Twenty-three% of the savings achieved were non-recurrent, for example temporary vacancy freezes. While all savings programmes will include non-recurrent measures, non-recurrent savings will not produce the service transformation expected through QIPP programmes.

THE IMPACT ON THE PROVISION OF ADULT SOCIAL CARE OF THE 2010 SPENDING REVIEW SETTLEMENT AND THE REMOVAL OF RING FENCING FOR SOCIAL CARE GRANTS

— The picture of the impact on adult social care in 2011–12 from the 2010 spending review is far from clear. This is because there is little up-to-date data available, other than some one-off survey data.

— We plan to publish more material on council spending plans in later in the autumn and will forward that to the Committee when available.
The Ability of Local Authorities to Make the Necessary Efficiency Savings

— Councils face challenges in improving value for money. To do this, they can consider how to reduce the costs of services and the efficiency of their processes, while preserving quality and focusing on outcomes.

— Councils are already taking action that will improve value for money in adult social care in both the short and long term. However, while we identified some innovations, councils are, in the main, using tried and tested techniques to improve efficiency.

— Transactional efficiencies will offer cash-releasing savings within this Spending Review period; while transformational efficiencies may result in better outcomes for people but are unlikely to yield material savings in the short term, and possibly in the longer term as well.

— National data on spend, on patterns of services and on unit costs show a great deal of variation. Councils must ensure that they have the capacity and capability to gather and use high-quality data that will enable them to review, compare and challenge their costs and service quality.

The USE of the ADDITIONAL £1 Billion FUNDING for Social Care made available through the NHS Budget

— We have little evidence on how councils are spending the additional £1 billion funding. This is because it is too early in the process.

— We plan to publish a briefing on the health and social care interface in October. We will send the Committee a copy.

Progress on Making Efficiencies through the Integration of Health and Social Care Services

— Department of Health guidance creates a strong expectation that integration will be an important way of achieving inefficiencies in the future. However, our analysis of adult social services efficiencies in 2009–10, and those planned for 2010–11, shows that integration and working more closely with the NHS was one of the least common ways of achieving savings.

— There are opportunities for local authorities to make savings in their own services, as demonstrated by the significant variations in unit costs for day care and residential care. However, progress in achieving transformational change to more community based provision has so far been slow.

— NHS bodies and local authorities have achieved short-term savings with more traditional ways of securing efficiencies but will need to increase the level of transformational change if they are to achieve all the necessary savings in the longer-term.

— Our forthcoming briefing on value for money across the interface between health and social care will be relevant to this inquiry and will be sent to the Committee when published.

Progress on and Implications of Changing the Tariff Structure

— Our work on the assurance of reference costs is relevant to this inquiry and we will send the Committee further information on the implications for changing the tariff, once our report is published.

3. The evidence provided in this submission draws on existing Audit Commission work. We have extracted the most relevant points for the Committee from our published reports on NHS finances and value for money in social care. The full reports, NHS financial year 2010–11: A summary of auditors’ work and Improving value for money in adult social care are available to download from the Commission’s website, www.audit-commission.gov.uk

Detailed Response

The plans made by NHS bodies to deliver the Nicholson Challenge

4. The Health Select Committee has consistently highlighted the Nicholson Challenge in its inquiries. To achieve it, the NHS needs to release £20 billion of savings by 2015, which equates to an average saving of £5 billion, or about 5% of budget, every year from 2011–12. These savings will need to be a combination of cash-releasing and productivity savings.

5. Savings can be recurrent, meaning the saving is permanent, such as staff cuts or changes to clinical procedures that allow more treatments to be carried out at the same cost. Alternatively, savings can be non-recurrent, meaning they are only a one-off saving within the financial year. An example would be through spending less than was budgeted on a project. The NHS is making both types of savings.

6. Auditors reviewed management and delivery of 2010–11 cost improvement plans (CIPs) and planned 2011–12 CIPs in the first half of 2011 at 97 PCTs (64%) and 54 NHS trusts (47%). Figure 1 shows the planned and actual savings achieved for the years 2009–10 to 2011–12 from our sample of PCTs and NHS trusts. The figures show that the NHS is planning, and achieving, ever greater levels of savings.
7. Figure 1 shows that, at the NHS bodies in our sample, 2010–11 plans have been more ambitious than in 2009–10 but achievement against them had worsened. Plans for 2011–12 are again more ambitious, particularly in PCTs. However, past experience suggests they will not be fully achieved.

8. Figure 2 shows that in 2010–11, 19% of both NHS trust and PCT plans were not achieved. Overall, 23% of the savings achieved were non-recurrent (2009–10 figures are not available). This means that NHS bodies will need to find extra savings in 2011–12 to match the one-off savings made in 2010–11, to reach the target of £20 billion recurrent savings. However, not all the recurrent savings schemes will have been in place for the entire year. This means that recurrent savings made in 2010–11 may deliver greater savings in future years.
9. NHS trusts are delivering more savings than PCTs when measured as a proportion of their gross expenditure. PCTs spend much more money than the NHS trust sector, so a 4% saving on PCTs’ total gross operating costs in 2010–11 would have been £4.1 billion, compared with £1.1 billion of NHS trusts’ combined gross operating expenditure. However, national tariff prices for healthcare determine a significant proportion of PCTs’ expenditure. The tariff has in-built efficiency savings, which are not included in the PCT savings figures because they are counted in the savings made by NHS trusts delivering the healthcare. Department of Health guidance asks NHS bodies to ensure that planned savings are recorded consistently and the same savings are not double-counted by both PCTs and NHS trusts.

10. There is also geographical variation in the reported savings, with greater savings reported in the southern strategic health authority areas. This could be a reflection of general financial health, where health economies in the north have better financial positions and so have less need to make savings in 2010–11 to achieve financial balance.

11. Total efficiency savings reported by NHS trusts and PCTs in 2010–11 amounted to £3.1 billion. Monitor reported that FTs delivered savings of 3.9% of their operating costs, which equates to £1.2 billion. The total NHS efficiency savings reported is £4.3 billion—roughly 4% of total NHS expenditure. Also, some of the savings found were non-recurrent. If the proportions of non-recurrent and recurrent savings are the same as those in the sample of savings plans reviewed by auditors, the recurrent savings achieved in 2010–11 would be £3.3 billion.

The Changes Proposed and Whether the NHS is Succeeding in Making Efficiency Gains Rather Than Cuts

12. Auditors recorded the main savings areas in 2010–11. These are summarised into themes, as shown in Figure 3.
13. Most of the savings have been made through clinical productivity and efficiency, pay and workforce savings. The clinical productivity and efficiency category includes savings such as demand management, reduced length of stay, moving to day case surgery or outpatient treatments, bed closures and contract renegotiation. Pay and workforce includes reducing management costs, reducing overtime costs, vacancy freezes and decreases in the use of bank and agency staff, and changes to staff grade mix.

14. The planned savings areas in 2011–12 reported to auditors mainly focused on clinical productivity and making transformational savings. Auditors carried out the reviews where they judged the delivery of the CIP to be a local risk. Following their review, 46% of auditors reported concerns about the overall arrangements in place to deliver the CIP.

15. The main reasons for slippage in CIPs reported by auditors were delays in starting projects and over-optimistic savings plans, or schemes that did not produce any savings. Some auditors found slippage occurred because of poor governance and an inability to take corrective action. This was compounded by being unable to find substitute savings plans. However, for many of those organisations that did find substitute programmes, the savings were non-recurrent. The main slippage in specific programmes was in failing to reduce emergency admissions as expected, failure to manage demand and to reduce length of stay.

**THE IMPACT ON THE PROVISION OF ADULT SOCIAL CARE OF THE 2010 SPENDING REVIEW SETTLEMENT AND THE REMOVAL OF RING FENCING FOR SOCIAL CARE GRANTS**

16. The picture of the impact on adult social care in 2011–12 from the 2010 spending review is far from clear. Data from several surveys is available, which each give different results.

- The Association of Directors of Adult Social Services survey suggests spending on adult social care has fallen by 6.8%.
- Age UK found that spending on older people had fallen by 8.4%.
- The Department for Communities and Local Government found the fall was less than 1%.
- A CIPFA/BBC survey suggested a 2.6% fall but with significant regional variation.

17. We expect to publish further information in the autumn from our own analysis and auditors’ work on local authority spending plans, including adult social care, and will send the Committee a copy when available.
There is significant variation in unit costs for providing residential care or day care for older people, and for people with a learning disability. For example, the average weekly spend per person on residential care for people with learning disabilities provided by councils varied from £262 to £11,282 in 2009–10. (Tables 1 and 2). The large differences in unit costs suggest the quality of the data may be variable. It also suggests that there is scope for some councils to review how much they are spending and how they compare to others.

### Table 1: Unit costs (average weekly spend per person) residential care 2009/10

<table>
<thead>
<tr>
<th>Service type</th>
<th>Minimum unit cost</th>
<th>25th quartile</th>
<th>Median unit cost</th>
<th>75th quartile</th>
<th>Maximum unit cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided by the council for people with learning disabilities</td>
<td>£262</td>
<td>£1,159</td>
<td>£1,678</td>
<td>£2,115</td>
<td>£11,282</td>
</tr>
<tr>
<td>Provided by the independent sector for people with learning disabilities</td>
<td>£612</td>
<td>£1,006</td>
<td>£1,302</td>
<td>£1,658</td>
<td>£3,072</td>
</tr>
<tr>
<td>Provided by the council for older people</td>
<td>£405</td>
<td>£726</td>
<td>£960</td>
<td>£1,220</td>
<td>£7,261</td>
</tr>
<tr>
<td>Provided by the independent sector for older people</td>
<td>£331</td>
<td>£419</td>
<td>£455</td>
<td>£522</td>
<td>£907</td>
</tr>
</tbody>
</table>

Source: PSSEX1 2009/10 final data from the Information Centre for Health and Social Care, adapted by the Audit Commission 2011

### Table 2: Unit costs (average yearly spend per person) day care 2009/10

<table>
<thead>
<tr>
<th>Service type</th>
<th>Minimum unit cost</th>
<th>25th quartile</th>
<th>Median unit cost</th>
<th>75th quartile</th>
<th>Maximum unit cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided by the council for people with learning disabilities</td>
<td>£25</td>
<td>£234</td>
<td>£295</td>
<td>£383</td>
<td>£1,101</td>
</tr>
<tr>
<td>Provided by the independent sector for people with learning disabilities</td>
<td>£12</td>
<td>£146</td>
<td>£234</td>
<td>£320</td>
<td>£1,322</td>
</tr>
<tr>
<td>Provided by the council for older people</td>
<td>£9</td>
<td>£72</td>
<td>£97</td>
<td>£152</td>
<td>£4,102</td>
</tr>
<tr>
<td>Provided by the independent sector for older people</td>
<td>£2</td>
<td>£42</td>
<td>£63</td>
<td>£97</td>
<td>£917</td>
</tr>
</tbody>
</table>

Source: PSSEX1 2009/10 final data from the Information Centre for Health and Social Care, adapted by the Audit Commission 2011

Councils are already taking action that will improve value for money in adult social care in both the short and long term. While we identified some innovations, such as Trafford’s project to involve local people in retendering services, councils are, in the main, using tried and tested techniques to improve efficiency. Councils are making efficiencies in several areas—for example, preventative services—and have been doing so without raising eligibility criteria or increasing charges.

Transactional efficiencies, such as better procurement, will offer cash-releasing savings within this Spending Review period. Transformational efficiencies, such as personalisation, may result in better outcomes for people but are unlikely to yield material savings in the short term, and possibly in the longer term as well.

Councils face clear risks, such as demographic change, and strategic choices, like whether to outsource services, in deciding on their savings and service strategies. The policy imperative is to transform services to...
deliver better outcomes for users. But the pace of change is slow and is unlikely to deliver short-term, or even possibly long-term, savings. Indeed, they may require short-term investment. Focusing management time on transactional efficiencies may deliver savings but will not deliver all the efficiencies required.

**The Use of the Additional £1 Billion Funding for Social Care Made Available through the NHS Budget**

22. It is too early for robust evidence on how the additional funding is being used. The experience and views of our local auditors is that areas with a strong history of partnership working are collaborating on how best to use the funding to benefit the whole system. Where relationships are less strong, it seems that agreeing shared priorities and allocating funding has been less smooth.

**Progress on Making Efficiencies through the Integration of Health and Social Care Services**

23. Analysis of adult social services efficiency savings in 2009–10 and 2010–11 showed that integration and working more closely with the NHS was one of the least common ways of achieving efficiencies. However, Figure 4 shows more councils plan to focus more on this area of partnership working in future.

![Figure 4: Council Efficiencies in 2009–10 and Planned Efficiencies for 2010–11](image)

**Figure 4**

COUNCIL EFFICIENCIES IN 2009–10 AND PLANNED EFFICIENCIES FOR 2010–11

24. Analysis conducted for our forthcoming briefing on the NHS and social care interface suggests there is wide variation in performance on the measures that indicate joint working across the NHS and social care. For example, emergency admissions of people aged over 65 and admissions to care homes.

25. In addition, the evidence on the impact of partnership initiatives is not strong, as the recent work by the Nuffield Trust on the impact of a sample of Partnerships for Older People Projects initiatives shows.5

26. We are currently working on a briefing on value for money in the health and social care interface and we will send the Committee a copy when it is published in October 2011.

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5 Adam Steventon, Dr Martin Bardsley and Professor John Billings (2011) An Evaluation of the Impact of Community-Based Interventions on Hospital Use Nuffield Trust: London
ACKNOWLEDGMENT

We acknowledge the advice and support received from colleagues in other organisations.

INTRODUCTION

1. The LG Group is pleased to submit a written response to the Health Select Committee’s inquiry on public expenditure and looks forward to giving oral evidence on 13 September.

2. Anticipating a number of questions covering a range of different topics during our oral evidence session this written evidence does not strictly follow the Committee’s questions. Instead it offers an overall commentary on the developments with current health reforms and a similarly broad commentary on the challenges facing adult social care.

3. Many of the Committee’s questions focus on the “on the ground” experience of, for example, integration and use of resources. We believe our colleagues in the Association of Directors of Adult Social Services are best placed to answer these questions in more practical detail, leaving our response to focus on the more strategic questions surrounding the funding and efficiency agendas.

THE LG GROUP RESPONSE—COMMENTARY ON HEALTH

4. The Health and Social Care Bill represents a major restructuring, not just of health care services, but also of councils’ responsibilities in relation to health improvement and the coordination of health and social care.

5. The Bill presents an opportunity to truly join up the commissioning and delivery of health and social care provision through Joint Strategic Needs Assessments and Health and Wellbeing Boards. In order for this to become a reality these boards need teeth so that they can drive forward action at a local level and address health inequalities. They therefore need to have equal status and power as GP commissioning consortia, the NHS Commissioning Board and Public Health England.
14. While GPs may be best placed to commission services for patients they have contact with, we are concerned about the commissioning of so-called “Cinderella Services” such as health and wellbeing services for homeless people, dementia, carers or people with learning disabilities. Councils have a strong track record in commissioning the complex mix of services that are necessary to support vulnerable people and improve their health outcomes. GPs should work with councils to ensure these groups are adequately provided for.

15. We believe that there is a risk—in clustering PCTs—of disrupting existing local relationships and planning arrangements, such as on free nursing care, continuing healthcare and NHS passported money for carers. On the final point we know from evidence collated by the Princess Royal Trust for Carers that the money for carers is not getting through to the intended beneficiaries.

16. We welcome the focus on securing better health outcomes, in particular in reducing health inequalities by use of incentives to reward progress. However, the proposed “payment by results” system could fail to take into account the fact that there are multiple influences on the health choices and outcomes that individuals make and create perverse incentives. Financial rewards need to be balanced with resources to support communities that have the least assets and the greatest challenges in relation to health improvement.

17. The LG Group strongly supports integrated commissioning of health and social care services. We are concerned, however, that—as currently worded—the Health and Social Care Bill does not make it clear that GPs are responsible for commissioning services for everyone in an area. We believe that if this is not explicit, it will allow for gaps and may unfairly affect vulnerable groups.

18. It is widely acknowledged by both local government and the NHS that the move towards coterminosity between social care authorities and PCTs has been a key driver of greater partnership working and integration and should, as far as possible, be preserved.

The LG Group Response—Commentary on Adult Social Care

The local government funding picture

19. The 2010 Spending Review in October last year set out real terms reductions of 28% in local government budgets over the next four years, which compared with overall cuts of 8.3% across all departmental budgets. The December local government finance settlement included a two-year settlement for 2011–12 and 2012–13. The settlement saw central government Formula Grant funding for councils fall by 12.1% in 2011–12.

20. It is no exaggeration to say that local government has been handed one of the toughest settlements across the public sector. Alongside the significant cut to Formula Grant cost pressures continue to mount in various areas. Adult social care is one such area and we estimate that demographic pressures for this service will cost local authorities in the region of 4% per annum. This estimate is comparable with research carried out for the previous government’s 2009 Green Paper, Shaping the Future of Care Together.

21. As a result we estimate that local government faces a funding gap in the order of £6.5 billion in 2011–12. This gap reflects the difference between what local authorities across England would need to spend to maintain frontline services in their current form, and the income they will be able to raise from grants, fees and charges, business rates and council tax.

22. It has been suggested that councils should be more efficient in the management of their internal affairs before they are required to consider changes and reductions to frontline services. A common suggestion is that if councils cut chief executive pay, joined back office services, and eliminated so-called “non-jobs” then they could protect frontline services.

23. The Prime Minister has acknowledged that “local government is officially the most efficient part of the public sector” and that “councils achieve well in excess of the sector’s spending review targets, beating central government savings by a country mile” (Rt Hon David Cameron MP, Cutting the Cost of Politics, speech, 2009).

24. Councils made savings of more than £3 billion between 2005 and 2008 and a further £1.7 billion in 2008–09. In 2009–10 councils made efficiency savings of more than £4.8 million every day. Councils know that it is likely that more efficiency savings can be made, and the LG Group is investing heavily in a national productivity programme. But efficiency savings are not a quick, short-term fix and what has to be saved over the next few years goes far beyond what can be achieved by conventional efficiency savings.

25. The very clear reality is that councils have had to face extremely tough choices about which services they can keep on running. Councils also continue to show that they are doing everything they can to minimise the effect of these cuts, and building on their record of delivering new and better ways of doing things in order to keep public services running.

26. As we have long argued, these difficult decisions are best made at the local level. Councils—working with their local partners—have a thorough and expert knowledge of their communities needs and continue to strive to ensure that scarce resources are targeted where they are needed most.
The adult social care funding picture

27. The government did respond positively to some of the central arguments made by local government in the run up to the Spending Review. There is new adult social care funding of £530 million in 2011–12, rising to £1 billion in 2013–14, and a further £1 billion funding for joint working with the NHS. These monies constitute the “extra £2 billion” that government argues social care has received.

28. This additional money is certainly welcome but its impact would only be truly felt if we were in a settled state. The picture presented above makes clear that we are not. Given the expected rise in the annual cost of adult social care we therefore anticipate a multi-billion pound shortfall by 2014–15 and have concerns about this funding gap being met. Without significant real terms increases in funding it is likely that there will be considerable pressure on councils’ ability to maintain care services on current eligibility criteria in the coming years.

29. We will shortly be conducting our own analysis of the amount needed between now and the likely implementation of any funding reform post-Dilnot to cope with demand and changing levels of service. This will be done alongside an analysis of the proposed costs of Dilnot’s model. We would be happy to share this work with the Committee.

30. The transfer of learning disability funding from health to social care is being achieved through the introduction of a specific grant called the Learning Disability and Health Reform Grant. It amounts to £1.325 billion in 2011–12, rising to £1.357 in 2012–13. This is in the range that we were expecting, which is welcome since this is one of the fastest growing pressures on local authority budgets.

31. Our estimate is that local government in England will see a decline in its funding for services other than schools and children’s services over the next four years. The funding reduction is estimated to be about 16% in real terms. Currently, spend on adult social care absorbs almost one-quarter of this funding. This is the backdrop against which questions about the adequacy of funding for social care have to be answered.

32. In March 2011 the Local Government Association’s Analysis and Research Team conducted Council Budgets, Spending and Saving Survey 2011. This was sent to Directors of Finance (or equivalent) in all local authorities in England in membership of the LGA. Against the backdrop of a severe finance settlement (as outlined above), and with councils finalising their budgets for 2011–12, the survey was conducted in order to establish as complete an evidence base as possible of the factual context in which budget decisions were being made.

33. The survey revealed that councils have cut senior management costs while trying to protect the services that the most vulnerable rely on, with nine out of 10 councils having already reduced the cost of senior officers, and eight out of 10 cutting middle-management costs.

34. In terms of adult social care the survey showed that more than half of councils were seeking to protect the service (57%). With regard to eligibility the survey showed that 61% of authorities currently offered services at “substantial” and above, and a further one in five offered services at “moderate” and above. 79% of councils had decided not to change the lowest eligibility band at which they offered services in 2011–12. The majority of the small number of councils who had changed their lowest band had moved to “substantial”, with the main factors influencing their decision being demand for/volume of care home placements, and demand for/volume of domiciliary care.

35. The ADASS budget survey (May 2011) provides further valuable information on the state of adult social care funding, post Spending Review. This reveals that councils are reducing their budgets for adult social care by £991 million, representing a 6.1% reduction against a 10% reduction in overall spending by councils. This breaks down as “efficiency” (£681 million), “income” (£84 million), and “service reduction” (£226 million).

36. The survey also indicates demographic cost pressures across all groups totalling £425 million. 17% of councils are not funding these pressures, 42% of councils are partially funding them, and 41% of councils are funding them in full.

37. In respect of fees (to the independent sector) the survey reveals that 61% of councils have frozen their fees and 18% have reduced them. 18% report an increase in fees with 3% still awaiting final decisions. The fact that well over three quarters of councils have frozen or reduced their fees is evidence of the difficulty councils face in keeping pace with inflation and fee increases. This certainly poses questions about the stability of the market and the recent case of Southern Cross (though not solely an issue of fees) is an indicator of the type of issue the sector may continue to face over the coming months.

38. In terms of the NHS transfer the survey reveals that 99% (£646.9 million) of the total allocation was identified. 24% was being deployed to avoid cuts to services, 10% was being used to cover the costs of demography, and 9% was being spent on additional services. At the time of the survey, councils were still planning the use of the remaining funding (57%). Where those decisions are still to be made our anecdotal evidence is that this illustrates the, at times, difficult discussions on whether the money should be used as a substitute for services, for expanding existing services, or for meeting NHS demand for 100% additonality.
Dilnot and the future of adult social care funding

39. In the long term, the proposals of the Commission on Funding of Care and Support will be vital in putting in place a sustainable and affordable approach to managing future adult social care demand.

40. The Dilnot report must not be seen as an end in itself and should instead be viewed as part of a wider reform movement, which includes: the Law Commission’s recommendations for developing a simpler legal framework for care and support; political vision for reform; and developing cross-party consensus on the best way forward.

41. In today’s financial environment, and being acutely aware of the demographic shifts we are seeing, we believe a shared responsibility between the individual and the state for increasing available funding is a viable approach. We are pleased to see the Commission recommend that a safety net should continue to exist for those who would not be able to afford the individual contribution; reform must work for everyone.

42. Local government, and the LG Group, is ready to play its part in helping to realise an adult social care system that is fit for purpose. We are clear that any future system must involve a strong role for councils—not just their adult social care departments, but their other linked services (such as housing, transport and leisure), and those of their partners (such as health).

43. If we are to meet the needs of our ageing population we must act now. This issue will not disappear and whatever the solution there will inevitably be some unpopular choices. That must not detract us from the bigger prize, however, and it is incumbent upon all of us to urgently tackle this significant policy question. Any delay in designing a solution will only put further strain on an already stretched system.

September 2011

Written evidence from The King’s Fund (PE 29)

1. The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

SUMMARY

2. The King’s Fund welcomes the Committee’s inquiry into public expenditure. There is a lack of systematic monitoring of the measures being taken to meet the Nicholson Challenge, so it provides an important opportunity to evaluate progress so far and assess the impact of current financial pressures on health and social care services. In summary:

— Despite the headlines generated by the government’s reforms, meeting the “Nicholson Challenge” is the key priority facing the NHS. We remain concerned that the structural reorganisation set out in the Health and Social Care Bill presents a real risk to delivering on this challenge.

— Challenging cost improvement targets have been set across the NHS, with many trusts facing targets of 6% or more and emerging evidence suggesting some uncertainty about whether these targets will be met.

— We are concerned that too much emphasis is being placed on delivering financial savings instead of productivity gain, with emerging evidence suggesting that many trusts are restricting access to services.

— More needs to be done to tackle unwarranted variations in NHS performance and major reconfigurations of hospital services are needed if the Nicholson Challenge is to be met.

— High-quality leadership and management are essential to delivering the Nicholson Challenge—the denigration of NHS managers by politicians should stop and the target to cut the number of managers by 45% should be re-visited.

— Despite the additional funding announced in the Spending Review and the best efforts of councils, it is clear that spending on social care will fall in 2011–12, with efficiency savings unlikely to make up for cuts in local authority budgets.

— While the Health and Social Care Bill could provide a platform for improving health and social care integration, a more ambitious approach is needed to align the £121 billion currently spent on health and social care much more closely around the needs of patients and service-users.

3. Our responses to the questions set out in the inquiry’s terms of reference are set out below.
The plans being made by NHS bodies to enable them to meet the Nicholson challenge

4. In April, The King’s Fund published the first in a series of new quarterly monitoring reports, which include the views of a panel of NHS finance directors. A second report was published in July. Although these reports aim only to provide a snapshot of views and the panel is not intended to be a representative sample, they provide some insight into the plans being made by the NHS in response to the Nicholson Challenge.

5. In July, almost all the finance directors among our panel (27 of 29) indicated that their trust has a productivity target of 4% or more for 2011–12, with nearly half (13) citing a target of 6% or more. This is consistent with other publicly available information. Monitor’s annual review of foundation trust plans found that the FT sector is planning to deliver productivity savings of 4.4% in 2011–12, while in April 2011 it revised its “downside” efficiency requirement to 6.5% for the acute sector and 6% for the non-acute sector.

6. This shows that many NHS organisations have higher targets than the average of 4 to 5% needed to deliver the Nicholson Challenge over the next four years. The key reason for this is the decision to make 40% of the savings required (£20 billion a year) through reductions in the tariff in the acute sector. As the tariff currently covers around £30 billion of annual income for trusts, this implies a productivity gain of nearly 7% a year. Local factors and requirements to hold back money to meet targets for surpluses to carry over to next year and act as a buffer to meet the costs of the government’s reforms also contribute to this.

7. Our quarterly monitoring reports suggest that many trusts may struggle to meet their targets. In our July report, nearly half our panel of finance directors indicated that they are uncertain of meeting their targets, while eight of the 13 panelists with targets of 6% or more indicated that they are uncertain of meeting them. Similar findings have been reported elsewhere. Information published by GP magazine found that 50% of primary care trusts may fail to meet their targets. A recent survey of senior managers published by the Health Service Journal found that 55% of respondents were not confident that their organisation will be able to make the savings needed.

Where changes are being proposed, and whether the NHS is succeeding in making efficiency gains rather than cuts

8. The lack of systematic monitoring of the measures being taken locally through QIPP plans means that it is not yet possible to evaluate the extent to which the NHS is succeeding in making efficiency gains rather than cuts. In the absence of auditable data, we are concerned that ambitious QIPP plans may in part only be achieved at the expense of quality and reductions in volume.

9. We are also concerned at the emphasis being placed on the financial value of the productivity gain being sought—the £20 billion. While this provides a legitimate broad brush target (and is in line with previous analysis provided to the Committee by The King’s Fund), we are concerned that many in the NHS have interpreted this figure as the financial savings to be made over the four years to 2015, rather than simply a monetary expression of the value of the productivity gain to be achieved. Improving value for money for patients does not just involve reducing unit costs—in many ways, and perhaps more importantly, it means identifying where value can be improved for a given level of spending.

10. We have previously argued that there are opportunities to improve productivity by reducing unwarranted variations in performance. For example, the NHS Institute for Innovation and Improvement has estimated that £4.5 billion in efficiency savings could be delivered in acute hospitals by bringing performance up to the level currently achieved by the top quartile. There are significant opportunities to improve workforce productivity—for example, savings of up to £400 million could be made by tackling poor performance among GPs. Significant savings could also be delivered by improving the prescribing and management of drugs, which account for 12% of the NHS budget.

11. Major reconfigurations of hospital services are essential to meet the Nicholson Challenge and to improve the quality and safety of care. We remain concerned at the lack of clear responsibility for driving forward this agenda under the Health and Social Care Bill. We have recently published proposals to improve the decision-making process for hospital reconfigurations, which is complex and bureaucratic and often undermined by resistance to change from local MPs and councillors, even when there is strong clinical and financial evidence of the need for it.

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6 How is the NHS performing? Quarterly monitoring report; The King’s Fund, April 2011
7 How is the NHS performing? Quarterly monitoring report; The King’s Fund, July 2011
8 Review of NHS foundation trusts’ annual plans (2011–12); Monitor, August 2011
9 Letter to foundation trusts and foundation trust applicants from Stephen Hay, Chief Operating Officer, Monitor, 27 April 2011
10 GP, 4 August 2011
11 Health Service Journal, 28 July 2011
12 Memorandum to the Health Select Committee’s inquiry into public expenditure, The King’s Fund, September 2010
13 Speech by Bernard Crump to the NHS Institute for Innovation and Improvement Faculty Conference, 30 September 2009
14 Achieving world class productivity in the NHS 2009/10—2013/14: Detailing the size of the opportunity; McKinsey and Co, 2009
15 Appleby J et al; Improving NHS productivity: More with the same not more of the same, The King’s Fund, 2010
16 Imison C; Reconfiguring hospital services, The King’s Fund, September 2011
12. Emerging evidence suggests that a combination of efficiency savings, restrictions to services and cuts in staff are being used to meet productivity targets. For our April monitoring report, we asked finance directors to identify the top three ways in which productivity targets will be met in their organisations. Responses were as follows:

- Frontline efficiencies (eg reductions in length of stay): 20.
- Workforce changes (eg reducing agency staff, reducing headcount): 16.
- Whole system efficiencies (eg redesigning or reconfiguring services): 13.
- Closing wards and services: 12.
- Reducing activity (eg demand management): 5.
- External contracts (eg improving procurement): 3.

13. This mixed picture is supported by other emerging evidence which suggests that access to some treatments and procedures is being restricted. GP magazine recently reported that two-thirds of PCTs are restricting referrals for treatments that are “non-urgent” or of low clinical value, with a third increasing the number of procedures they will restrict funding to over the next year. Pulse also recently reported that two-thirds of PCTs have expanded procedures classified as low clinical priority.

14. Data also shows the number of redundancies is increasing. The six months to March 2011 saw an almost three-fold increase in the number of compulsory redundancies, with 1,250 NHS staff made redundant in the last quarter of 2010-11, of whom 234 were clinical staff. High-quality leadership and management are essential to delivering the Nicholson Challenge. Nevertheless, senior members of the government continue to denigrate NHS managers as “bureaucrats”. This should stop. As the report of our Commission on Leadership and Management in the NHS showed, while there is evidence that the NHS is over-administered as a result of extensive and overlapping demands from regulators and performance managers, there is no persuasive evidence that it is over-managed. While reductions in management costs must play a part in meeting the Nicholson Challenge, the arbitrary target to cut the number of managers by 45% should be re-visited and a more sophisticated approach should be taken to assessing the leadership and management needs of the NHS.

15. Restricting access to treatments may, in some cases, reduce variations in procedures that offer little benefit to patients. For example, our research shows that the rate of tonsillectomies—a procedure that has been questioned since the 1930s—is 10 times higher in Coventry PCT than in Kingston PCT. However, reports that access is being restricted to procedures such as hip and knee replacements and cataract operations is a significant concern as this is likely to harm patient care.

16. Our research also highlighted opportunities for delivering productivity improvements by reducing variation in the way some procedures are carried out. For example, although most operations on varicose veins can be undertaken as day cases, with some PCTs doing this in 90% of cases, some PCTs only manage this in 30% of cases.

**The Cost of the Continuing Reorganisation of NHS Structures in line with the Provisions of the Health and Social Care Bill**

17. There is currently no up to date estimate of the cost of the structural reforms outlined in the Health and Social Care Bill. The Regulatory Impact Assessment published alongside the Bill estimated the cost “attributable to the changes in the system architecture” as £1.4 billion. The Health Service Journal recently reported that the Department of Health business plan includes an updated estimate of the cost of the “transition programme” as £1.49 billion. No independent assessment of the cost of the structural reforms has been published, although in July 2010, Kieran Walsh, Professor of Health Policy and Management at Manchester Business School, estimated it to be between £2 billion and £3 billion. The government has indicated that a revised Regulatory Impact Assessment will be published shortly.

18. More broadly, we remain concerned that the scale of the structural reorganisation set out in the Bill and the challenges associated with implementing it present real risks to delivering on the Nicholson Challenge. The uncertainty of the past few months has caused significant instability within the NHS. It is essential to move on from this so that it can focus on delivering the productivity improvements needed to maintain quality and avoid significant cuts to services.

19. High-quality leadership and management are essential to delivering the Nicholson Challenge. Nevertheless, senior members of the government continue to denigrate NHS managers as “bureaucrats”. This should stop. As the report of our Commission on Leadership and Management in the NHS showed, while there is evidence that the NHS is over-administered as a result of extensive and overlapping demands from regulators and performance managers, there is no persuasive evidence that it is over-managed. While reductions in management costs must play a part in meeting the Nicholson Challenge, the arbitrary target to cut the number of managers by 45% should be re-visited and a more sophisticated approach should be taken to assessing the leadership and management needs of the NHS.

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17 GP, 27 July 2011
18 Pulse, 19 July 2011
19 The Quarterly, Department of Health, June 2011
20 Appleby J et al; Variations in healthcare: The good, the bad and the inexplicable, The King’s Fund, 2011
21 Health and Social Care Bill 2011: Coordinating document for the Impact Assessments and Equality Impact Assessments; Department of Health
22 Health Service Journal, 28 July 2011
23 Reorganisation of the NHS in England; Kieran Walsh, British Medical Journal, 16 July 2010
24 The future of leadership and management in the NHS: No more heroes; The King’s Fund, 2011
The Impact on the Provision of Adult Social Care of the 2010 Spending Review Settlement and the Removal of Ring-Fencing for Social Care Grants

20. The King’s Fund prepared a supplementary memorandum for the Committee’s previous inquiry which explored the implications of the 2010 Spending Review for adult social care. On the basis of a reduction in local authority spending on social care of 7% a year, it concluded that that a funding gap of £1.2 billion could develop by 2014, unless local authorities are able to find efficiency savings of 2% a year.\(^{25}\) This estimate was based on a number of assumptions, including the budget decisions made by 152 local authorities.

21. It is now clear from local authorities’ actual budget settlements for 2011–12 that they are reducing expenditure on adult social care by £991 million—a 6.9% reduction in spending in a single year.\(^{26}\) In the context of a 10% reduction in overall spending by local authorities, this suggests that councils have sought to prioritise adult social care and that the removal of ring fencing has not had a deleterious impact on spending.

22. The planned reduction in expenditure includes explicit decisions to reduce services by £226 million and generate additional income through charging of £84 million. The intention is that the remaining £681 million will be delivered through efficiency savings and the redesign of services. This would amount to a 4.7% efficiency gain and seems very optimistic (see below). Some of the reduction in expenditure will be mitigated by the £648 million made available in 2011–12 from the NHS budget to spend on social care services. Nevertheless, it is clear that the key question is not whether adult social care spending will fall this year, but by how much.

23. In its previous report, the Committee expressed doubts about whether local authorities would be able to deliver sufficient efficiency savings to avoid restricting eligibility criteria. A further 15 local authorities changed their eligibility criteria for services from moderate to substantial in 2011–12, meaning that 82% now offer services only to those with substantial or critical needs.

24. The squeeze on local authority budgets over the next four years suggests that the gap between needs and resources will continue to widen, despite the additional £2 billion announced in the Spending Review and the best intentions of local authorities to protect social care. It seems likely that access to services will be further restricted in response to these pressures. The need to secure a sustainable long term funding settlement for social care has never been more urgent—the government must move quickly to undertake detailed work on the recommendations made the Dilnot Commission and honour its pledge to publish a white paper followed by legislation in 2012.

The Impact on NHS Plans Currently Being Made by Local Authorities

25. We would expect the pressures on social care budgets to produce knock on consequences for the NHS, for example in terms of increased emergency admissions delayed discharges from hospital. However, there is no evidence that these pressures are feeding through yet. Delayed transfers of care are stable and remain significantly below the very high levels recorded in 2003–04.

The Ability of Local Authorities to Make the Necessary Efficiency Savings

26. Local authorities have a mixed record in delivering efficiency savings. Historically, efficiency in adult social care has declined, with productivity falling by 15.3% between 1997 and 2008.\(^{27}\) This trend has been reversed recently, with local authorities finding more than £940 million in efficiency savings in the past three years.\(^{28}\) However, it is very optimistic to expect adult social care services to deliver efficiency savings of £681 million in a single year.

The Use of the Additional £1 Billion Funding for Social Care Made Available through the NHS Budget

27. We are not in a position to evaluate how the additional £1 billion in funding for social care made available through the NHS budget is being spent, although anecdotal evidence suggests this has been a useful spur for initiating local discussions between the NHS and adult social care. We note that the Department of Health has recently written to PCTs to collect information about this.\(^{29}\)

Progress on Making Efficiencies through the Integration of Health and Social Care Services

28. Evidence suggests that significant efficiency gains can be made by improving integration between health and social care. For example, analysis of Torbay’s Integrated Care Project has highlighted low rates of emergency admissions, emergency bed day use and discharges into residential care compared with other areas.

\(^{25}\) Supplementary memorandum to the Health Select Committee’s inquiry into public expenditure, The King’s Fund, November 2011

\(^{26}\) ADASS Budget Survey 2011, Association of Directors of Adult Social Services, May 2011

\(^{27}\) Total public service output, inputs and productivity, Office for National Statistics, 2010

\(^{28}\) Submission to Comprehensive Spending Review 2010; Association of Directors of Social Services, 2010

\(^{29}\) Letter from the Department of Health, 24 August 2011
in the South West. As a result of the project’s work, the average number of daily occupied hospital beds fell from 750 in 1998–9 to 502 in 2009–10.\textsuperscript{30}

29. It is too early to judge progress in delivering efficiencies by integrating health and social care under the coalition government’s policies. Anecdotal evidence suggests that significant barriers remain. In our quarterly monitoring report published in July, eight of our panel of finance directors identified integration between local partner organisations including social care as one of the top three barriers to achieving productivity improvements. This was the second highest response.

30. The Health and Social Care Bill could provide a platform for rectifying this, with the requirements on clinical commissioning groups to promote integrated care providing an opportunity for local initiatives to be clinically driven. The amended Bill includes stronger duties on health and wellbeing boards to deliver health and social care integration and the government has indicated that the boundaries of clinical commissioning groups should not now cross those of local authorities, unless this can be justified in terms of benefits to patients and integration of services.

31. However, the legislation is only the starting point. Experience shows that the key to delivering integration is stable leadership and an evolving vision and trust between local partners. We are concerned that the complex organisational change now being implemented in the NHS could disrupt existing relationships. For example, the advent of clinical commissioning groups and the move to PCT clusters potentially threatens the shared management arrangements which have developed between some local authorities and PCTs.

32. Integrated care has been a recurrent goal of public policy under successive governments for over 40 years. However, despite some notable successes, progress has been limited with less than 5% of NHS and social care budgets subject to joint arrangements with wide variations across different parts of the country in the quality and achievements of joint working.

33. Making significant progress on this agenda demands a more ambitious approach. In our view, this should be centred on aligning the £121 billion currently spent on health and social care much more closely around the needs of patients and service-users by pooling local budgets and, potentially, moving towards a single, strategic assessment of the funding needs of the NHS and social care. We welcome the inclusion of a workstream on integrated care in the next phase of the NHS Future Forum’s work and hope this will provide an opportunity to explore radical options.

\textbf{Progress on and Implications of Changes to the Tariff Structure}

34. The policy decision taken by the Department of Health to make 40\% of the savings required of the NHS through real reductions in the tariff in the acute sector is very significant (see above). We cannot comment extensively on the implications of changing the tariff structure at this stage.

35. However, we believe that perverse impacts may result from some specific changes such as the decisions not to reimburse hospitals for emergency readmissions within 30 days of discharge following an elective admission and for all other readmissions within 30 days of discharge to be subject to locally agreed thresholds, and to pay providers to support people for 30 days following discharge from hospital. Care pathways should be redesigned to reduce unplanned hospital admissions and make care closer to home a reality, but the focus should be on ensuring commissioners redesign care pathways to make this happen.

36. More radical changes to the tariff system, for example using bundled payments across pathways of care and linking payments to improvements in quality and patients’ health outcomes instead of activity, could improve incentives and benefit patients. However, it should be recognised that there are limits to the ability of Payment by Results or any pricing system to unambiguously direct providers’ behaviour.

\textit{September 2011}

\textbf{Written evidence from the NHS Confederation (PE32)}

\textbf{1. About the NHS Confederation}

1.1 The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of the different parts of the healthcare system.

1.2 We are pleased to have the opportunity to submit evidence to the Health Select Committee’s current inquiry on public expenditure. Our evidence to the Committee’s 2010 inquiry into public expenditure remains very relevant today. We have sought to provide new insight and evidence in our current submission. Our evidence draws particularly on the results of an NHS Confederation survey of NHS Chairs and Chief Executives

\textsuperscript{30} Thistlethwaite P; Integrating health and social care in Torbay: Improving care for Mrs Smith, The King’s Fund, March 2011
undertaken between 20 May and 16 June 2011, which included responses from 287 individuals from 243 organisations across the NHS.

2. Executive Summary

2.1 The NHS faces an exceptional financial challenge, requiring unprecedented savings year on year of at least 4% p.a. until March 2015 to bridge the gap between a broadly flat budget and rising demand for care. Previously, rising demand has been met through increasing the NHS’s budget, but this is no longer the case. Action to reduce demand may help, but our ability to deliver this is unproven and any benefits will take some time to materialise. Therefore other ways must be found to achieve cash and productivity savings to meet rising demand.

2.2 The NHS can meet this challenge, but needs the support of government, politicians and the public to do so. Some savings can be achieved through increasing productivity and improving efficiency and by stopping provision of some treatments, particularly those known to be less cost-effective. However, the scale of the challenge facing the NHS requires more fundamental change in the ways care is provided. Difficult choices need to be made and action taken in areas where many have hitherto resisted change. This will involve decisions on:

- How and where care is provided, which will involve new services and ways of providing care closer to home, but it must also involve concentrating some services at specialist centres and closing existing hospital beds, services and even some hospitals. Often this is likely to improve quality with better patient experiences and outcomes.
- Reducing the costs of care, particularly staff costs which represent at least 60% of NHS costs. Action will be needed on staff numbers, skill mix, pay and terms and conditions, including for front-line clinical staff.

2.3 The scale of the challenge facing the NHS is exacerbated by:

- Rapidly increasing healthcare costs, particularly for new treatments and drugs
- Higher than previously anticipated inflation
- Additional demand for NHS services, some of which is associated with cuts in local authority expenditure. In the longer term, a solution on social care funding is essential if we are to avoid the NHS buckling under the pressure of emergency and unplanned care, and delayed discharges.
- Current NHS reforms and their associated costs.

2.4 Targeting management costs can contribute to savings, but the NHS’ total management costs are a fraction of the £20bn. Good management also plays a vital role in improving productivity and overly severe cuts will harm the NHS’s capacity to deliver efficiency savings.

2.5 The scale of the savings required and the challenge is not spread evenly across the NHS, and some providers are likely to be financially unsustainable in the tougher financial climate of the NHS. Equally some commissioners will face particularly severe financial pressures. The new failure regime must not prevent providers and commissioners from doing the right thing in these situations, nor must slow decision making processes make providers unsustainable due to inertia.

2.6 Most of our members feel they can manage within their budgets and maintain the quality of care in the short term. However, a significant minority expect quality of services to decline in future. Our members thought that patient access to care is the aspect of quality most likely to worsen over the next 12 months, and waiting times are already increasing in some areas.

2.7 Most NHS organisations achieved their savings targets in 2010/11, but often in part through one-off savings. Many of the ‘easier’ savings have now been exhausted, and NHS organisations expect meeting the financial challenge to become more difficult.

2.8 The gravity of the situation is not widely understood. NHS leaders can get a grip but their task is made harder by the current environment where there is:

- A lack of political support for significant service changes.
- Misligned incentives for provider organisations.
- Lack of agreement with staff side on pay and job protection.
- Lack of clarity and low morale for NHS managers and leaders as a consequence of the proposed NHS reforms.
- A wider pressure on public services and cuts to local authority spending.

2.9 The challenge in the current environment is to ensure the NHS avoids ad hoc and short-term solutions. As financial problems become more profound, it will also become harder for individual organisations to look outwards and invest in cross-organisational collaborations that deliver more efficient, integrated, better patient

31 Picker Institute Europe NHS Confederation Members Survey Wave 2 Final Report (June 2011): 287 surveys were returned completed, representing 243 organisations. Response rates varied by type of organisation and region. Responses were received from all types of NHS body (providers and commissioners of care), and third sector and independent sector providers of care.
care. Achieving this scale of transformational change will require leadership, investment (particularly to establish new services), planning and courage. A greater effort is required to explain to the public both the benefits of change and the consequences of inertia.

3. Scale of Financial Pressure

3.1 The NHS faces significant financial challenges on a number of fronts as it responds to increasing demand for its services, particularly because of the aging population, and above-inflation increases in costs against a backdrop of widespread cuts in public expenditure and major structural reform. These pressures mean that even with its Comprehensive Spending Review settlement the NHS will still have to find up to £20bn of efficiency savings by 2015. This will require unprecedented productivity savings of at least four percent a year, with some organisations having to find much greater savings.

3.2 Our recent member survey (based on 287 replies representing 243 organisations)\(^\text{32}\) clearly indicates that financial pressures are already very real and a significant challenge for the NHS, and in some cases this is starting to impact on service quality. Forty-two\(^\%\) of our members said that the financial position facing their organisation was the "worst they had ever experienced" while an additional 47\(^\%\) said it was very significant.

4. The Financial Situation is Expected to Worsen

4.1 Many of our members believe the financial challenges will get worse in both the short-term (70\(^\%\) thought it would get worse over the next 12 months) and medium-term (67\(^\%\) thought it would get worse over the next three years).

4.2 Even organisations that have traditionally managed their finances well are likely to be under increasing financial pressure, particularly as the growth of cash funding will be significantly less than the rate of inflation. The general rate of inflation is now 4\(^\%\) which is above the rate of inflation assumed in the CSR settlement. The impact of increased fuel and energy costs is significant for providers, with fuel costs a big problem for ambulance trusts and community service providers. In addition, healthcare costs continue to rise more steeply than the general rate of inflation.

4.3 Income is being squeezed for both providers and commissioners. The average recurrent cash funding growth for PCTs for 2011–12 will be just 2.2\(^\%\) compared with the latest GDP deflator of 2.9\(^\%\), in an environment where demand for health services continues to rise. PCTs have largely met their savings targets to date. However scope for further efficiency savings by PCTs is quite limited: they have already had to cluster to run their slimmed down organisations so it is unlikely that any new savings will be achieved as a result of sharing of back-office functions/ clustering, and management costs represent a very small percentage of PCT total expenditure. They will also have to invest in the development of the emerging Clinical Commissioning Groups.

4.4 Providers face a net price reduction of -1.5\(^\%\) across all services, efficiency savings in the tariff and new rules restricting payment for emergency activity. One potential positive however is that the general lack of progress to date on structural change in areas where there is overcapacity does mean that there is still latent capacity to make significant efficiency savings in some places—though this will be difficult for reasons already described.

4.5 Despite the financial pressures, the majority of members responding to our survey (82\(^\%\)) did not expect their organisation to overspend on budget in the next twelve months. However a minority (13\(^\%\)) did anticipate an overspend, although most of these predicted an overspend of less than 2\(^\%\) of budget. Respondents from the CCG acute sector were most likely to say they would overspend their budget.

4.6 Evidence of the pressure on NHS budgets, is reflected in the Audit Commission report on the financial year 2010–11\(^\text{33}\), which showed nine out of 276 organisations (seven NHS non-foundation trusts and two PCTs) failed to achieve financial balance. The Commission identified overspends for 2010–11 ranging from one to 9\(^\%\) of turnover. However it should be noted that in a minority of cases trusts’ additional income for strategic change or financial support can obscure the underlying financial health of an organisation. We also estimate that a further 13 out of 138 foundation trusts ended 2010–11 in deficit.

4.7 Monitor’s review of foundation trusts’ annual plans for 2011–12 also highlights the growing pressures\(^\text{34}\). This shows a significant increase in the number of trusts forecasting the highest levels of financial risk ratings. Monitor concludes that trusts with the most severe financial problems will take longer to recover and the complexity of some financial issues will require long-term solutions that take time to plan and implement.

5. NHS Plans to Achieve Cost Improvement Targets/Efficiency Savings

5.1 Despite the considerable financial challenges, all NHS organisations have plans to deliver efficiency savings to achieve the target of £20bn savings by 2015:

\(^{32}\) Picker Institute Europe NHS Confederation Members Survey Wave 2 Final Report (June 2011)
\(^{33}\) Audit Commission: NHS financial year 2010–11 a summary of auditors’ work (August 2011)
\(^{34}\) Monitor: Review of NHS Foundation Trusts’ annual plans (2011–12)
— NHS foundation trusts have set ambitious targets for the reduction in operating costs for 2011–12 of 4.4%, with similar levels for following years.
— NHS organisations are developing a range of initiatives as part of the QIPP programme. These include programmes such as:
  — Achieving non-recurrent savings through querying and subsequent non-payment of contract activity (though this is savings-neutral for the NHS as a whole).
  — Improved procurement of non medical services by grouping together to achieve economies of scale.
  — Use of Enhanced Recovery experience to drive down lengths of stay.
  — Tendering of pathology services to secure efficient provision.

However, the QIPP programme does not cover all aspects of NHS care, particularly there is no formal programme for mental health.

5.2 Many parts of the NHS are making efficiency savings which both improve patient outcomes and save money. For example, mental health providers’ use of liaison psychiatry services in the acute sector. One such service is the Rapid Assessment Interface and Discharge (RAID) team at City Hospital which is jointly commissioned by Heart of Birmingham and Sandwell PCTs. This has led to improved health outcomes for patients who have mental health problems as well as another condition by promoting quicker discharge from hospital and fewer re-admissions, thus saving money.

5.3 At the same time, there is some evidence that to avoid cutting frontline services, under-spends on capital projects are being used to meet the required efficiency gains. This short-term solution is likely to lead to significant long term problems, particularly for the maintenance of existing facilities.

5.4 Recent Audit Commission and Monitor reports conclude that the NHS made good progress towards achieving savings in 2010–11:
— PCTs, NHS Trusts (excluding Foundation Trusts) and SHAs reported a total surplus of £1.5bn.
— The NHS achieved overall reported savings of £4.3bn in 2010–11 with:
  — PCTs saving £1.9bn or 1.9% of PCTs gross operating costs.
  — NHS trusts (non Foundation Trusts) saving £1.2bn or 4.3% of gross operating expenses.
  — Foundation trusts delivered cost improvement plans of 3.9% of operating costs (£1.2bn).

However, the picture is mixed with the Audit Commission estimating that almost one in five (19%) of cost savings plans were not achieved. In many cases, this was because of unrealistic plans to reduce costs and achieve efficiency savings.

5.5 Looking ahead to 2011/12, while the majority of our members (76%) were confident of achieving their QIPP or Cost Improvement savings objective, almost one in four (23%) were not very confident. Confidence was lowest among acute trusts and PCT Commissioners.

6. The Cost of the Continuing Reorganisation of NHS Structures

6.1 The latest DH estimates of the costs of restructuring associated with the NHS reforms are £1.49bn (July 2011), a significant increase on the earlier estimates. Recent changes to the proposed reforms are likely to further increase costs, including expensive locum cover and administrative support for clinicians participating in CCGs, clinical networks and clinical senates. There are concerns that these changes could also make decision-making more convoluted which would also add additional costs through a failure to realise projected savings.

6.2 We continue to reiterate our concern that a major reorganisation of the NHS at the same time as it has to make significant financial savings risks diverting attention from the key task of delivering productivity gains so increasing the danger of quality of care or control of the finances slipping. Indeed when we surveyed our members:
  — 85% of respondents identified delivering the reforms and savings simultaneously as one of their organisation’s top three barriers to achieving QIPP or cost improvement objectives.
  — 70% of respondents identified lack of certainty over the reforms as one of their top three barriers.

6.3 For some local health economies the scale of the financial challenge is increased by the requirement for PCTs to clear any legacy debt by the end of 2010–11 before transition to the planned clinical commissioning groups. As at 31 March 2011, £54m legacy debt remained across five PCTs (NHS Cambridgeshire (£17m), NHS Surrey (£16.7m), NHS Peterborough (£12.8m), NHS Buckinghamshire (£5.3m) and Bexley NHS Care Trust (£1.8m)).

35 Centre for Mental Health and London School of Economics and Political Science Draft report for the NHS Confederation Mental Health Network Economic Evaluation of the RAID Service (August 2011)
36 Audit Commission: NHS financial year 2010–11 a summary of auditors’ work (August 2011)
37 Monitor: Review of NHS Foundation Trusts’ annual plans (2011–12)
6.4 In addition to the current NHS reforms, the pre-existing requirement for community services to be separated from PCTs has meant that virtually all community services have moved to a different organisation in the last few months. Although in the longer term this offers potential for improved efficiency, in the short term providers have had to invest significant management time and resource in managing these changes.

7. Impact of Local Authority Funding on the NHS

7.1 The Committee has rightly identified the close inter-relationship between local authority budgets and the NHS. The cuts to local authority budgets are significant (7.1% pa for four years), and with a large degree of variation will have a major impact on some health economies, especially in inner city areas.

7.2 Three quarters of members responding to our survey thought cuts in local authority funding would affect their organisation’s services. Concern was particularly high amongst community providers, with 47% saying that the impact of local authority cuts would be extremely problematic, and mental health providers. Members felt these cuts would lead to increased demand and delays in discharge. In relation to efficiency savings, just over half (51%) of respondents identified cuts in local authority services as one of the top three barriers to their organisation achieving the QIPP or Cost Improvement objectives and a similar number felt that stronger partnerships with the local authority would help achieve the required efficiency savings.

7.3 The additional £1bn funding for social care being made available through the NHS budget is in the context of reduction in government grant and is not ring fenced. In some cases, this money may have been used to offset deficits in local government budgets. However in some areas, such as West Berkshire, this money has resulted in joint working between three local authorities and the new community service provider to fund rapid response and re-ablement services which are already delivering savings.

7.4 The NHS Confederation is particularly concerned about the absence of an appropriate long-term solution to social care funding. Increasing levels of unmet need are resulting from a growing older population that increasingly includes people who are very old and/or frail, a decline in the capacity of many individuals to self-fund that care as a result of the current economic situation and a tightening of eligibility criteria for social care. If a solution is not found the NHS will buckle under the pressure of demand—particularly for emergency and unplanned work, and delayed discharges.

7.5 Local authority cuts are not only affecting mainstream social care services but also some of the other community support services and voluntary sector initiatives. There are numerous examples of significant cuts, for example Third Sector reported in July that Croydon Council was planning to cut grants to local voluntary organisations by almost 66% over four years. Our Mental Health Network reports that their voluntary sector members are experiencing significant reductions in local authority funding and losing contracts. Where initiatives to support particularly vulnerable sections of the community are cut this is likely to result in people turning to NHS to meet their immediate support and care needs.

7.6 If we are to deliver the most efficient services and best outcomes for people, both the NHS and local government are very aware that we must avoid cuts which simply result in shifting costs from the local authority to the NHS and vice versa. However the gravity of NHS organisations’ and local authorities’ financial situations mean this is still happening in some places. For example, members of our Mental Health Network already report growing numbers of local authorities withdrawing from integrated older people’s and other adult services. We are concerned that as financial problems become more profound, it will become harder for individual organisations to look outwards and invest in cross organisational collaborations that deliver more efficient, more integrated, better patient care.

7.7 At the same time as facing significant cuts to their budgets, local authorities are also taking responsibility for some aspects that were previously the responsibility of NHS organisations, most notably public health. While local authorities will receive a ring-fenced budget to cover their public health activity we are concerned that this will become the only expenditure on public health activity and that existing local authority activity on wellbeing will no longer be funded due to overall budgetary pressures.

8. Progress on and Implications of Changing the Tariff Structure

8.1 Greater competition for the provision of NHS services has implications for what services are on tariff and how that tariff is structured. A significant expansion in the scope of payment by results is planned, which is intended to gather pace in future years. While this is welcome, it is important to understand the lead time for tariff development is lengthy so impact of these plans will inevitably be slow. We also remain concerned about the limitations of the structure of current tariffs. For example, the revised Health and Social Care Bill emphasises integrated care but current tariff structures do not very effectively incentivise integrated services. It is important that the tariff allows ‘bundling’ of services where interdependence is needed, for services such as long-term conditions.

8.2 A significant proportion of services (particularly mental health and community services are not on tariff) and are still on block contracts. In 2012–13 the expansion will focus mainly on currencies rather than mandatory tariffs, meaning the majority of non-acute services will continue to remain outside of tariff. Providers of services which are not covered by tariff have expressed concerns that this leaves them exposed to having to make greater budget reductions than providers whose services are covered by tariff. There are commitments
from the Department of Health for the development of tariffs for mental health and for community services as part of the any willing provider policy, however we know this will be difficult to achieve and that badly designed tariffs can lead to unintended consequences for providers and commissioners. Tariff development is technically complex and we are concerned that there should be a commitment to make available the level of resources necessary to develop and extend the tariff effectively.

9. **The New Failure Regime for Providers**

9.1 The NHS Confederation has argued that the government must publish details of how the failure regime will work. This is a highly complex area in which most if not all policy solutions have potential downsides. However based on our initial analysis of the details announced on 1 September we have a number of questions and concerns about how the new regime will work in practice.

9.2 Under these proposals Monitor will make fundamental decisions affecting the sustainability and future of individual services and the pattern of local NHS provision and we are concerned that it is unclear how Monitor will take these decisions and how it will be held accountable. We are also concerned that some of the proposals -eg the power to increase tariffs where a provider is in financial difficulties—simply pass the problem from the provider to the commissioner. This begs questions about the commissioner failure regime which is unclear.

9.3 The intended new decision-making processes for service changes to deliver recovery appear to be as complex and cumbersome as the current processes—and may even be more complex with the involvement of health and wellbeing boards and clinical senates. We need to make sure that slow decision-making processes do not make providers unsustainable due to inertia. It will also be important to ensure that the failure regime offers clear solutions and does not prevent providers and commissioners from doing the right thing in situations where overcapacit in the system is making providers more likely to fail.

10. **Capital Funding Remains a Significant Problem**

10.1 Some parts of the NHS faces significant financial costs associated with PFI schemes, which were used to overcome broader capital financing issues. These have left some providers with large PFI debt and fixed financial obligations, which may prove difficult to meet. In some cases, the level of PFI-debt may make it almost impossible for the provider to achieve foundation trust status.

10.2 Most PFI schemes were planned at a time when future NHS income for most NHS providers looked stable. However, the current reforms envisage greater competition for provision for NHS services both from other NHS organisations and new providers of NHS services, as well as the movement of services out of hospital into community based or primary care settings.

10.3 Under the CSR settlement, the capital spending limit for the NHS will decrease from £5.1bn in 2010–11 to £4.4bn for the next three years. The Chancellor has indicated that the focus of capital projects will be essential maintenance and equipment alongside some priority hospital schemes. These strict limits on capital spending will make it extremely difficult for the NHS to secure the investment necessary to replace unsustainable buildings or to support service reconfigurations. Future PFI projects are unlikely to be the answer and accessing this capital commercially will be extremely expensive. The NHS Confederation previously outlined to the House of Commons Treasury Select Committee as part of its inquiry into PFI the case for an NHS banking function, which could provide the necessary collateral to support a wide-ranging investment programme in the medium term38.

10.4 We have previously told this Committee that current tariffs do not adequately reflect the cost of capital as they are based on historic costs, which reflect a significant number of fully depreciated buildings that are not fit for purpose rather than reflecting the real costs of a modern, fit-for-purpose estate. The treatment of capital costs in the tariff must be changed to enable investment in modern facilities that are fit for purpose and the new patterns of service provision that will be required to achieve the level of efficiency savings needed. However such an approach could not be allowed to simply increase the overall cost of care as this would be unaffordable.

11. **Our Members are Concerned that Savings will Affect Quality**

11.1 Our survey indicates the majority of our members remain confident that the quality of services will continue to improve despite the financial challenges (58% of respondents thought service quality would improve over the next 12 months and 51% over the next three years).

11.2 However, there was not universal confidence that the NHS will be able to maintain the current quality of services in the short to medium term, let alone improve service quality. A significant minority (20%) felt quality would decrease over the next 12 months, while 30% expected service quality to decline over the three years. Community providers were the least optimistic about improving the quality of services in the next 12 months (just 35% thought it would improve), while PCT commissioners were the least optimistic about quality improving over the next three years (just 30% thought it would improve).

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38 NHS Confederation Supplementary Evidence to the Treasury Committee’s PFI Inquiry (June 2011)
11.3 Over half of all respondents (53%) felt that patient access would get worse. A third thought the quality of patient experience would deteriorate over the next 12 months.

12. **How can the NHS Make Efficiency Gains in Future?**

12.1 A proportion of the savings made in 2010/11 were one-off savings\(^{39}\). The savings targets are also increasing each year. So NHS organisations will have not only have to find new areas of savings in future years but also further additional significantly higher levels of savings in new areas in every future year. The implications of the choices that will increasingly be involved is not widely understood.

12.2 Broadly, the NHS can reduce costs or improve productivity in four main ways:

- reducing the costs of care, which are predominantly staffing costs.
- redesigning the way services are organised.
- increasing productivity or improving efficiency.
- reducing the range of services offered.

These sorts of changes are challenging for the NHS to deliver and can often be contentious with groups of clinical staff and with the public. They need to be managed well and to be properly evidence based. They also take time, which is starting to run out so action is urgent.

12.3 These kinds of changes become impossible without political support. The alternatives however are far worse. Without action, the NHS as a whole will start to overspend leading to serious compromises in quality. We therefore urge politicians—local and national; government and opposition—to start to make the case for change, to understand the difficulties in delivering this change and to back the leadership of the NHS to deliver it.

12.4 The honest discussion that will be required with the public about the financial challenges the NHS faces will also present a significant opportunity to engage the public more in thinking about how they use NHS resources over the longer term. One way of making this happen could be to develop the ‘care footprint’ idea, akin to that of the carbon footprint, to raise public awareness of the costs involved in the avoidable use of services against a backdrop of restricted health budgets.

13. **Reducing the Costs of Care**

13.1 Many of the savings in staff costs so far can be attributed to reductions in management costs. However, the total efficiency savings required across the NHS are far greater than the NHS’ total management costs. High quality management and leadership are crucial to providing effective and good quality services to patients and achieving efficient and well-run services, so seeking to reduce management costs too far would be counter-productive.

13.2 Despite government promises to protect front-line services, inevitably some of the savings will affect front-line staff. Pay and workforce costs represent the largest proportion of the running costs of organisations providing NHS care (we estimate between 60- 70% of overall running costs).

13.3 The pay freeze for most NHS staff (saving approximately £1–1.5bn over two years) and changes to the NHS pension will help to reduce costs. However, the commitment to continue paying annual increments is still adding pressure. We also note that pay freezes or reductions can damage industrial relations and create shortages of trained staff or recruitment difficulties, which disrupt services.

13.4 The NHS has also begun to reduce its headcount, largely through not filling vacancies though in some cases this will be the result of the effective redesign of services. Some of these savings were non-recurrent, often as result of temporary vacancy freezes. Other key savings include reducing overtime costs, reductions in the use of bank and agency staff, and changes to staff grade mix. For example, one trust has reduced its spend on agency staff by 26% through better sickness management.

13.5 We note that the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust may recommend defined staffing numbers or ratios for key hospital services, and while this could be an effective way of ensuring quality and safety are maintained it could also significantly increase costs in some places.

14. **Addressing Patterns of Service Provision**

14.1 Historic patterns of service provision focused on local district general hospitals do not necessarily reflect current healthcare needs (especially the growing older population living at home with long-term conditions), modern healthcare technology or the challenges of providing appropriate and adequate medical cover at all times to comply with the European Working Time Directive.

14.2 For a number of reasons, it will be necessary to close some services or even possibly whole hospitals, with associated staff redeployment, retraining or redundancy.

\(^{39}\) The Audit Commission estimates that 23% of savings were non-recurrent (Audit Commission: NHS financial year 2010–11 a summary of auditors’ work (August 2011))
— In some areas there is an intrinsic over-supply of services which needs to be tackled systematically and thoughtfully.
— We need to release resources from some existing health services to invest in others.
— Some acute providers are not financially sustainable in their current form, particularly if they are to attain foundation trust status.
— Evidence shows that concentrating certain services (for example, trauma and stroke services) in specialist centres significantly improves safety and outcomes for patients.
— Some services could be better provided closer to, or at, home.

However, achieving public and clinical support for such changes is often extremely difficult. A greater effort is needed to explain to the public both the benefits of change and the consequences of inertia.

14.3 A recent independent review of health services in North Yorkshire and York commissioned by the strategic health authority demonstrates how it is possible to develop a clear, evidence-based plan that brings together all the players across a local health economy to build a sustainable solution. As well as tackling significant historic financial problems the review’s recommendations seek to maintain quality and care while achieving savings of approximately £230m (20%) by 2015. Recommendations include redesigning models of care, extending and improving community services, making more use of telehealth and other assistive technologies, redesigning the journeys patients take through the system, and more preventative work. Successful implementation will require cooperation across geographical, professional and organisation boundaries. With the abolition of SHAs and PCTs, there is a concern about who will provide the necessary leadership and support for such major, systematic service change. Additionally, as financial challenges increase, will individual organisations be willing to cooperate across organisational boundaries to achieve more fundamental gains or cost savings that do not directly benefit their organisation?

15. INCREASING PRODUCTIVITY AND OTHER EFFICIENCY GAINS

15.1 There is plenty of evidence that the NHS is not uniformly efficient (eg variation in day case rates, lengths of stay) and significant improvements in productivity and efficiency could be achieved across the NHS. The majority of savings achieved in 2010–11 identified by the Audit Commission (51%) were attributed to clinical productivity and efficiency gains, such as demand management, reduced length of stay, moving to day case surgery or outpatient treatments, bed closures and contract renegotiation.

15.2 Managing the supply chain and reducing variation in prices is one area where the NHS can still achieve efficiency savings and potentially improve quality through greater standardisation. Many organisations are paying more for drugs, medical technologies and facilities than they should and action on this is potentially an easy win but does require effective collaboration between provider organisations. Examples of good progress in this area include work done by UCL Partners on effective procurement, and the North West Collaborative Contracting Agency.

15.3 Significant gains in productivity and cost savings can be achieved through changes in clinical practices. Our report Clinical Responses to the Downturn involved eight different specialist groups of clinicians who recommended a range of ways in which clinical practice in their specialist areas could contribute to cost savings and efficiencies. These included some common themes such as:

— Reducing inappropriate referrals to secondary care through better guidelines for GPs and other primary care clinicians.
— Development of care pathways to facilitate better care planning and clearer distinctions about what should be done in primary care and secondary care.
— Separation of elective and emergency activity.
— Better discharge planning.
— Stopping unnecessary and duplicate testing or diagnostic procedures.
— More efficient use of theatre time.
— Improved procurement of devices.
— Consistent approaches to procedures or techniques of low/ questionable value.

15.4 However the NHS must tackle a number of challenges in achieving sustained productivity gains, including:

— Difficulties in securing effective clinical engagement.
— Finding the money to invest in new services to deliver long term savings whilst also paying for existing services. For example, investment in a falls prevention service will take time to show benefits in reduced hospital admissions or demand for orthopaedic services.

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41 Audit Commission: NHS financial year 2010–11 a summary of auditors’ work (August 2011)
16. REDUCING THE RANGE OF SERVICES OFFERED

16.1 The NHS continues to look to stopping low value clinical interventions or increasing thresholds for treatment for others as a way of achieving significant savings.

16.2 The Audit Commission report \(^{42}\) *Reducing spending on low clinical value treatments* estimates that PCTs could save between £179m to £441m if they reduced their spending on low clinical value treatments. It supports this work with a tool based on the “Croydon list of low priority treatments”. However, it is important to recognise the impact that not undertaking the procedure can have on the individual’s quality of life, particularly their ability to remain independent, and the potential demand for other health and social care services that may result. Such action is often resisted by clinicians affected and unpopular with the public, but a more holistic approach to these decisions is likely to increase their acceptability to both clinicians and patients.

16.3 Developing evidence based clinical guidelines is the best way of securing disinvestment in procedures and techniques that are of low clinical value. The National Institute for Health and Clinical Excellence has a key role to play in this area, and already produces “don’t do” lists and recommendation reminders. The potential value of such advice in a more decentralised commissioning environment will be considerable, particularly as a way of tackling unexplained variations in care and increasing fairness between patients. NICE will need to grow its role in working with the medical royal colleges to establish an effective evidence base to facilitate the take-up of cost effective treatments.

*September 2011*

Additional written evidence from the Local Government Association and the Association of Directors of Adult Social Services (PE 35)

The LGA was pleased to give oral evidence to the Health Select Committee last month on public expenditure and welcomes the opportunity to provide a further written note on two of the Committee’s specific questions. This note has been prepared in collaboration with the Association of Directors of Adult Social Services and uses information captured from their annual budget survey.

We believe that the Health Select Committee is looking primary at one side of the expenditure puzzle (amount of funding), but not picking up the other side; demand and the sector’s cost pressures (activity/unit costs of complex need/inflation).

**DEPARTMENT OF HEALTH EVIDENCE**

*Provisional data on actual adult social care expenditure in 2011–12 will be available in the autumn of 2012. However, in the interim the Department is monitoring budgeted expenditure data. The Department for Communities and Local Government published 2011–12 budgeted expenditure data on 30 June 2011. This showed that budgeted net current expenditure on adult social care was £14,898 million for 2011–12, compared to £14,439 million in 2010–11.*

*These two figures are not directly comparable as local authorities have taken responsibility for commissioning services for people with learning disability from PCTs, funded through the £1.3 billion Learning Disabilities and Health Reform grant. The 2011–12 figure also does not include the additional income of £648 million received by local authorities from PCTs for spending on social care services that benefit health.*

*Adjusting the data for these two funding streams suggests a like-for-like budgeted net current expenditure of £14,220 million in 2011–12. This represents a budgeted spending reduction of just over £200 million—or around 1.5%—compared to last year.*

**OUR RESPONSE**

The adjusted level of “budgeted spending” shows a reduction of £200 million (approximately 1.5%) between 2010–11 and 2011–12; it does not adequately explain the gap between funding levels and the cost of adult social care. The ADASS budget survey asked local authorities to directly identify areas of adult social care savings required to enable Local Authorities to set a balanced budget for 2011–12. The adult social care savings of £991 million (6.9%) are real savings proposals developed by local authorities and are required to meet:

1. Reduction in funding to local authorities from central government.
2. Growth in demand for services (demography), which is represented both in an increased number of people with needs requiring adult social care support and the unit cost of support for people with very complex and profound disabilities.
3. Inflation/cost pressures of adult social care services.

\(^{42}\) Audit Commission “Reducing spending on low clinical value treatments” Health Briefing, April 2011.
For 2011–12 and 2012–13, no authority will face more than an 8.9% reduction in spending power (including income from council tax and NHS support for social care), with an average reduction in spending power for 2011–12 of 4.4%.

Our Response

The ADASS budget survey identified adult social care savings for 2011–12 were £991 million. This saving expressed as a percentage of the budget which adult social care would have had for 2011–12 before savings is 6.9%.

The reduction in spending power for local authorities is part of the picture. Adult social care also needs to meet demand increase for demographic pressures whilst also managing an adult social care market which has inflation/cost pressures. A proportion of the 6.9% ASC savings is needed to meet these expenditure pressures.

Conclusion

In line with our oral and written evidence—and the additional information provided above—our position remains the same; the sector is facing an extremely challenging situation with regards to funding and we anticipate having to deal with a significant funding gap. Because of this, it is imperative that the government deals with both structural reform and funding reform in the forthcoming White Paper. We are clear that reform cannot happen without additional resources and, vice-versa, a more adequately funded system will not succeed without necessary structural reforms.

October 2011

Supplementary written evidence from the Department of Health (PE 01A)

At this year’s public expenditure inquiry hearing, held on 11 October, I promised to provide further detail to the Committee on two specific issues that were raised, namely:

— spend on management consultants; and
— the arrangements that HM Treasury have made to allow departments to carry underspends over from one year to the next in this Spending Round.

Expenditure on Management Consultancy

Table 1 shows a time series of expenditure by the Department of Health on management consultancy (2008–09 to 2010–11).

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<thead>
<tr>
<th>Year</th>
<th>Expenditure (£ million)</th>
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<tbody>
<tr>
<td>2008–09</td>
<td>102.0</td>
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<tr>
<td>2009–10</td>
<td>108.0</td>
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<tr>
<td>2010–11</td>
<td>9.8</td>
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Further, you asked for specific recent expenditure with McKinsey. In 2010–11, the expenditure was £139,000. Total expenditure to date with McKinsey in 2011–12 is £200,300. This is a closed contract and was for analysis of the viability of pipeline trusts achieving foundation trust status.

Underspend

The current government inherited a system of End Year Flexibility (EYF), which allowed departments to carry forward unspent budget provision into future years across Government. This system had led to an accumulated EYF entitlement of around £20 billion, which, if spent, could not have been met by underspends elsewhere and so would have further increased the deficit. As a result, the Treasury had to limit allocations of EYF on the basis of need, realism, and the wider fiscal position. The system of EYF was abolished formally in the Spending Review 2010.

However, the Department of Health has annually honoured underspends within the NHS, allowing underspends to be carried over as EYF and making provision for these within its budget. The Department has published the levels of EYF that the NHS is expected to draw down in the Operating Framework in each year.
Going forward, Treasury have announced that a new regime of Budget Exchange will be introduced from 2011–12, to replace the EYF system. In Budget 2011, the Chancellor said that:

“The Government announces the introduction of a new Budget Exchange system from 2011–12 to replace the End Year Flexibility system which has now been abolished. This will provide departments with flexibility to deal with slippage in expenditure while strengthening spending control. Budget Exchange will allow departments to surrender an underspend in advance of the end of the financial year in return for a corresponding increase in their budget in the following year, subject to a prudent limit”.

The Treasury will publish further details around Budget Exchange in due course.

In the years after 2011–12, the Department will be able to take advantage of the new Budget Exchange system that will provide flexibility while maintaining firm control of spending.

I hope that this further evidence provides you with the answers to your queries.

Andrew Lansley CBE MP
October 2011

Further written evidence from the Audit Commission (PE 19A)

The Audit Commission is a public corporation set up in 1983 to protect the public purse.

The Commission appoints auditors to councils, NHS bodies (excluding NHS Foundation trusts), police authorities and other local public services in England, and oversees their work. The auditors we appoint are either Audit Commission employees (our in-house Audit Practice) or one of the private audit firms. Our Audit Practice also audits NHS foundation trusts under separate arrangements.

We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.

The Audit Commission’s Response

Summary

1. In its inquiry into public expenditure, the Health Select Committee wished to consider the progress on and implications of changing the tariff structure. In the Audit Commission’s submission, we indicated that our work on the assurance of 2009–10 reference costs at all acute trusts was relevant to this matter and we promised to send the Committee further details, once our report was published. We are now able to do so.

2. The main findings from our work, relevant to the Committee’s inquiry are the following.

   — We found that most trusts’ reference costs submissions were materially accurate at the total aggregate level. However, the accuracy of individual unit costs varied and, sometimes, could be poor.

   — Unit costs for items already covered by Payment by Results (PbR) were usually accurate. Most of the errors occurred in services not yet covered by PbR, such as community services, chemotherapy and other specialist areas.

   — Extending the coverage of PbR to these areas is a key Department of Health (DH) policy. However, the data is often of such poor quality and the spread of unit costs so wide that developing a tariff using reference costs will be potentially impossible without a significant improvement in data quality. This will not be easily achieved as much of the data comes from non-standard patient administration systems. The problems are unlikely to be addressed in time for the 2015–16 tariff.

   — The DH, NHS Commissioning Board and Monitor should explore different ways of tariff setting that do not rely on reference costs. They should also investigate whether different forms of payment—based on episodes of care or populations—offer an easier way to implement new payment systems and a better way to incentivise more efficient, higher quality care.

3. A copy of the full report, Improving Coding, Costing and Commissioning, is available to download from our website www.audit-commission.gov.uk.

Detailed Response

Introduction

4. In 2010–11 the Audit Commission undertook the first comprehensive review of reference costs in seven years, auditing the 2009–10 reference costs submissions at all acute NHS trusts and foundation trusts in the country. This followed a pilot review in 2009–10. The Audit Commission last reviewed reference costs submissions in 2004 as part of its then programme of data quality reviews.
5. Reference costs are a nationally mandated data submission that calculates the average cost to a trust (and therefore the NHS) of providing a defined service (such as a hip replacement) in a given financial year. In 2009–10, reference costs described how the NHS spent over £51 billion.

6. The primary national use of reference costs is to inform the national tariff setting process for PbR. This ensures that tariffs properly reflect the national average cost of activity for each Healthcare Resource Group (HRG). In 2010–11, PbR covers approximately £28.9 billion or 32.4% of PCT spending or, on average, 62% of acute trust provider income.

7. The DH plans to extend PbR to a number of new services: adult mental health (approximately £10.7 billion), adult and neonatal critical care (£2.2 billion), chemotherapy (£0.8 billion), ambulance services (£1.6 billion), renal dialysis (£0.5 billion) and some community services. Our findings have implications for tariff development in some of these areas. For example the following.

— A new national data set and tariff is planned for community services, but our findings suggest implementing both will be difficult for most organisations.
— There is national interest in developing a chemotherapy tariff, but chemotherapy has a wide variation of costs delivered across many settings.
— Critical care and coronary care use many different service models and tariff development has been consistently difficult in this area.
— Recently the DH introduced HRG4 for costing and for payment, which more than doubled the number of HRGs used. However a full implementation of HRG4 for payment was not possible in some areas because of problems with data quality.

8. Issues identified with reference cost data quality need to be addressed quickly if they are to have an impact on the accuracy of future national prices. Based on the current timetable, tariffs for 2014–15 will be set using costs in the current financial year (2011–12). It is unlikely the defects we identified in data quality in current non-tariff areas will be sufficiently addressed in time for 2014–15 tariffs or indeed those for 2015–16.

A summary of our reference cost assurance work

9. The objectives of the 2010–11 national programme of reference costs audits were to:

— form a view on the data quality and therefore accuracy of individual 2009–10 reference costs submissions from acute and specialist trusts;
— identify problems and areas for improvement for trusts and PCTs; and
— identify national messages and best practice.

10. The Audit Commission surveyed all PCTs and acute, mental health and ambulance trusts to understand their uses of reference costs. We found that over 90% of respondents used reference costs locally, in particular, to inform pricing and activity levels for the non-tariff parts of local contracts. However, respondents in both our and the DH’s reviews expressed concern about the quality and accuracy of reference costs submissions, affecting confidence in the PbR tariff.

11. Our auditors also reviewed all acute trusts to identify:

— the organisational arrangements for ensuring the accuracy of submissions;
— the accuracy of the total cost quantum used;
— the quality of activity reporting by service; and
— the accuracy of individual unit costs.

12. Auditors reached two judgements on each trust’s 2009–10 reference costs submission:

— the accuracy of the trust’s overall reference costs submission: whether the total activity and total costs used within the submission were materially accurate; and
— the accuracy of individual unit costs: whether one or more unit cost was materially incorrect.

13. We found that most trusts’ reference costs submissions were materially accurate at the total aggregate level. However, the accuracy of individual unit costs varied and, sometimes, could be poor. One quarter of trusts had one or more individual unit costs that were materially inaccurate, and the audits resulted in three-quarters of trusts having recommendations to review their cost allocations in one or more areas.

14. Unit costs for items covered by the tariff were usually accurate. Most of the errors occurred in services not yet covered by PbR, such as community services, chemotherapy and other specialist areas. Most of the errors were the result of weaknesses in recording activity.
15. For example, one trust overstated the activity of a single high cost drugs HRG by 55 times—recording activity of 1.2 million when it should have been 23,277. This resulted in a national reference cost of £4. Without the trust’s data it would have been £521. This year, the DH have used our findings to exclude some trusts from the reference costing exercise.

16. Extending the coverage of PbR is a key policy for the DH. However, the data is often of such poor quality and the spread of unit costs so wide that developing a tariff using these reference costs will be potentially impossible without a significant improvement in data quality. To do so would need significant investment as much of the relevant activity data comes from non-standard patient administration systems. In addition, the wide variance in unit costs in some areas suggests that a single tariff may not be suitable for some services at the moment.

17. These findings have local implications as contracts in non-tariff areas are often based on reference cost data from the providing trust.

Chemotherapy: suitability for a national tariff

18. The figure below, taken from our report, shows a breakdown of unit costs for one chemotherapy HRG. For tariff setting the majority of activity and costs should group into a single cost band. The figure clearly shows activity and costs ranging from under £500 to over £3,000, with no clear indication of the suitable cost band for this activity.

19. Not only would commissioners be charged inconsistently across the country for this activity compared with current payments, but setting a tariff based on such a spread of costs would be inappropriate. The national average of costs is not representative of most of the trusts in the sample. This issue cannot be corrected by simply excluding outliers. It requires a more fundamental review of how the setting of care is categorised and less variation in trusts’ efficiency of delivery.

![Figure 2: Unit costs and activity levels for SB09Z - Procure chemotherapy drugs for regimens in band 9](image)

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20. Our findings show that the current method of cost collection for services already within the scope of PbR, is accurate enough. Whilst there is always scope for improvement, radical innovation is not necessary in this area. However, our findings also show that the same methods of cost collection—combined with poor activity recording—are inadequate for the purposes of extending the scope of PbR into new areas.

21. The DH, NHS Commissioning Board and Monitor should concentrate on these areas. Specifically, they should explore different ways of tariff setting that do not rely on reference costs. Another approach would be further development of the PbR system by disaggregating problematic HRGs into less heterogeneous groups of treatments or services.

22. They should also investigate whether different forms of payment—based on episodes of care or populations—offer an easier way to implement new payment systems and a better way to incentivise more efficient, higher quality care. Whichever approach is chosen, good data quality will always be a basic requirement.

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— any director/member or officer in their individual capacity; or
— any third party.

October 2011

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**Supplementary written evidence from NHS Confederation (PE 32A)**

As you may recall, when Jo Webber and I gave oral evidence to the Committee’s public expenditure inquiry on 13 September 2011 I undertook to clarify the proportion of hospitals’ income which was tariff.

I stated that around 60% of acute activity was covered by the tariff. This figure is supported by the December 2010 National Audit Office report, “Management of NHS hospital productivity” which stated, “in 2010 around 40% of hospitals’ income is not covered by Payment by Results” (page 7). It is worth noting, however, that the proportion of a provider’s activity which is covered by the tariff varies significantly because some services (for example, ambulance services and many community and mental health services) are not on tariff. I hope this clarification is helpful.

September 2011