

House of Commons Health Committee

Public expenditure on health and social care

Seventh Report of Session 2013–14

Report, together with formal minutes relating to the report

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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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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.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/healthcom and by The Stationery Office by Order of the House.

Evidence relating to this report is published on the Committee's website at www.parliament.uk/healthcom.

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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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Summary

The need for the NHS to achieve 4% year-on-year efficiency gains has been the dominant issue for the Committee throughout the Parliament as it has looked at expenditure issues. In this inquiry, evidence has indicated that the straightforward savings have been achieved and that little progress has been made on transformative change. The conclusions that we draw from this evidence are that:

- the NHS has provided savings during the first two years of the programme, but that there is a question mark about how sustainable they are
- the straightforward savings which are possible have now been made, and
- the transformation of care that will be required to make the NHS sustainable in the future and able to deal with increasing demand has yet to take place.

On this final point, the key question, raised in evidence, is not 'what has been saved?' but rather 'what has the money "saved" been spent on?'. That is currently not transparent, and more needs to be done to demonstrate what new activity has been possible because of the gains of the efficiency process.

Pay restraint

In our report last year the Committee said that "although pay restraint is undoubtedly key in the short term, it is neither prudent nor just to plan for sustainable efficiency on the basis that NHS pay continues to fall relative to pay elsewhere in the economy". Pay restraint has contributed substantially to the efficiency programme but, as the Secretary of State told us, "we cannot constantly rely on the kind of pay restraint that we have had to date". The Committee welcomes the Government's recognition that the future of the health and care system cannot be built on an open-ended pay freeze. If the health and care system is to be a good employer (which it needs to be if it is to deliver high quality care) it needs to undertake transformative change in order to ensure that its committed staff are better able to meet the needs of users of its services.

Allocation of resources

The allocation of funds and the formulae used to do it will always be contentious. The Committee acknowledges that NHS England has set out its plans both transparently and in good faith. In a system in which there is a limited increase in funding, however, it becomes even more difficult to make changes to allocations than in times of plenty. The concept of target funding is as old as the NHS itself. Although the formula will continue to change, with the result that the day when all CCGs receive their target funding will never arrive, the Committee endorses the general approach while recognising that there will always be debate about how quickly actual funding should close the gap with target funding. It is clearly more difficult to make meaningful progress when the overall budget is largely stable

in real terms.

Trusts and Foundation Trusts

This is the fourth report which the Committee has issued during this Parliament on the implications the Government's spending plans for health and care services. In each report we have drawn attention to the urgency of transformative change of the care model if the needs of patients are to be met. The fact that the number of NHS Trusts and NHS Foundation Trusts reporting underlying deficits continues to grow represents evidence that the pace of change has not been sufficient to meet the challenge.

Integration of health and social care

The problem at the heart of the desire for greater integration between health and social care is that the NHS, although coping with a static budget for the first time in its history, is better funded than social care. Social care authorities are facing reduced budgets and rising demand. Improved integration in these circumstances therefore requires a switch in funding from health services, particularly those in the acute sector, towards community-based services and social care. The challenge is to achieve this without destabilising existing services so that they can no longer function effectively before new arrangements are in place, leading to gaps in care for patients.

The Committee welcomes the emphasis which the Government is now putting on service integration, both within healthcare services and between healthcare and social care. The Committee also recognises the logic of creating the Better Care Fund to provide and incentive for health and social care authorities to cooperate in new ways and facilitate the transfer of resources into community services with is a necessary part of the change process.

The Committee remains concerned, however, that the pressures on available resources across the whole system, but particularly in social care, are now much greater than they were a few years ago, with the result that successful integration of high quality health and care services represents a substantial and growing challenge. We continue to believe that fragmented commissioning structures significantly inhibit the growth of truly integrated services. We have recommended in previous reports that Health and Wellbeing Boards (HWBs) should be encouraged to develop their role to provide an integrated commissioners' view of the transformative change which is necessary in the health and care system. We repeat that recommendation in this report and further recommend that NHS England and the Local Government Association should commission a review to establish the best practice method of consolidating the commissioning process through HWB's with minimum disruption of ongoing activity.

The Committee also repeats the recommendation it made last year that the current level of real terms funding for social care should be ring-fenced. As we said in our report last year, this would "ensure that resources were no longer seen as 'belonging' to a particular part of the system but to the local health and care system as a whole". We believe that in the

absence of stronger commissioners and a commitment to ring-fenced real terms funding for health and social care, there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead.

Reconfiguration

Integration will also require reconfiguration of services. Advocating service integration without recognising that the consequence of integration is reconfiguration of acute services is simply dishonest. The case for acute service reconfiguration is often presented as an economic necessity, but that is only half the story. It is certainly true that economic pressures mean that changes in acute services are necessary if the health and care system is to meet the demands placed upon it. The argument for reconfiguration, leading to reduced emphasis on acute services, is however supported by considerations of clinical quality as well as economic pressure. Our system currently places insufficient emphasis on identifying early symptoms and supporting normal life, with the result that it has provide reactive acute care to patients whose condition should never have been allowed to become acute. The challenge facing NHS policy makers, at both national and local level, is to explain this underlying policy requirement to a sceptical public.

Changes which lead to the closure of hospitals or remove services from hospitals are notoriously controversial with local communities. Too often this is because the first a community hears about proposed changes is when the acute facility is proposed for closure. If these proposals are notoriously controversial, it is too often because the case for change is notoriously badly made.

Part of the benefit of involving Health and Wellbeing Boards in the commissioning decisions about health and care, with a single overview for a given community, should be to engage the local professional and lay communities in a greater understanding of the care quality issues which underlie the case for service reconfiguration, as well as the economic issues involved.

System leadership

It is unclear who will take the lead on system change on a local or regional level. The Committee was told that with more organisations in the system, none of which are big enough or influential enough to shape the system, strategic change will have to be brought about through collaboration "which, history suggests, tends to be less effective". There is a real danger that, without a body which can take charge of decisions about reconfiguration and integration of services, change which needs to be made to maintain and improve services will not happen. The evidence we heard in this inquiry confirms to us that, in the present system, this is the most viable approach to ensure continuity of and improvement in services.

Health and Wellbeing Boards were established by Parliament to enable commissioners to take a view across the whole of a local health and care economy. In the light of the urgent need to increase the pace and scale of service reconfiguration in the health and care system,

the Committee repeats the recommendation it has made in earlier reports that the role of HWBs needs to develop to allow them to become effective commissioners of joined-up health and care services.

Competition

There was a consensus amongst witnesses that the most significant issue in relation to competition was the potential extended delays to mergers designed to improve quality of service for patients. Witnesses from Monitor, the Local Government Association and the NHS Confederation all agreed that in competition matters the essential requirement was that decisions on mergers and other competition issues should be taken without undue delay. We were told that "whatever process we have in place needs to both assure competition and act speedily in the interests of the system".

For reasons of both financial viability and quality of service, the OFT and Competition Commission need to ensure that their decisions on mergers are reached as quickly as possible. They should also have regard to the principle legislated for in the Act in respect of Monitor that it must allow 'provision of services in an integrated way' where this improves quality of provision or reduces inequalities in relation to access to services or to outcomes.

In September 2013, Sir David Nicholson was quoted as saying that competition was not working to improve quality from patients and that a change in the law might be needed to ensure the intent of policy was implemented. It is clearly significant that less than six months after the Act came into force, the Chief Executive of NHS England has said in terms that this key aspect of the Act is not working as had been intended and that competition rules are impeding changes that would provide a better service to patients. We have also heard that some commissioners are concerned by uncertainty about those provisions, which is inhibiting the way in which they commission services. This is clearly an unsatisfactory situation.

The Secretary of State told us that he did not consider that there was a case as yet for seeking to change competition law. The Committee is concerned, however, that in the case of Bournemouth and Poole the competition authorities intervened to obstruct a proposed service reconfiguration on competition grounds without being able to substitute another proposal to deliver service change. The Committee has stated its view many times that there needs to be an increase in the pace and scale of service change. The Committee recommends that the Government should examine the background to the Bournemouth and Poole proposal in order to ensure that unnecessary impediments to necessary change are removed.

"Cherry-picking"

Another issue that we discussed in evidence was the suggestion that some providers select patients whose treatment is straightforward, leaving others with more complex needs to be treated by the default NHS provider on the same tariff. The concern is twofold:

- Firstly, that the rigidity of the tariff system leads some providers to overpaid, and others to be underpaid, with potentially serious consequences for the both the availability and quality of patient care; and
- Secondly, that the transfer of care of some patients to other treatment centres may undermine the viability of the original unit.

It is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement.

Introduction 1

- 1. Throughout this Parliament, the Committee has argued that the main issue facing the NHS and social care is the funding situation and the impact that it has on services. This report contains our latest review of the financial situation of the health and care system and our commentary on how best to utilise resources to meet demand.
- 2. The Committee issued the following call for evidence for this inquiry on 9 October this year:

"In its work during this Parliament the Health Committee has consistently underlined the importance of the "Nicholson Challenge"-in which Sir David Nicholson, with cross party support, spelt out the requirement for health and social care services to achieve 4% year-on-year efficiency gains to allow them to meet rising demand for care through a period of minimal real resource growth.

The Committee published reports in December 2010, January 2012 and January 2013 which examined the progress made towards delivering this objective.

The Committee plans to return to the subject this autumn. In its inquiry the Committee will consider, amongst other issues:

- The plans being made by NHS bodies to enable them to meet the Nicholson Challenge, and whether the NHS is succeeding in making efficiency gains rather than cuts
- The effectiveness of the mechanisms by which resources are distributed geographically in the NHS
- The prospects for the long-term viability of NHS Trusts and NHS Foundation Trusts
- Reports of particular financial pressures in the system, such as funding for General Practice, and for Accident and Emergency services
- The impact on the provision of adult social care of the 2010 spending review settlement and the ability of local authorities to make the necessary efficiency savings
- The impact on NHS plans of decisions currently being made by local authorities and the use of the additional funding for social care being made available through the NHS budget
- Progress on making efficiencies through the integration of health and social care services."

3. The Committee held three evidence sessions,² at which it took evidence from Rt Hon Jeremy Hunt MP, Secretary of State for Health; Una O'Brien, Permanent Secretary, Richard Douglas, Director General, Finance and NHS, Jon Rouse, Director General Social Care, Local Government and Care Partnerships, Department of Health; Sir David Nicholson, Chief Executive, NHS England (on two occasions); Paul Baumann, Chief Financial Officer, NHS England; John Appleby, Chief Economist, Health Policy, The King's Fund; Anita Charlesworth, Chief Economist, Nuffield Trust; Matt Tee, Chief Operating Officer, NHS Confederation; Councillor Katie Hall, Chair, Community Wellbeing Board and Andrew Webster, Associate Director of Health and Care Integration, Local Government Association. We also received 34 written submissions, and we are grateful to all those who contributed to this inquiry.

Meeting the challenge 2

The current situation

4. The need for the NHS to achieve 4% year-on-year efficiency gains has been the dominant issue for the Committee throughout the Parliament as it has looked at expenditure issues. As we noted last year, "Given trends in cost and demand pressures, the only way to sustain or improve present service levels in the NHS will be to continue the disciplines of the Nicholson Challenge after 2015". The Committee also said that

The evidence presented to the Committee demonstrates that the measures currently being used to respond to the Nicholson Challenge too often represent short-term fixes rather than the long-term transformation which the services needs.4

5. In its memorandum to the current inquiry, the Department of Health says that

In the first two years of the QIPP delivery period, the NHS has delivered in line with its forecast efficiency savings, with primary care trusts (PCTs) reporting delivery of £5.8 billion savings in 2011–12 and a further £5.0 billion in 2012–13.

While this is an encouraging performance through the first half of the QIPP delivery period, it will require concerted effort across the health system to maintain delivery over the second half of the period in a sustainable way that prepares the NHS for continuing financial challenges in 2013-14 and beyond...

The situation is, however, becoming more difficult:

QIPP plans for 2013–14 are expected to deliver savings of £4.2 billion. Based on the latest results (August 2013), NHS England expects to deliver £4.0 billion in 2013-14, 5% below the target. This was split between provider productivity savings delivered through the tariff reduction in contracts (£2.2 billion planned) and CCG/direct commissioning (£2.0 billion planned)...⁵

6. The King's Fund also indicates that the NHS is finding it harder to generate the necessary efficiency gains:

Since April 2011, The King's Fund has published a quarterly monitoring report which analyses NHS performance against key indicators and tracks progress in improving productivity based on a regular survey of NHS finance

³ Health Committee, Eleventh Report of Session 2012-13, Public expenditure on health and care services, HC 651, paragraph 16.

⁴ ibid, paragraph 19

⁵ Department of Health (PEX 28), paras 1.1,2 and 1.2,7.

directors. Although the survey is not a representative sample...it does provide valuable insight into how the NHS is responding to the Nicholson Challenge.

The reports show that NHS organisations made good progress in meeting productivity targets during the first two years of the Nicholson Challenge. In 2011/12, an average saving of 4.7 per cent was reported by those responding to our survey, against an average cost improvement programme (CIP) target of 5.1 per cent. In 2012/13, an average saving of 4.6 per cent was reported against an average CIP target of 4.9 per cent. These findings are broadly consistent with other evidence about the progress made in meeting the Nicholson Challenge, including the National Audit Office's assessment of savings made in 2011/12.

However, our two most recent reports reveal a significant fall in confidence among those surveyed about whether CIP targets can continue to be met. Our most recent report, in September 2013, found that only a third of NHS trust finance directors were confident of meeting an average CIP target for 2013/14 of 4.9 per cent. This contrasts with around 70 per cent who were confident of meeting their target for 2012/13 in our February report. This reinforces warnings that the quick wins have been identified and that savings will become progressively harder to achieve over time.

We note the assurances given to the Committee's previous inquiry and the findings of the National Audit Office report that the bulk of the savings made in 2011/12 were recurrent. Nevertheless, we remain concerned that a significant element of the progress so far has been delivered through pay restraint, reductions in the tariff and cuts in management costs rather than genuine improvements in productivity. We also reiterate our concern that too much emphasis has been placed on generating financial savings, rather than on improving the quality of services for patients.⁶

7. John Appleby of The King's Fund argued in evidence that

the real issue is not about saving money—that is the 'half way there', as it were—but what you spend that money on. Presumably, we are saving admin costs not because we like to save admin costs but because we face the need to provide more hips and do more. It is about spending that money on something else. My point about the reporting, in a sense, is that we do not quite know where the money has gone.

8. The Nuffield Trust concurs that "the NHS has so far succeeded in delivering the headline financial targets set out in QIPP. It has done so while under-spending the health budget each year, by 2.1 billion in both 2011/12 and 2012/13."8

The King's Fund (PEX 33), paras 3-5, 7

Nuffield Trust (PEX 27), section 1.1

9. The Trust also agrees with the King's Fund that most of what has been achieved so far has come through changes from the centre:

The approach to the financial challenge to date has relied on centrally driven initiatives. Pay restraint has played a critical role: we estimate that it could provide over £5 billion of the total £13 billion of savings we believe is required across services formerly commissioned by Primary Care Trusts, which account for 80% of the NHS budget. Cuts in administrative staff and pressure on CCG management costs have led to further savings. These savings have been partially negated in the short term by the costs of reorganisation and redundancies, estimated at over £1.1 billion, but while these costs were non-recurrent, the savings will largely be permanent. Cuts in the tariff prices paid to hospital trusts have delivered savings for commissioners, but may be associated with the difficulties facing provider finances...9

10. Anita Charlesworth of the Nuffield Trust told us in evidence that "It does feel as if we are hitting an imbalance. People have made the easy savings and they are running out. By NHS England's admission, we are not seeing very much progress with transformative savings, and quality pressures are really starting to bite."10

11. The conclusions that we draw from the evidence are that:

- the NHS has provided savings during the first two years of the programme, but that there is a question mark about how sustainable they are;
- The straightforward savings which are possible have now been made; and
- the transformation of care that will be required to make the NHS sustainable in the future and able to deal with increasing demand has yet to take place.
- 12. On this final point, the key question, raised in evidence, is not 'what has been saved?' but rather 'what has the money "saved" been spent on?'. That is currently not transparent, and more needs to be done to demonstrate what new activity has been possible because of the gains of the efficiency process.

NHS pay

13. In its evidence to the NHS pay review bodies, the Department of Health has argued that money set aside for a pay increase this coming year should be used to help reform the pay system rather than fund a general increase.

Pay restraint has been, and will continue to need to be, a key part of delivering this. Although the NHS is forecasting significant savings from non-pay elements of expenditure, national pay frameworks and the occupational pension scheme represent about two-thirds of a Trust's total expenditure at local level. Employers are therefore facing the consequences of a stark choice for staff on national pay contracts. This is to either pay staff more, accepting that this may do little to improve the quality of care for patients and is likely to restrict the number of staff employers can afford to employ, or, to reform contracts to enable employers to use their pay bill, as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity...

Currently, Agenda for Change (AfC) provides for annual pay progression, which means employers face a two per cent (about £700m pa) pressure on the pay bill each year even during a pay freeze. Last year, for example, in addition to the one per cent basic pay rise for AfC staff (about £350m), around 60 per cent of NHS staff on AfC pay, terms and conditions received pay progression of between 0.6 and 6.7 per cent averaging at about 3.5 per cent. This is out of step with our wider policy on public sector pay...

The one per cent that the Government has made available for pay, in the Spending Round, would, in our view, be best deployed in supporting the modernisation of national pay frameworks. In particular, that the reform of AfC should seek to improve the quality of patient care and therefore outcomes by ensuring there is a better balance between pay, performance and productivity, rather than time served. Substantial reforms to progression pay will be taken forward or are already underway across the public sector.¹¹

14. In written evidence, the NHS Confederation told the Committee:

Employers in the NHS tell us that they want to support NHS staff and improve morale and they recognise the important role pay plays in that. However, with the NHS under growing financial pressure, their focus is on improving patient care. Restraining the pay bill is essential to ensure this, as well as in minimising job losses. There is no denying the hard work of NHS staff but a one per cent increase in doctors pay, for example, would cost the NHS more than £100 million, the equivalent of over 2,000 registrars working in hospital. Despite a headline pay freeze in the last two years, most NHS staff have been receiving incremental pay increases of around three per cent as they climb up through their pay bands.

This is a crucial time for negotiations on pay in the NHS. Nurses, support staff, cleaners and other healthcare professionals have already agreed on changes to sick pay and linking pay progression to performance. The BMA has agreed to negotiations with NHS Employers on consultant and junior doctors contracts. This represents a real opportunity to move forward on some important issues, not least facilitating more seven day working in the NHS, and is an opportunity for doctors to show leadership on this.

In the long term, we need to engage with our staff and unions to explore how we can come out of a period of pay restraint in a sustainable way, recognising the significant contribution of staff to delivering high quality patient care and generating solutions to the financial and demand challenge that we face. 12

15. Anita Charlesworth of the Nuffield Trust told us that "It is important to emphasise how significant the pay policy has been in enabling the NHS to fill the gap". She added that NHS England had said that around 25% of the efficiency gains so far had come from pay.¹³ In its written evidence, the Trust said that it estimated that pay restraint "could provide over £5 billion of the total £13 billion of savings we believe is required across services formerly commissioned by Primary Care Trusts, which account for 80% of the NHS budget".14

16. The Committee asked the Secretary of State about the Department's position on a general salary increase and whether he considered continuing pay restraint to be necessary. He told us:

Yes, I do...I will make two points. First, I dearly want to give NHS employees the 1% rise that we want to give across the public sector. If money was no object, I would like to give them more because I think they are working extremely hard under very challenging circumstances, but budgetary constraints exist.

The commitment that the Government made was not 1% regardless of any other increments that you may be getting in your pay package; it was that everyone in the public sector should get at least a 1% rise, and we want to honour that, but we do need to negotiate on the increments that are a part of many NHS contracts, which means that pay in certain contracts can go up by as much as 6% or 7% automatically. My concern is that, if we do not do that and we agreed to the 1%, essentially an unaffordable 1% increase in the pay bill equates to about 10,000 front-line posts. The thing that makes the NHS different from other parts of the public sector is that we are expanding in terms of the number of people we employ at the front line, and we want to employ more people, particularly in the wake of the Francis report. Hospitals want to employ another 4,000 nurses compared with a year ago, and I want them to employ those extra nurses. It is something we need to do to meet our commitments under Francis. I want to make sure that trusts end up with a financial position that enables them to do that.¹⁵

17. He also said, however, that "We recognise that the pay freeze that we started this Parliament with is not sustainable and that is why we have moved to 1%. We also recognise...that that means we have to be even more imaginative in finding other ways to

¹² NHS Confederation (PEX 29), paras 8.1 to 8.3

¹³ O 159

¹⁴ Nuffield Trust (PEX 27), section 1.1

¹⁵ O 248

make efficiency savings because we cannot constantly rely on the kind of pay restraint that we have had to date."16

18. In our report last year the Committee said that "although pay restraint is undoubtedly key in the short term, it is neither prudent nor just to plan for sustainable efficiency on the basis that NHS pay continues to fall relative to pay elsewhere in the economy". ¹⁷ Pay restraint has contributed substantially to the efficiency programme but, as the Secretary of State says, "we cannot constantly rely on the kind of pay restraint that we have had to date".

19. The Committee welcomes the Government's recognition that the future of the health and care system cannot be built on an open-ended pay freeze. If the health and care system is to be a good employer (which it needs to be if it is to deliver high quality care) it needs to undertake transformative change in order to ensure that its committed staff are better able to meet the needs of users of its services.

Allocation of resources

20. In December 2012, NHS England announced its first allocation of funding to Clinical Commissioning Groups (CCGs). It agreed that each CCG would receive a 2.3% increase for 2013-14 in comparison with their predecessor bodies rather than redistributing funds in line with the proposed formula. In a statement it said that "the formula proposed by the [independent] Advisory Committee on Resource Allocation accurately predicts the future spending requirements of CCGs based on the pattern of need as it is being met from that particular budget". It added however that using the formula alone to redistribute funding "would predominantly have resulted in higher growth for those areas that already have the best health outcomes compared with those with the worst".

On the face of it, this appears inconsistent with the NHS Commissioning Board's public purpose to improve health outcomes for all patients and citizens and reduce health inequalities. [The board] will therefore conduct an urgent fundamental review of the approach to allocations, drawing on the expert advice of ACRA and involving all partners whose functions impact on outcomes and inequalities. 18

The review was to be completed in time for its initial conclusions to inform allocations for 2014-15.

21. In a letter to NHS bodies sent on 10 October 2013, Sir David Nicholson said that "we want to provide certainty to commissioners. To this end, we intend to notify CCGs of their financial allocations for both 14/15 and 15/16 to help them plan more effectively. We are currently working with a subgroup of the Commissioning Assembly to finalise proposals for future allocation formulae for CCGs and direct commissioning, but stability is a key

¹⁷ Health Committee, Eleventh Report of Session 2012–13, Public expenditure on health and care services, HC 651, para

¹⁸ NHS England bulletin, 18 December 2012.

consideration and the pace of change is likely to be slow, given that we are operating with very limited financial growth overall."

22. The issue of the formula for allocation of resources was raised in evidence on 5 November 2013. Paul Baumann, Chief Financial Officer of NHS England told the Committee:

The most deprived boroughs in the country will get the most money. The least deprived boroughs in the country, subject to those other two factors of population and age, will get the least money. You will see that spectrum when we set out the allocations. It was already there to a large extent in the ones you are commenting on, but it will become clearer, I think, with the possible deprivation adjustment that we are going to make.

It is not the case that we give less money to the deprived areas and more money to the south—quite the opposite. The issue is that, when you compare it with a formula that is now several years out of date and that has not kept pace with the population and with the ageing in that population, there will be changes. Unless we preserve everything on the basis of what we happened to have in 2006, which was probably the last time we had any significant move in the formula, there will at some point need to be changes. I think the formula sets that out in a sensible way.

The other decision the board has in December is how fast to move from what we currently have to whatever this formula, with a deprivation adjustment, would suggest. I think it is obvious that, at a time when there is not an awful lot of growth around to put into the equation, the speed at which we can make those sorts of changes will be quite measured, because to do anything other would be problematic.¹⁹

23. The King's Fund said in its written evidence that

NHS England is currently reviewing the NHS allocations process, having rejected proposed changes to the current allocations formula as being inconsistent with its duty to reduce health inequalities. While recent debate has largely focused on the relative weight that should be given to age and deprivation in the formula, more fundamental questions should be asked about whether the current process, which has remained largely unchanged since the 1970s, is fit for purpose. At the heart of this is whether the resource allocation process is simply a mechanism for distributing funding or should be a more active policy tool for supporting wider NHS objectives. As we set out in a report on this earlier this year, there is significant scope for it to be used as the latter.

In the short term, immediate improvements could be made to reduce the complexity of the current formula, increase transparency and improve the way that need is estimated. The review should also examine the operation of

the 'pace of change' adjustment (previously decided by ministers, now by NHS England) which is built in to the process to prevent areas being destabilised by large year-on-year swings in funding. In practice, this has reduced the impact of efforts to reallocate funding and insulated areas from change.20

24. Anita Charlesworth told us:

An awful lot of work and energy goes into the formula, but I think, especially now, when resources are so constrained, there has been much less focus on how you implement the formula and how you make change happen. There are two things there. One of the things that happened routinely was that you got your allocation and, if you were a growth area, you were then set something called a control total, which was what bit of your allocation you were allowed to spend, which was agreed. By and large, that meant that, if you were a growth area, you had most of that differential growth taken away because someone else might need to be bailed out.

Then you think, "What was the point of the allocations process?" We need to decide how we are going to do resource allocation, which is informed by good empirical work but is significantly a policy question. But then, if you do not align the rest of the system to it and work out how you are going to move out around real resources, people, buildings and so on, you end up back where we were, where people have a theoretical allocation and then the reality of their control total, which just undermines all the credibility and discipline in the system and is counter-productive.²¹

25. John Appleby added that

There has been some work done by two economists, Professor Matt Sutton at Manchester and Professor Nigel Rice at York, looking at the impact of the weighted capitation system going back to 1970. Their conclusion, in a nutshell, is that it has done almost nothing in terms of the central objective, which is equal opportunity of access for those in equal need, which was the starting point for the original working party, RAWP. We have had over 30 years of moving billions of pounds around the country, but, as Anita points out, you give with one hand and take with another.²²

26. In the event, the approach which NHS England chose to take in respect of 2014/15 and 2015/16 was to give all CCGs at least a flat real terms increase on the grounds of maintaining stability in the system, with around 70 CCGs receiving more on the basis of levels of deprivation and of changes in population. Sir David Nicholson told the Committee:

²⁰ The King's Fund (PEX 33), paras 16 and 17.

^{21 0 205}

²² ibid

With the allocation arrangements that we have put into place, first, the most deprived populations get the most money. That is the first and most obvious thing.23

- 27. The allocation of funds and the formulae used to do it will always be contentious. The Committee acknowledges that NHS England has set out its plans both transparently and in good faith. In a system in which there is a limited increase in funding, however, it becomes even more difficult to make changes to allocations than in times of plenty.
- 28. The concept of target funding is as old as the NHS itself. Although the formula will continue to change, with the result that the day when all CCGs receive their target funding will never arrive, the Committee endorses the general approach while recognising that there will always be debate about how quickly actual funding should close the gap with target funding. It is clearly more difficult to make meaningful progress when the overall budget is largely stable in real terms.

Trusts and Foundation Trusts

29. In September, the NHS Trust Development Authority reported on the current financial position of acute trusts. It said that

Acute trusts however are experiencing significant levels of financial pressure...At the 31 July 2013, 48% of acute trusts are forecasting a deficit in 2013/14 with many signalling operational pressures in urgent and emergency care.24

30. The NAO, in a report in July 2013 on the financial sustainability of the NHS, said that

The number of foundation trusts and NHS trusts reporting a deficit has fallen from 31 at the end of 2011-12 to 25 at the end of 2012-13. However, the underlying position is that some NHS trusts may be breaking even only because they are receiving additional local revenue support from strategic health authorities and PCTs. Without extra financial support, the picture is reversed: 43 trusts may have been in deficit in 2011-12, and 44 in 2012-13. The amount of non-recurrent financial support given to trusts has also increased, from £123 million in 2011-12 to £203 million in 2012-13. Fifteen of the 23 trusts receiving support in 2012–13 also did so in 2011–12.²⁵

31. The NAO also noted that while foundation trusts were in general in a better financial position than trusts, "there are a number of foundation trusts that have persistently been unable to meet the standards of finance or governance that Monitor expects foundation trusts to achieve. At 31 March 2013, there were 19 foundation trusts in breach of their

²³ Q 328. For the full exchanges on the allocation process, see questions 322 to 336.

²⁴ NHS Trust Development Authority, <u>Summer report for the period 1 April to 31 July 2013</u>, page 20.

²⁵ National Audit Office, 2012-13 update on indicators of financial sustainability in the NHS, 18 July 2013, page 5

terms of authorisation, of which four had been in breach for over three years. Of the 19 trusts in breach, 14 were in breach wholly or partly because of financial problems."26

32. It is widely acknowledged that many Trusts are finding their financial position increasingly difficult. The King's Fund says that:

Despite the challenging financial environment, NHS providers have so far held up reasonably well at the aggregate level. Overall, the NHS in England reported a surplus of just over £2 billion in 2012/13. Our latest quarterly monitoring report found that nearly 90 per cent of NHS trust finance directors and CCG finance leads surveyed expect to break even or record a surplus in 2013/14. However, these figures obscure the fact that an increasing number of trusts are struggling - seven of 42 NHS trust finance directors reported that they are forecasting a deficit.

These findings are echoed by other evidence. Monitor's latest quarterly monitoring report found that, in the first quarter of 2013/14, 48 foundation trusts were in deficit (41 of which were acute trusts), up from 36 in the same period last year. It noted that trusts are finding it increasingly difficult to deliver efficiency savings and that some of those reporting deficits have not done so before. It also noted that many of those planning a surplus are forecasting that this will be less than 2.5 per cent of income, suggesting that more organisations are in a potentially vulnerable financial position. The NHS Trust Development Authority recently reported that 31 NHS trusts (30 of which are acute providers) are planning a deficit by the end of 2013/14, an increase of five on the beginning of the year and potentially leaving the NHS trust sector with a deficit of around £150 million. Overall, this means around half of all acute providers are now either in or predicting a deficit.²⁷

33. The Nuffield Trust painted a similar picture:

At the end of July 2013, 48% of non-foundation acute NHS Trusts are now forecasting a deficit for 2013/14 (31 organisations), and the aggregate net position for all non-foundation acute trusts is now forecast at a deficit of £232 million for the financial year. Crucially, their margins for earnings before interest, taxes, depreciation and amortization (EBITDA), a vital comparable indicator of fundamental operational viability, are falling. Fortytwo per cent of all NHS Trusts (43 organisations) ended 2012/13 below the 5% Monitor would normally require to grant FT status. Adjusting for nonrecurrent spending, the trend in EBITDA averages since 2010/11 has been downward

As of March 2013, 32 acute NHS Trusts working towards becoming FTs were rated red in their readiness for this status, and a further 18 were rated amberred. Unless there is a very significant improvement in financial performance in 2013/14, it appears that the number of acute NHS Trusts which will not be able to pass the FT approval process will be significantly more than the 20 previously identified by the NAO. Resolving these organisations' financial difficulties and ensuring that they have clinical and financially sustainable futures is proving very challenging. As the number of NHS hospitals in deficit increases, and underlying financial performance deteriorates, there must be questions about how the NHS approaches these providers, and whether the failure and oversight regime is suitable for the scale of the potential challenge.²⁸

34. On 10 September 2013 the Government announced that £250 million of additional funding would be allocated to 53 Trusts on the basis of needs to address A&E pressures for the coming winter. On 22 November NHS England announced it would provide a further £150 million to 157 CCGs to distribute to other Trusts as a further measure to help improve the situation in A&E departments in the coming months.

35. We asked the Secretary of State about the criticism that some in the NHS had made that the initial allocation of £250 million could be seen as rewarding failure. He told us:

It was a very difficult call, because what happened with the £300 million [of winter pressures funding last year was that essentially it was distributed evenly, including to a lot of areas that were performing extremely well, and of course you have to make a call. I decided that it would be a better use of taxpayers' money and would have more impact for the winter if that money was distributed to the areas where we thought the biggest problems existed. Of course, by definition, those are the areas that are less successful. But because we were then able to identify another £150 million of underspend, as it happens... we were in fact able to give all areas broadly the same as they received. When you tot it up to the £400 million, basically all areas got broadly what they got last year, but areas with particular problems got more.29

36. The squeeze on tariff funding has had a considerable effect on Trusts and Foundation Trusts. Paying Trusts less for the same work is not in itself a saving-it is how trusts accommodate that deficit that provides the efficiency gain. As the Nuffield Trust told us "Cuts in the tariff prices paid to hospital trusts have delivered savings for commissioners, but may be associated with the difficulties facing provider finances". The Foundation Trust Network said that

The financial penalties and risks that have been allocated to NHS providers are hindering, rather than incentivising, the necessary changes to how health and care services are delivered. In the absence of longer-term and more

mature planning, contracting and payment models, community providers, for example, are often one contract away from financial distress. 30

37. Once again, this highlights the need for transformative change. As the Foundation Trust Network went on to say:

The era of salami-slicing and traditional cost improvement plans is ending. If the efficiency challenge is to be met, more recurrent savings through service redesign are needed. These transformational changes require funding and strategic and political support if they are to be successful. 31

38. This is the fourth report which the Committee has issued during this Parliament on the implications of the Government's spending plans for health and care. In each report we have drawn attention to the urgency of transformative change of the care model if the needs of patients are to be met. The fact that the number of NHS Trusts and NHS Foundation Trusts reporting underlying deficits continues to grow represents evidence that the pace of change has not been sufficient to meet the challenge. This is the subject of the next section of the report.

Integration of health and social care 3

39. In its report of the 2012-13 Session, the Committee made a series of recommendations about integrating health, social care and other services in one system locally:

100. Against the background of a common desire to avoid further management upheaval, and recognising the dangers of an over-prescriptive approach, the Committee repeats its recommendation that health and wellbeing boards and clinical commissioning groups should be placed under a duty to demonstrate how they intend to deliver a commissioning process which provides integrated health, social care and social housing services in their area...

102. The Committee believes that the best way to provide services which treat people rather than conditions and services which adapt to people rather than causing people to adapt to services is to bring together funding, planning and commissioning of services around the forum of the Health and Wellbeing Board. All health and social care services in a given area should be included in this pooled process, including those which are developed to fund and implement the Dilnot proposals...

106...the Committee recommends that the Government should introduce a ring fence to protect the current level of real-terms funding available to social care. This approach would ensure that resources were no longer treated as 'belonging' to a particular part of the system, but to the local health and care system as a whole. With agreement on local priorities, and with binding commitments on the amount of money available to fund them, a flexible, responsive health and care economy could be established which would use the total budget provided for health and care more efficiently than is the case at present with separate funding streams and different objectives.³²

40. In its response, the Department said amongst other things that

Although the Government agrees that health and social care services need to be integrated around the needs of the people they serve, we do not support the recommendation that health and wellbeing boards need direct responsibility for funding or commissioning services. Health and wellbeing boards have been established to take on the function of joining up the commissioning of local NHS services, social care and health improvement: setting a strategic approach and promoting integration across health and adult social care, children's services including safeguarding, and the wider local authority agenda.

The arrangements that have been put in place give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. The aim is to ensure coherent and coordinated local commissioning strategies across all health and care services. We have also simplified and extended the use of powers that enable joint working between the NHS and local authorities, making it easier for commissioners and providers to adopt partnership arrangements.33

41. It did not directly respond to the point about ring-fencing, but said that

At the 2010 Spending Review, local government gave a strong message that reducing ring-fencing would allow them to make better prioritisation decisions and redesign services at a local level, thus delivering better services more efficiently. This is why the Government has given them this flexibility over this Spending Review period. We have placed certain conditions on the money transferring from the NHS to local authorities during this period to ensure that it is used for social care that also has a health benefit.³⁴

42. There is a general consensus that integrating health and social care and redesigning services is crucial to both improved quality and making resources go further. However, as The King's Fund notes:

Progress in implementing integrated care locally remains variable. Anecdotal evidence indicates increasing interest, with some parts of the country making good progress in developing and delivering ambitious plans. However, the finding from our survey that most HWBs have not identified it as a priority highlights the need for them to take a much stronger lead in driving it forward locally. 35

43. The King's Fund also says that "transformational change takes time to demonstrate results. The potential for integrated care to deliver financial savings remains to be seen, and there may be a need to invest in new models of care before resources can be released from existing models." That issue is reflected in the Nuffield Trust evidence:

Nuffield Trust research shows that resources have continued to move towards rather than away from hospitals from 2009/10 to 2011/12, while spending on general practice has declined in real terms-by 1.2% in 2011/12. Activity in hospitals also continues to increase. Emergency admissions, the key indicator of improved care outside hospitals, rose by 1.9% comparing the most recent months for which figures are available in 2013 to the same period the year before. Outpatient appointments rose even more quickly, by 9.2%, although data in this area is less reliable.³⁷

³³ Department of Health, Government response to the House of Commons Health Select Committee Report into Public expenditure on health and care services (Eleventh Report of Session 2012-13) Cm 8624, June 2013, paras 56 and 57.

³⁴ *ibid*, para 58

³⁵ The King's Fund (PEX 33), para 36.

³⁶ *ibid*, para 35

³⁷ Nuffield Trust (PEX 27), section 1.3.

Integration Transition Fund (the Better Care Fund)

44. In the Spending Review in July, the Chancellor announced that in 2015-16 £3.8 billion would be allocated to a joint NHS and social care budget to be called the Integration Transition Fund (ITF). In October, in a letter to NHS Commissioners and providers, Sir David Nicholson said that

The ITF is a 'game changer': it creates a substantial ring-fenced budget for investment in out-of-hospital care. However, it will also require us to make savings of over £2bn in existing spending on acute care. This implies an extra productivity gain of 2-3% across the NHS as a whole in 15/16. We will work with Monitor to determine how this is reflected in the expectations placed on commissioners (in the form of QIPP savings from demand management, pathway change, etc) and providers (in the form of the efficiency deflator incorporated in tariff). We are currently exploring the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16.38

45. It is also interesting to note Sir David's comments earlier in the year, before the ITF had been announced, on the issue of further transfers of money from the NHS budget to social care:

Sir David said there would be "consequences" if a further £1bn of NHS funding ended up in the social care budget which those making the decision would have to "sign up to".

Acknowledging the shift of funds may be in the interests of the public, he said: "My issue is that £1bn will have to come out of the existing hospitals services. There is nowhere else to take it from."

He added: "There isn't a spare billion hanging around in hospitals. So that means radical change in the way hospitals operate. If people want to explain to me how the billion is going to be transferred, and how hospitals are going to have to be altered to make that happen and will sign up to the consequences, I'm all for it". 39

46. The Nuffield Trust discussed the role the ITF will play from 2015-16:

The Government's £3.8 billion Integration Transformation Fund (ITF), scheduled for implementation in 2015/16, is an important recognition of the support needed to enable integrated care to happen at scale. There are already concerns that the large cuts seen in social care spending are weakening the capacity to provide social care for vulnerable people before they develop the most severe needs and the impact on the NHS of further

³⁸ Letter of 10 October 2013, Planning for a sustainable NHS: responding to the 'call to action', Publications Gateway Reference No. 00542

³⁹ Health Service Journal, Nicholson: Transferring NHS funds to social care would mean 'radical changes' to hospitals, 6 June 2013.

cuts to adult social care budgets up to and including in 2015/16 must be addressed. However, the decision to take funds from the NHS budget means that their re-allocation through the ITF must result in enough savings to pay for itself, as well as making a substantial contribution to savings within the NHS.

Reductions in emergency hospital admissions and hospital occupancy are the central mechanism by which this could be achieved. However, recent Nuffield Trust evaluations of several community-based interventions, designed in part to ease pressure on hospitals, showed no evidence of an impact on admissions. The Nuffield Trust has also evaluated the first year of the integrated health and social care model developed in North West London for over-75s and people with diabetes. We found no significant reduction in emergency hospital admissions in the short term.⁴⁰

47. In oral evidence, John Appleby from the King's Fund highlighted the fact that none of the money in the ITF is 'new money':

In some sense, none of it is new money. The NHS has been transferring, as you say, up to £1 billion or so to local government anyway. That has just gone. There have been various other budgets that the NHS or the Department has managed, and then they have been reclassified and they are now over with the local authorities and so on. Once you add all these up and there is again an extra £2 billion or so in 2015 of money that has been allocated to the NHS which will go into this pooled budget—it is £3.8 billion, but you are right to say, in a sense, that none of it is new money.

Is it enough? It depends what you want to do with it. We do not know yet what the plans are. CCGs, health and wellbeing boards and so on have to come up with some plans by next April. I think it is going to vary tremendously around the country. There will be some areas that will do great things with this money and others that will not. 41

48. Anita Charlesworth said that planning was a major problem:

My anxiety is that planning is happening too late for this and it is happening too late to co-ordinate with the acute sector. This means that acute hospitals will need to deliver an efficiency saving in 2015-16 of something in the region of 6%. If I look at last year's cost improvement plans of foundation trusts, I think it was 3.4%, and they are declining. Let us assume that this fund is a fantastic success and in year pretty much everywhere they implement plans that are completely effective, they save significant numbers of hospital admissions and lead to a big reduction in average length of stay. What you have to do to make the money add up in year is then take all that cost out of the acute sector. Hospital costs are lumpy. They are people on fixed employment contracts—professional people in the main—and buildings. Taking money out is quite difficult.

If this is going to work, first, we need to be sure, especially in areas where the acute sector is very fragile, that the plans are robust, and if you are going to hit the ground running at that speed you need to have planned very early; and then, secondly, there need to be well co-ordinated plans with the acute sector, because, essentially, you need to know now broadly how far you are coming down and be planning in a very tightly co-ordinated way to bring that capacity down. I do not see that. So I think we are at real risk of a very big crisis in the acute sector in that year. 42

49. Matt Tee, Chief Operating Officer of the NHS Confederation, echoed that concern:

We support the principle of the integration transformation fund. Our worry is that the time when it is going to happen is coming very quickly and we do not see enough planning taking place in enough places for us to be sure of the effect that this money will have... It feels to me as if there is the potential for a good conversation and for some good deals to be done there, but there is a real urgency about involving the right people in those conversations so that health plays the part it should play in integrated treatment, but also so that health understands what it can legitimately expect in terms of reduction in demand on the health system.⁴³

50. The Secretary of State, who told us that the ITF had been renamed the Better Care Fund, agreed that the fund was not new money "in that it comes from the NHS budget". He said that

It represents an additional £2 billion going from the annual NHS budget into integrated support through the health and social care system. The intention is to improve out-of-hospital services for some of the most frail and vulnerable older people who use the social care system by giving them a joined-up service and by being a catalyst. In order to access that money, CCGs and local authorities will have to jointly commission services...It is deliberately designed to be a sufficiently large sum of money so that no one will feel that they cannot be bothered with accessing it. They will feel they have to access it. Things like record sharing will be part of it, and having a named accountable clinician responsible for each and every one of those vulnerable older people will also be a part of it. But it comes from the NHS budget.

The other point about it is that we expect there will be significant savings both to the NHS and the social care sector in terms of, particularly,

admission avoidance by proactively looking after people better in the community. 44

51. We asked him about concerns that the planning for integration was not sufficiently robust and not effectively worked through. The Secretary of State told us

It is absolutely right to express that concern because it is very important that this is a real transformation, not just either a cosmetic transformation or a continuation of what we had before, which was much more limited in its ambition. But we have tried to mitigate the risk of that happening through a very aggressive timetable. The fund is for the financial year 2015-16, so it starts in April 2015, and we have said that we require all CCGs and local authorities to have put together their plans by April 2014, a whole year in advance. That gives us time to go through those plans in detail to check they are robust, but also, importantly, for the plans that are good, we believe that many local authorities and CCGs will not want to wait. Even though they are not going to get access to the fund till 2015, they will probably want to start a lot of the integration well before April 2015 and indeed make it part of their 2014-15 cycle because of the prospect of significant savings being made. 45

52. John Rouse, Director General Social Care, Local Government and Care Partnerships at the Department of Health spoke about the fourteen integration pioneer areas, noting that having invited bids

We actually got 99 and some of those had more than one local authority in them, so we had well over 100 of the 152 upper tier authorities bidding to be integration pioneers and putting all the work with their CCGs and their providers into those applications. I think there is a real momentum out there. I travel pretty extensively around the country visiting localities. Most places are planning pretty transformational integration models and I have high hopes that that will be reflected in the plans. 46

53. The Committee put it to the Secretary of State that the implication of the Better Care Fund was more community-based services, which in turn means disinvestment from acute services. He responded that

I would say "less money" rather than "disinvestment". Less money means more efficient use of resources, but it does mean less money in the acute sector. As a result of the better care fund, which is going to be real, we have to increase the QIPP savings that we will be requiring from around £4.5 billion a year currently to around £5.5 billion in 2015-16, and we will have to find that extra money. I am very happy to talk to you about how we can do that,

⁴⁴ O 271

⁴⁵ Q 272

⁴⁶ Q 274

but, yes, we will have to make savings because it will mean less cash spent in the acute sector.47

He added that "we do intend, before the end of March, to publish how we will get to the necessary QIPP savings for 2015-16, and that will show how we think we can deliver that for that period of time. But there is a lot of work happening right now in order to firm up the realistic possibilities for saving money."48

54. The Secretary of State highlighted the significant increase in QIPP savings that the introduction of the Better Care Fund would require in 2015-16, which Sir David Nicholson wrote about in his letter of 10 October 2013. The Foundation Trust Network expressed serious concern about the adverse impact that this could have on care across the NHS:

...it is impossible to see how such savings-between 6 and 8% annual savings for all NHS providers-can be delivered in a way that will not adversely and significantly impact on the safe and effective delivery of patient care. Particularly when the vast majority of providers, despite their best efforts, are now patently unable to deliver the current requirement of 4% annual recurrent efficiency savings...New models of working require investment and time to deliver, whereas ITF resources will immediately be shifted directly from the NHS frontline-often from pressure points in the system, including accident and emergency care. 49

55. It added that

The Chief Executive of NHS England has described the ITF as "a game changer". We hope it will change the game in a positive way, but believe the balance of probability is strongly loaded the other way in the short term: it is likely to bring major risk to effective NHS service delivery and patient care as it diverts a significant amount of funding away from existing NHS service delivery. We understand the policy intent, but worry that the consequences for NHS services have not been fully accounted for.50

56. This has to be set alongside the funding situation for social care. In its written evidence to the Committee, the LGA told us that

Despite having attempted to protect adult social care services as much as possible, councils have had to reduce their adult social care budgets by £2.68 billion, 20 per cent of the budget, over the last three years in response to reduction of overall council funding.⁵¹

57. The LGA also noted that there would be funding consequences arising from the provisions of the Care Bill [Lords]:

⁴⁷ O 278

⁴⁸ Q 279

⁴⁹ Foundation Trust Network (PEX 12), para 24

⁵⁰ ibid, paragraph 27

⁵¹ Local Government Association (PEX 24), paragraph 5.2.

The additional costs for the funding reforms and Care Bill are yet to be fully understood and agreed. The Government has allocated £335 million for implementation costs in 2015/16 and must also meet any additional costs with new money.⁵²

In a subsequent memorandum to the Public Bill Committee on the Care Bill, however, the LGA and ADASS said that

The Department of Health has also identified £135 million of other costs associated with reform to cover, for example, national eligibility, training for social workers, and the implementation of statutory Safeguarding Adults Boards. The Government's position is that these costs should be funded through the Better Care Fund. Local government does not oppose this money sitting in the BCF. These costs should however cover new burdens meaning that the £135 million has to be new money to councils.⁵³

58. It appears from comments made in the Public Bill Committee on the Care Bill by Norman Lamb MP, Minister of State for Care and Support, that the Government's position is that all the costs attributable to the Care Bill will be funded through the Better Care Fund. He said:

The Better Care Fund sensibly encompasses all the different elements of sums both for the implementation of the Bill and adaptations to people's homes and money coming from the NHS. Of course, the whole point is that it is grouped together into one fund, because all this is related. However, these are clearly identified resources that will be used to implement this Bill and are additional to what councils would otherwise have had.⁵⁴

Conclusions

59. This series of comments sets out the problem at the heart of the desire for greater integration between health and social care. The NHS, although coping with a static budget for the first time in its history, is better funded than social care. Social care authorities are facing reduced budgets and rising demand. Improved integration in these circumstances therefore requires a switch in funding from health services, particularly in the acute sector, towards community-based services and social care. The challenge is to achieve this without destabilising existing services so that they can no longer function effectively before new arrangements are in place, leading to gaps in care for patients.

60. The Committee welcomes the emphasis which the Government is now putting on service integration, both within healthcare services and between healthcare and social care. The Committee also recognises the logic of creating the Better Care Fund to provide an incentive for health and social care authorities to cooperate in new ways and

⁵² ibid, paragraph 5.7

⁵³ Care Bill [Lords], Written evidence submitted by Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) (CB 18), paragraph 4.7

⁵⁴ Public Bill Committee Debates, Care Bill, 23 January 2014, col 373.

facilitate the transfer of resources into community services which is a necessary part of the change process.

- 61. The Committee remains concerned, however, that the pressures on available resources across the whole system, but in particular in social care, are now much greater than they were a few years ago, with the result that successful integration of high quality health and care services represents a substantial and growing challenge. The Committee does not believe that either the pace or the scale of the change which is necessary is sufficiently understood or that sufficient steps are being taken to explain the need for change to either the health community or the wider public.
- 62. The Committee continues to believe that fragmented commissioning structures significantly inhibit the growth of truly integrated services. The Committee has recommended in previous reports that Health and Wellbeing Boards should be encouraged to develop their role to provide an integrated commissioners' view of the transformative change which is necessary in our health and care system. It repeats that recommendation in this report and further recommends that NHS England and the Local Government Association should commission a review to establish the best practice method of consolidating the commissioning process through HWBs with minimum disruption of ongoing activity.
- 63. The Committee also repeats the recommendation it made last year that the current level of real terms funding for social care should be ring-fenced. As we said in the corresponding report in 2013, this would "ensure that resources were no longer seen as 'belonging' to a particular part of the system but to the local health and care system as a whole".55
- 64. The Committee believes that in the absence of stronger commissioners and a commitment to ring-fenced real terms funding for health and social care, there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead.

Reconfiguration

65. Integration will also require reconfiguration of services. As The King's Fund says:

Major reconfigurations of services are essential to improve quality of care and have the potential to improve financial sustainability (although they often result in significant short term costs, as is the case with the proposed changes to services in South London and Mid Staffordshire). However, progress continues to be slow and has been hampered by notable setbacks such as the failure to bring the long-running review of children's heart surgery to a conclusion. The picture is further complicated by the increased involvement of the competition authorities in decisions about mergers and service changes. There are clearly lessons to be learned for the NHS from the

Competition Commission's recent decision to reject the proposed merger between Bournemouth and Poole hospitals. However, the risk is that this and other decisions result in competition law being seen as an impediment to service change.⁵⁶

66. In oral evidence, John Appleby from The King's Fund told the Committee:

The first thing to say is that we should not assume that reconfiguration is about centralisation; it sometimes is, but it sometimes is not... Some services are much better provided face to face in people's homes; other services are better provided at a GP's surgery and so on. That is the approach that all medical health care systems have gone through and it is about trying to get that balance right.57

67. Anita Charlesworth added that

The Ara Darzi London experience is quite important because "Localise where possible, centralise where necessary" is a really important message, but, once you say that, what people see is the "centralise"; what they don't see is the "localise". When I look at the numbers, in terms of where the spending has gone, certainly if primary care is part of the "localise", the money is not getting there. Understandably, if you are a member of the public, you would ask, "What does this localised better service look like? How do I judge it? How do I even see and feel that it is still there and you have not cut it from underneath me?" We have put comparatively little effort, I would argue, as a system, into describing, modelling and then showing people what the "localise" is, and then working out a way that communities can judge whether it is being delivered and holding people to account for it. In that environment, it is logical for local communities to feel great nervousness about what they are losing, when what they are supposedly gaining is so amorphous. To my mind, the thing that would make the biggest difference would be to work out what the "local" means and to provide good transparency and accountability so that people could have some confidence in that before they let go of what they feel is a loss.⁵⁸

68. The Foundation Trust Network outlined some of the problems that needed to be overcome in order to achieve effective reconfiguration:

We welcome the debate that NHS England and Monitor are leading to inform the future of NHS delivery, but the sector urgently needs swifter, more joined up, decision making and a plan for the next two to three years. To survive, NHS providers must be allowed the freedom to transform

⁵⁶ The King's Fund (PEX 33), para 11

⁵⁷ Q 178

⁵⁸ Q 178

services and develop the new organisational models and service patterns that will deliver sustainable and better value outcomes for patients. 59

- 69. It also argued that one of the main requirements was for "clinically-led service redesign and reconfiguration to be more maturely debated and supported within and outside the NHS".60
- 70. Advocating service integration without recognising that the consequence of integration is reconfiguration of acute services is simply dishonest.
- 71. The case for acute service reconfiguration is often presented as an economic necessity, but that is only half the story. It is certainly true that economic pressures mean that changes in acute services are necessary if the health and care system is to meet the demands placed upon it. The argument for reconfiguration, leading to reduced emphasis on acute services, is however supported by consideration of clinical quality as well as economic pressure. Our system currently places insufficient emphasis on identifying early symptoms and supporting normal life, with the result that it has provided reactive acute care to patients whose condition should never have been allowed to become acute. The challenge facing NHS policy makers, at both national and local level, is to explain this underlying policy requirement to a sceptical public.
- 72. Changes which lead to the closure of hospitals or remove services from hospitals are notoriously controversial with local communities. Too often this is because the first a community hears about proposed changes is when the acute facility is proposed for closure. If these proposals are notoriously controversial, it is too often because the case for change is notoriously badly made. Part of the benefit of involving Health and Wellbeing Boards in the commissioning decisions about health and care, with a single overview for a given community, should be to engage the local professional and lay communities in a greater understanding of the care quality issues which underlie the case for service reconfiguration, as well as the economic issues involved.

Implementation of the Health and 4 Social Care Act 2012

73. This inquiry, which related to our work on expenditure, was the Committee's opportunity to take an early look at the NHS landscape following the coming into force of the Health and Social Care Act 2012 in April 2013. In the inquiry two issues in particular stood out: system leadership and competition

System leadership

74. One of the justifications for the changes brought in by the Health and Social Care Act 2012 was that the NHS should become a regulated system rather than a system with direct lines of management from the Department of Health and the NHS Executive. One issue that has been raised is how large-scale reconfigurations can be implemented under the new system. The King's Fund told the Committee:

We remain concerned about the lack of capacity in the new health system to undertake large-scale reorganisations across wide geographical areas, especially in London, where the need for change is particularly urgent. We have proposed that NHS England's London office takes on a city-wide planning role, working with CCGs, and that hospitals work together in largescale networks based on the three existing academic science networks to drive change. This would have the benefit of ensuring that major changes to services are overseen by the most experienced leaders and is an approach we believe could be replicated elsewhere in the country. 61

75. In oral evidence, John Appleby argued that changing services or closing whole hospitals "is difficult, I think, and has become more difficult." He said that

One of the reasons for that is that in many areas we do not have a co-ordinating body to oversee some of this stuff. We got rid of strategic health authorities. There may have been some very good reasons to get rid of SHAs, but one of the things they helped with was to co-ordinate across an area. We now have a more fragmented system, in a sense. It is, in a way, typified by the letter that went round the system about the integration transformation fund that was signed by four different bodies. In a way it was good that it was signed by four, but it also illustrates what has happened to the system. Doing these things quickly, it seems to me, is still difficult and perhaps more difficult.⁶²

76. When Sir David Nicholson gave evidence on 5 November 2013, the Committee raised a number of questions about staff made redundant being re-employed within the NHS. Much of that information he did not have available: the Committee has received some

further answers in correspondence with the Secretary of State. 63 One reason for that is that, even on the commissioning side of the NHS for which NHS England has direct responsibility, CCGs are statutory bodies in their own right and are held accountable for high level objectives (overall budget control) but not via NHS England on managerial issues (redundancies and re-employment). There is clearly a tension between this local autonomy and the desire by NHS England and the department to understand and influence system-wide issues. This may be part of the reasoning behind the announcement made following our discussion with Sir David, in December 2013, that CCGs would be subject to quarterly assessments of their effectiveness by NHS England, with the possibility of intervention if their performance was considered inadequate.⁶⁴

77. It is unclear who will take the lead on system change on a local or regional level. An issue at local level is that CCGs are smaller than the PCTs that they have replaced, and have control over fewer functions. The Committee was told that with more organisations in the system, none of which are big enough or influential enough to shape the system, strategic change will have to be brought about through collaboration "which, history suggests, tends to be less effective".65

78. This is potentially a very significant issue. There is a consensus that integration of services across health and social care and reconfiguration of health services are vital if the NHS is to maintain levels of service provision while making the efficiency gains demanded of it, and to maintain or improve quality of the treatment provided.

79. There is a real danger that, without a body which can take charge of decisions about reconfiguration and integration of services, change which needs to be made to maintain and improve services will not happen. As the Committee has noted earlier in this report, 66 the evidence we heard in this inquiry confirms to us that, in the present system, this is the most viable approach to ensure continuity of and improvement in services.

80. Health and Wellbeing Boards were established by Parliament to enable commissioners to take a view across the whole of a local health and care economy. In the light of the urgent need to increase the pace and scale of service reconfiguration in the health and care system, the Committee repeats the recommendation it has made in earlier reports that the role of Health and Wellbeing Boards needs to develop to allow them to become effective commissioners of joined-up health and care services.

Competition

81. One explicit change in the 2012 Act was to give a role to the Office of Fair Trading in examining the competition effect of mergers between NHS Foundation Trusts and some

⁶³ See O 252

⁶⁴ Assurance framework to rate CCGs quarterly, Health Service Journal, 6 December 2013

⁶⁵ Nigel Edwards, giving evidence on behalf of The King's Fund: Q 28, 14 May 2013, Implementation of the Health and Social Care Act 2012, HC 119-i.

⁶⁶ Paragraph 37.

other competition issues. This has led to concern within the health sector that competition considerations will be given priority over the judgment of health and social care professionals that a particular change or model of service provision is in the best interests of patients.

82. The main example which illustrates that concern is the way in which the proposed merger of the Royal Bournemouth and Christchurch Hospitals and Poole Foundation Trusts was handled. The OFT referred the proposed merger to the Competition Commission. The Commission produced its final decision on the merger on 17 October 2013, ten months after it had been referred to it. That decision was to turn down the proposal, with the Chair of the Competition Commission saying:

...while the broad aims of the merger are desirable ones, there simply isn't enough detail in the hospitals' plans for us to conclude that any of the claimed benefits are likely to materialise.⁶⁷

83. Unsurprisingly, the Chairs of the two Foundation Trusts were extremely disappointed at the news. In a joint statement they said:

The benefits of merger, which included increased access to consultant care and new patient facilities, will now be much more difficult to deliver, which is disappointing for both our patients and staff.

We recognise that the Competition Commission has a statutory role to perform and specific criteria which it must use to assess benefits, but we believe that the outcome of the process is fundamentally wrong.

The assessment of the merger was always weighted to put competition ahead of benefits to patients, and we do not believe the NHS is best served in this way. 68

84. When we took evidence on the implementation of the 2012 Act, we asked why this aspect of competition law had been reserved for the Competition Commission rather than allocated to Monitor. David Bennett told us:

It is the case in all other sectors where there is a sector regulator that the sector has...concurrent powers on competition. So we have concurrent powers with the OFT and the Competition Commission on competition issues, but mergers and acquisitions are left with the OFT and the Competition Commission. The reasoning is that it provides a bit of a check and balance. People worry that, if you have a single regulator doing all issues connected with competition, you can get regulatory capture and so on. This keeps them separate. I accepted the argument but did say at the time that I

thought in health there was a case for leaving it with the health-specific regulator.69

85. There was a consensus amongst witnesses that the most significant issue here was the potential extended delays to mergers designed to improve quality of service for patients. Witnesses from Monitor, the LGA and the NHS Confederation all agreed that in competition matters the essential requirement was that decisions on mergers and other competition issues should be taken without undue delay.⁷⁰ As Andrew Webster of the LGA put it, "whatever process we have in place needs to both assure competition and act speedily in the interests of the system".⁷¹

86. For reasons of both financial viability and quality of service, the Office of Fair Trading and the Competition Commission need to ensure that their decisions on mergers are reached as quickly as possible. They should also have regard to the principle legislated for in the Act in respect of Monitor that it must allow 'provision of services in an integrated way' where this improves quality of provision or reduces inequalities in relation to access to services or to outcomes.

Does competition law need to be changed?

87. In September 2013, Sir David Nicholson was quoted as saying that competition was not working to improve quality from patients and a change in the law might be needed to ensure that the intent of policy was implemented.⁷² It is clearly significant that less than six months after the Act came into force, the Chief Executive of NHS England has said in terms that this key aspect of the Act is not working as had been intended and that competition rules are impeding changes that would provide a better service to patients.

88. Sir David agreed that competition law could be an impediment to service change when he gave oral evidence to the Committee:

I think we have a problem, which may need legislative change to make it happen. If I think back to the conversations we had with the most senior politicians in the Government around the reforms and changes that we are having, they were very clear that the intent behind all of this was that competition was there to serve, not to control. One of the things that we constantly said was that competition was a tool to improve quality, to be used when commissioners felt it was the right thing to do, not something that would be brought in externally...

For whatever reason, legislatively and in practice, that is not what is happening. What is happening at the moment...we are in my view getting bogged down in a morass of competition law, which is causing significant

⁶⁹ Q 230, 11 June 2013, Implementation of the Health and Social Care Act 2012, HC 119-ii.

⁷⁰ Q 229, ibid

⁷¹ Q 228, ibid

⁷² Competition rules hold back quality, says Nicholson, Health Service Journal, 25 September 2013

cost in the system. We do not have a total for that, but undoubtedly we will find it in time. More than that, it is causing great frustration for people in the service about making change happen. That may be because of the way in which we are interpreting the law—we are talking to Monitor—but it may be because that is the law, in which case to make integration happen we will need to change it.⁷³

89. This followed on from an announcement in September that NHS England had delayed the publication of its choice and competition framework because of a lack of evidence of the benefit to patients. The document was due to have been published in July. Bill McCarthy, Policy Director at NHS England, is quoted as having told the NHS England Board on 13 September 2013that:

We're having [a discussion] with Monitor around choice and competition, and how best they can be applied in healthcare to improve outcomes for patients, including a better experience. That's taken a bit longer than we hoped. We had hoped to be able to put out some guidance early in the summer-I think that probably reflects... it is one of the areas where there is a paucity of evidence.

We're committed to being a system that works on evidence and in this area, even taking from international experience, the direct evidence of where best competition and choice works to improve outcomes is fairly limited. 74

90. We asked the Secretary of State whether he agreed with Sir David that the law needed to be changed. He told us:

I believe that what is happening on the ground is not what the Act intended as much as we want. We intended with the Act that local commissioners— GPs—would have the power to commission services in the way that they believed was right for patients. They are operating under the same procurement rules as the PCTs did, but they are new teams of people and they are finding that quite onerous. My own view is that we need to look at why that is and, in particular, whether there is advice and support we can give them so that they do not feel they are getting bogged down in that competition law. I do not think that it is a case of the competition law that, as I say, the PCTs themselves were operating under necessarily being wrong, but we need to make sure that CCGs feel they have the autonomy and the ability to commission in the way that is in the interests of patients.⁷⁵

91. Asked if he would promote a change in the law if he received a proposal from NHS England to do that, he said

Of course I would listen to them very carefully because I want the commissioning process to work and it is really important that it should work.

⁷³ O 59

^{74 &}lt;u>Competition guidance stalls amid lack of evidence of benefit to patients</u>, Health Service Journal, 16 September 2013.

⁷⁵ Q 280

So I want to make sure that the intentions of the Act are reflected in what happens on the ground. I do not think we are at that stage yet. 76

- 92. It is a serious matter that the Chief Executive of NHS England should raise significant concerns about the effect of the competition provisions of the Health and Social Care Act 2012 within six months of them coming into effect. We have also heard that some commissioners are concerned by uncertainty about those provisions, which is inhibiting the way in which they commission services. This is clearly an unsatisfactory situation.
- 93. The Secretary of State told us that he did not consider that there was a case as yet for seeking to change competition law. The Committee is concerned, however, that in the case of Bournemouth and Poole the competition authorities intervened to obstruct a proposed service reconfiguration on competition grounds without being able to substitute another proposal to deliver service change. The Committee has stated its view many times that there needs to be an increase in the pace and scale of service change. The Committee recommends that the Government should examine the background to the Bournemouth and Poole proposal in order to ensure that unnecessary impediments to necessary change are removed.

"Cherry-picking"

- 94. Another issue that we discussed in evidence was the suggestion that some providers select patients whose treatment is straightforward, leaving others with more complex needs to be treated at the original provider on the same tariff. The concern is twofold:
 - Firstly, that the rigidity of the tariff system leads some providers to be overpaid, and others to be underpaid, with potentially serious consequences for both the availability and quality of patient care;
 - Secondly, that the transfer of care of some patients to other treatment centres may undermine the viability of the original unit.

95. Anita Charlesworth of the Nuffield Trust told us:

Within the cherry-picking there are two things. One is that non-NHS providers—the voluntary sector and private providers—have become a much bigger part of the delivery of care over the past five years. We have doubled the amount of the NHS budget spent with them. If they are delivering that efficiently and delivering high quality, in one sense, does that matter? In terms of cherry-picking, if it is priced rightly so that they are efficient and high quality, does it matter? I guess it might still matter if you have what is called stranded capacity—if you have capacity in the NHS that you are paying for, but are struggling to afford that higher level of activity. It is becoming quite a significant amount of money.

As to the tariff system...it does not deliver efficiency. It does not change any of the financials of the NHS. It says whose job it is to drive out that efficiency. Where the tariff matters, I think, is that we set it correctly so that we price things properly to reflect the cost, but not too much. ... People spend a lot of time worrying about whether we should bundle more things up into the tariff and things like that, but we should worry a lot about whether we are setting the prices right. If we do things such as systematically under-price maternity, we will lead to people being in difficulty who might be perfectly efficient. Equally, if we overprice some bits of complex surgery, we will make people look very good financially when actually they could be very inefficient. That does not help the system overall; it means that where the problems emerge may not reflect what is underlying them. So I would like much more focus on getting the prices right."

96. Sir David Nicholson told us that he was aware of complaints over cherry-picking.

...it has absolutely been raised with me, but on almost every occasion where we have dealt with it in detail, we have found it either to be not the case or people have put in action to change it straight away.⁷⁸

97. It is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement.

Conclusions and recommendations

The current situation

- 1. The conclusions that we draw from the evidence are that:
 - the NHS has provided savings during the first two years of the programme, but that there is a question mark about how sustainable they are;
 - the straightforward savings which are possible have now been made; and
 - the transformation of care that will be required to make the NHS sustainable in the future and able to deal with increasing demand has yet to take place. (Paragraph 11)
- On this final point, the key question, raised in evidence, is not 'what has been saved?' 2. but rather 'what has the money "saved" been spent on? That is currently not transparent, and more needs to be done to demonstrate what new activity has been possible because of the gains of the efficiency process. (Paragraph 12)

NHS Pay

The Committee welcomes the Government's recognition that the future of the health 3. and care system cannot be built on an open-ended pay freeze. If the health and care system is to be a good employer (which it needs to be if it is to deliver high quality care) it needs to undertake transformative change in order to ensure that its committed staff are better able to meet the needs of users of its services. (Paragraph 19)

Allocation of Resources

4. The concept of target funding is as old as the NHS itself. Although the formula will continue to change, with the result that the day when all CCGs receive their target funding will never arrive, the Committee endorses the general approach while recognising that there will always be debate about how quickly actual funding should close the gap with target funding. It is clearly more difficult to make meaningful progress when the overall budget is largely stable in real terms. (Paragraph 28)

Trusts and Foundation Trusts

5. This is the fourth report which the Committee has issued during this Parliament on the implications the Government's spending plans for health and care. In each report we have drawn attention to the urgency of transformative change of the care model if the needs of patients are to be met. The fact that the number of NHS Trusts and NHS Foundation Trusts reporting underlying deficits continues to grow represents evidence that the pace of change has not been sufficient to meet the challenge. (Paragraph 38)

Integration Transition Fund (the Better Care Fund)

- The Committee welcomes the emphasis which the Government is now putting on 6. service integration, both within healthcare services and between healthcare and social care. The Committee also recognises the logic of creating the Better Care Fund to provide an incentive for health and social care authorities to cooperate in new ways and facilitate the transfer of resources into community services which is a necessary part of the change process. (Paragraph 60)
- The Committee remains concerned, however, that the pressures on available 7. resources across the whole system, but in particular in social care, are now much greater than they were a few years ago, with the result that successful integration of high quality health and care services represents a substantial and growing challenge. The Committee does not believe that either the pace or the scale of the change which is necessary is sufficiently understood or that sufficient steps are being taken to explain the need for change to either the health community or the wider public. (Paragraph 61)
- The Committee continues to believe that fragmented commissioning structures 8. significantly inhibit the growth of truly integrated services. The Committee has recommended in previous reports that Health and Wellbeing Boards should be encouraged to develop their role to provide an integrated commissioners' view of the transformative change which is necessary in our health and care system. It repeats that recommendation in this report and further recommends that NHS England and the Local Government Association should commission a review to establish the best practice method of consolidating the commissioning process through HWBs with minimum disruption of ongoing activity. (Paragraph 62)
- 9. The Committee also repeats the recommendation it made last year that the current level of real terms funding for social care should be ring-fenced. As we said in the corresponding report in 2013, this would "ensure that resources were no longer seen as 'belonging' to a particular part of the system but to the local health and care system as a whole" (Paragraph 63)
- The Committee believes that in the absence of stronger commissioners and a commitment to ring-fenced real terms funding for health and social care, there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead. (Paragraph 64)

Reconfiguration

- Advocating service integration without recognising that the consequence of integration is reconfiguration of acute services is simply dishonest. (Paragraph 70)
- The case for acute service reconfiguration is often presented as an economic 12. necessity, but that is only half the story. It is certainly true that economic pressures mean that changes in acute services are necessary if the health and care system is to meet the demands placed upon it. The argument for reconfiguration, leading to reduced emphasis on acute services, is however supported by consideration of clinical quality as well as economic pressure. Our system currently places insufficient

emphasis on identifying early symptoms and supporting normal life, with the result that it has provided reactive acute care to patients whose condition should never have been allowed to become acute. The challenge facing NHS policy makers, at both national and local level, is to explain this underlying policy requirement to a sceptical public. (Paragraph 71)

13. Changes which lead to the closure of hospitals or remove services from hospitals are notoriously controversial with local communities. Too often this is because the first a community hears about proposed changes is when the acute facility is proposed for closure. If these proposals are notoriously controversial, it is too often because the case for change is notoriously badly made. Part of the benefit of involving Health and Wellbeing Boards in the commissioning decisions about health and care, with a single overview for a given community, should be to engage the local professional and lay communities in a greater understanding of the care quality issues which underlie the case for service reconfiguration, as well as the economic issues involved. (Paragraph 72)

Implementation of the Health and Social Care Act 2012

- There is a real danger that, without a body which can take charge of decisions about reconfiguration and integration of services, change which needs to be made to maintain and improve services will not happen. As the Committee has noted earlier in this report, the evidence we heard in this inquiry confirms to us that, in the present system, this is the most viable approach to ensure continuity of and improvement in services. (Paragraph 79)
- Health and Wellbeing Boards were established by Parliament to enable 15. commissioners to take a view across the whole of a local health and care economy. In the light of the urgent need to increase the pace and scale of service reconfiguration in the health and care system, the Committee repeats the recommendation it has made in earlier reports that the role of Health and Wellbeing Boards needs to develop to allow them to become effective commissioners of joined-up health and care services. (Paragraph 80)

Competition

For reasons of both financial viability and quality of service, the Office of Fair **16.** Trading and the Competition Commission need to ensure that their decisions on mergers are reached as quickly as possible. They should also have regard to the principle legislated for in the Act in respect of Monitor that it must allow 'provision of services in an integrated way' where this improves quality of provision or reduces inequalities in relation to access to services or to outcomes. (Paragraph 86)

Does competition law need to be changed?

The Secretary of State told us that he did not consider that there was a case as yet for 17. seeking to change competition law. The Committee is concerned, however, that in the case of Bournemouth and Poole the competition authorities intervened to obstruct a proposed service reconfiguration on competition grounds without being able to substitute another proposal to deliver service change. The Committee has stated its view many times that there needs to be an increase in the pace and scale of service change. The Committee recommends that the Government should examine the background to the Bournemouth and Poole proposal in order to ensure that unnecessary impediments to necessary change are removed. (Paragraph 93)

"Cherry-picking"

18. It is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement. (Paragraph 97)

Formal Minutes

Tuesday 4 February 2014

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper Andrew Percy Andrew George Mr Virendra Sharma Barbara Keeley David Tredinnick Charlotte Leslie Valerie Vaz

Draft Report (Public expenditure on health and social care), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 97 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Seventh 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.

[Adjourned till Tuesday 11 February at 2.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at http://www.parliament.uk/business/committees-a-z/commons- select/health-committee/inquiries/parliament-2010/pex-2013/.

Tuesday 5 November 2013	Question number
Sir David Nicholson KCB CBE and Paul Baumann, NHS England	<u>Q1-158</u>
Wednesday 20 November 2013	
John Appleby, The King's Fund, and Anita Charlesworth, Nuffield Trust	Q159-206
Matt Tee, NHS Confederation, Councillor Katie Hall, Community Wellbeing Board, and Andrew Webster, Local Government Association	Q207-238
Tuesday 17 December 2013	
Rt Hon Jeremy Hunt MP, Una O'Brien, Richard Douglas, and Jon Rouse, Department of Health, and Sir David Nicholson KCB CBE, NHS England	Q239-374

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at http://www.parliament.uk/business/committees/committees-a- z/commons-select/health-committee/inquiries/parliament-2010/pex-

2013/?type=Written#pnlPublicationFilter INQ numbers are generated by the evidence processing system and so may not be complete.

- Chris Longley MBE (PEX0001) 1
- 2 The Royal College of Radiologists (PEX0002)
- Royal College of Surgeons (PEX 0003) 3
- 4 Gwyn Bevan (PEX0004)
- 5 The College of Emergency Medicine (PEX0005)
- West Midlands Security Network (PEX 0006) 6
- 7 Civil Service Pensioners' Alliance (PEX 0007)
- 8 Manchester City Council (PEX0008)
- 9 Surrey County Council (PEX0009)
- 10 4Children (PEX0010)
- Roche Diagnostics Limited (PEX 0011) 11
- 12 Foundation Trust Network (PEX0012)
- 13 Partnership Assurance Group (PEX0013)
- 14 Optical Confederation (PEX0014)
- 15 Association of the British Pharmaceutical Industry (PEX0015)
- Royal College of Physicians of Edinburgh (PEX0016) 16
- Healthcare Financial Management Association (HFMA) (PEX0017) 17
- Monitor (PEX0018) 18
- The Royal College of Pathologists (PEX0019) 19
- 20 Carers UK (PEX0020)
- 21 Leonard Cheshire Disability (PEX0021)
- 22 Scope (<u>PEX 0022</u>)
- 23 Royal College of Physicians (PEX0023)
- Local Government Association (PEX 0024) 24
- 25 Age UK (PEX 0025)
- Hospedia (PEX0026) 26
- 27 Nuffield Trust (PEX0027)
- 28 Department of Health (PEX0028)
- 29 NHS Confederation (PEX0029)
- Royal College of Nursing (PEX 0030) 30
- 31 Staffordshire County Council (PEX0031)
- 32 County Councils Network (PEX0032)
- 33 The King's Fund (PEX 0033)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/healthcom.

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

Session 2013-14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee's Ninth Report of Session 2012–13	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744
Fifth Report	2013 accountability hearing with the Nursing and Midwifery Council	HC 699
Sixth Report	2013 accountability hearing with the Care Quality Commission	HC 761
Session 2012–13		
First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652

Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)
Session 2010–12		
First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)