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

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1 Introduction

1. On 19 March 2013, the House of Commons Health Select Committee published *Public Expenditure on Health and Care Services: Eleventh Report of Session 2012–13* (HC 651). The report followed an inquiry by the Committee, which sought evidence from the Secretary of State for Health along with other witnesses, including the NHS Confederation, the NHS Foundation Trust Network and local government representatives.

2. The Government has carefully considered the Committee's report and the issues that it raises, and this paper sets out the Government's response.

3. The Government agrees with most of the Committee's overall conclusions, in particular about the scale of the financial challenge facing the health and care system. However, as a result of the reforms we have introduced, our commitment to increase health funding in real terms, and the steps we are taking to promote integration, we believe the system is well placed to achieve the efficiencies and deliver the transformation required to sustain and improve services into the future.

2 Government response to the Committee's conclusions and recommendations

Health funding

In our view it would be unwise for the NHS to rely on any significant net increase in annual funding in 2015–16 and beyond. 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, focusing on a transformation of care through genuine and sustained service integration. (HC 651, paragraph 16)

Our working assumption is that annual spending on health services in real terms will show little if any variation above or below the 2010–11 baseline. (HC 651, paragraph 39)

4. The Government is committed to real terms spending increases in health spending. The 2013 Budget confirmed the Government's plan for the economy, first set out in the June 2010 Budget: one based on fiscal responsibility and a credible deficit reduction strategy. The Budget also reaffirmed our commitment to protect health spending up to and including 2015–16.

5. In light of the projections for the public sector finances beyond 2015–16 and the demographic challenges presented by an ageing population, the Government agrees with the Committee that prudent planning is required for the medium-term.

6. As the Committee recommends, NHS England is continuing to promote the Quality, Innovation, Productivity and Prevention (QIPP) programme in order to maintain or improve the quality of healthcare services in a constrained funding environment. The Government also recognises that over the long term, the NHS cannot rely on pay restraint and reductions in the unit cost of care to deliver QIPP-scale efficiencies. Rather we need to transform the way in which health and social care services are delivered, using available resources more effectively and focusing on integrated care and prevention to improve patient outcomes and experience.

7. The Government's reforms will enable commissioners to make changes that will deliver real improvements in quality through commissioning that is driven by clinical insight, patient choice and a focus on improving outcomes. This will promote greater integration of services at the local level, including a more coordinated approach to assessment, care planning and care management.

8. Together with increased patient choice and a more rigorous and transparent system for regulating providers, these reforms will provide much stronger incentives and opportunities to deliver more integrated, personalised and preventive care.

Quality, innovation, productivity and prevention

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 transformations which the service needs. (HC 651, paragraph 19)

While nationally driven initiatives have certainly produced some short term cost savings and may have produced some sustainable efficiency gains, the response to the Nicholson Challenge necessarily involves large scale transformational change. The Committee believes that the case for this transformational change needs to be better made and better understood. (HC 651, paragraph 54)

The primary response of the NHS to the Nicholson Challenge should be to prioritise fundamental service redesign which will lead to better quality care for more NHS patients. Counting cuts to the NHS asset base as Nicholson Challenge savings risks distorting the programme's priorities. (HC 651, paragraph 70)

Our principal concern is, however, the implication that there is a distinction to be drawn between "provider-driven change" and "transformational change". A successful response to the Nicholson Challenge would involve sustained, year on year efficiency gain in the health and care system at twice the long term average rate which prevails in the rest of the UK economy. The Committee believes that it is simply inconceivable that this performance can be delivered – together with the quality improvement that is also required – if planning proceeds within traditional silos. The commitment to "transformational change" needs, therefore, to embrace every aspect of the QIPP Programme including – in particular – the major existing providers. (HC 651, paragraph 82)

At the current rate of progress, we doubt that the predicted savings through transforming and integrating NHS services will be fully realised by the end of the Nicholson Challenge period. Unless significant steps are taken to plan now for service redesign and integration, a significant opportunity to improve the effectiveness and quality of NHS healthcare will have been missed. (HC 651, paragraph 83)

9. The Government agrees that it is vital for organisations to work together collaboratively to deliver and communicate the case for transformational change: both to benefit patients and to improve efficiency. While we are protecting health funding in real terms, this does not mean that all services should remain unchanged. The NHS will need to adapt and evolve to meet the challenges of future demographic trends and rising demand expectations.

10. The Department and NHS England have a key role to play in setting out and driving the case for transformational change. For example, the Secretary of State has challenged the NHS to go 'paperless' by 2018, highlighting the potential benefits for patients and for taxpayers. The Mandate[1] to NHS England set objectives for it to lead the health and care system in driving better integration of services; and we will hold NHS England to account for its performance.

11. Clinical commissioning groups (CCGs) and their local partners need to ensure

1. Department of Health (2012) *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015* www.gov.uk/government/publications/the-nhs-mandate

that where changes to local services are proposed, these have the clear support and involvement of local stakeholders and clinicians. NHS England has committed in its business plan to developing and overseeing a framework for local service change, setting out the roles and responsibilities of different organisations and developing a range of tools and guidance to support CCGs delivering transformational change.

12. However, service transformation cannot be imposed from the top. Clinical commissioners and their partners at local level are best placed to understand the needs of their communities and the opportunities for improvement. Engagement on specific local service changes needs to be locally led and as part of the authorisation process for CCGs, NHS England has sought assurances that locally CCGs are taking the necessary steps on service transformation.

13. The Government has always been clear that efficiencies in the early years of the QIPP period would focus more on central actions (e.g. pay, cutting bureaucracy) and improving productivity; and that savings from more transformational changes would take longer.

14. We also recognise that the efficiency challenge requires the delivery of recurrent efficiency savings of up to £20 billion by 2014–15. This means that any one-off savings will need to be replaced with other sources of savings in subsequent years. The National Audit Office has confirmed that the vast majority (over 90%) of efficiency savings delivered to date are recurrent.[2]

Although it is certainly true that public sector pay restraint has the short term effect of reducing the cost of service provision to the NHS budget, the Committee does not accept that can be regarded as a sustainable form of efficiency gain. Sustainable efficiency gain involves securing improved quality or value for a given expenditure – it is not delivered by simply suppressing staff salaries alone. (HC 651, paragraph 24)

The NHS will not be able to rely on the present rate of paybill savings once the present restraints on public sector pay are relaxed in April 2013. Furthermore, 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. Short term pay settlements will always reflect prevailing circumstances, but in the longer term NHS employees will share the same aspirations as employees elsewhere in the economy to participate in economic success. (HC 651, paragraph 68)

15. Pay restraint is an important part of the Government's strategy to meeting the current economic and fiscal climate, while maintaining services and jobs. We have set clear expectations on pay restraint across the public services, with public sector pay awards averaging up to 1% in 2013–14 and 2014–15. In addition, the 2013 Budget confirmed that public sector pay awards in 2015–16 will be limited to an average of up to 1% and that significant further savings through reforms to progression pay will also be sought in the forthcoming spending round. We recognise, of course, that in the longer term, pay trends will be dependent on wider economic factors.

Still less is efficiency gain secured for the NHS by reducing the tariff paid by an NHS Commissioner to an NHS Provider. Tariff payments are internal transfers; they only result in efficiency gain for the NHS if the NHS Provider changes the way care is delivered. The Committee is concerned that it has received insufficient

2. National Audit Office (2012) *Progress in making NHS efficiency savings* (HC 686) www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

evidence of such service change by NHS Providers; it is also concerned that both NHS Management and ministers appear to be convinced that changing an internal transfer payment constitutes a form of efficiency gain. (HC 651, paragraph 25)

We have highlighted in previous reports our concerns about the use of tariff reduction as an overall policy to drive efficiencies on the provider side. Tariff reduction does not encourage efficient behaviour on the commissioner side, and we have received little evidence to suggest that the tariff is being used intelligently to drive service transformation and greater integration. We fear that further turns of the tariff ratchet will lead to further salami-slicing of NHS Provider services in ways which prioritise expenditure reductions over imaginative service redesign. (HC 651, paragraph 78)

16. The Government recognises that the tariff is a pricing mechanism: while the setting of tariff prices provides important incentives for efficiency, it does not, in itself, represent an efficiency saving. As the Committee points out, efficiency savings are only made when providers take action to ensure they can live within the income they receive through the tariff. In aggregate, the provider sector is in financial surplus, which suggests that savings are being made, though some individual providers do face specific challenges.

17. The tariff is just one of a number of levers to help promote service transformation and integration, and the tariff alone cannot deliver transformational changes in how care is provided locally. Nevertheless, real progress has been made: for example, the introduction of an increasing number of 'best practice tariffs' where payment reflects the cost of best practice models of care rather than simply average cost. When a new best practice tariff was introduced for the care of patients with a fragility hip fracture, the proportion of patients receiving surgery within 48 hours of admission increased from 60% to 70%. The academic evaluation[3] estimates this increase was four percentage points higher for providers participating in the best practice tariff compared with those that did not.

18. As NHS England and Monitor take joint responsibility for setting the tariff from 2014–15, they have committed to developing a longer-term strategy that uses pricing as effectively as possible to drive better outcomes and efficiency.

At a time when steadily rising demand for health and care services needs to be met within very modest real terms funding increases for the NHS and even tighter resource constraints on social care, the Committee remains convinced that the breadth and quality of services will only be maintained and improved through the full integration of commissioning activity across health and social care. (HC 651, paragraph 30)

19. The Government agrees with the Committee that health and social care services must be seen as one system, and be planned together accordingly.

20. Person-centred health and care services need an integrated approach to commissioning and service provision, with the precise model depending on local circumstances. Integrated care is about local authorities and the NHS working together, with support from national government, to find local solutions to their priorities in order to transform public services within available resources. Central government will support local authorities and the NHS to find these

3. University of Nottingham and University of Manchester (2012) *A Qualitative and Quantitative Evaluation of the Introduction of Best Practice Tariffs* www.nottingham.ac.uk/business/news/documents/bpt-dh-report-21nov2012.pdf

solutions, but local leaders must work together on how best to achieve integration for their area.

21. This approach will ensure high quality, responsive and efficient services that meet the needs of local populations within the funding available.

22. Through the reforms in the Health and Social Care Act 2012, the Government has put in place a series of powers to drive the process of fundamental change in person-centred service provision. The Act strengthens integration duties both locally and nationally and places commissioners – including NHS England, CCGs and local authorities – at the centre of decision-making. It will be for local health and wellbeing boards to coordinate these efforts to respond to the rising demand for health and care services.

23. Health and wellbeing board members will include all local health and care commissioners and budget holders. Jointly, they will be responsible for identifying and assessing needs and co-producing a Joint Health and Wellbeing Strategy that sets out how local partners' commissioning activities across health, social care and the wider determinants of health will meet the needs of their local community within local resource constraints.

24. This arrangement will allow local partners and budget holders to hold each other to account, and will enable local communities, HealthWatch and elected representatives to ensure local commissioners deliver the best outcomes and use of resources. This includes using pooled funding and integrated commissioning.

25. In November 2012, the Minister for Care and Support, Norman Lamb, committed to encouraging local experimentation, ". . . at scale and pace". In support of this, on 14 May 2013, the Department along with our national partners in healthcare and support published, *Integrated Care and Support: Our Shared Commitment*,[4] which sets out 10 commitments that the national partners have made to enable and encourage change at scale and pace, as well as expectations on local areas in return. The national partners have also invited the most ambitious areas to apply to become 'pioneers' and act as exemplars to address local barriers and support the rapid dissemination, promotion and uptake of lessons across the country.

Health spending rules

We recommend that the Department of Health, the NHS Commissioning Board and the Treasury review the operation of accounting policies and rules which apply to revenue and capital expenditure on health services. (HC 651, paragraph 51)

26. The Government's budgeting rules (set out in HM Treasury's consolidated budgeting guidance)[5] are kept under regular review. However, the Government does not see the need to change the current budgeting rules at this time. These rules have two main objectives:

- To support the achievement of macro-economic stability by ensuring that public expenditure is controlled in support of the Government's fiscal framework.
- To provide good incentives for departments to manage spending well to provide high-quality public services that offer value for money to the taxpayer.

4. Department of Health (2013) *Integrated Care and Support: Our Shared Commitment* www.gov.uk/government/publications/integrated-care
5. See www.hm-treasury.gov.uk/psr_bc_consolidated_budgeting.htm

27. This system applies to all bodies classified by the Office for National Statistics (ONS) as 'central government bodies'. For the Department of Health, this includes: CCGs; NHS providers (NHS trusts and NHS foundation trusts); Public Health England (an executive agency); special health authorities; and, executive non-departmental public bodies such as NHS England.

28. Allocations to the Department's bodies have to be considered within the constraints of the budgeting rules and the funding available for that year. The Department has committed to providing surpluses generated by the commissioning sector back to them in the following year. It would not be prudent for these bodies to use the entire underspend in the following year, because carrying a surplus provides the flexibility to respond to unexpected costs. Therefore, plans are agreed that involve a steady use of the underspend over a number of years, funded from the wider Department of Health budget.

The Committee is particularly concerned that the rules around budget exchange for NHS Providers are unnecessarily inflexible. Provided NHS Commissioners are subject to effective expenditure control, and provided also that Monitor is able to exercise effective control over recurrent deficits in NHS Providers, the Committee believes that the controls on the use of reserves by NHS Providers should be abolished to encourage Providers to invest in necessary service change. (HC 651, paragraph 52)

29. Although the Department is bound by the budget exchange rules that govern the ability to carry forward underspends from one year to the next, NHS providers are not subject to these rules. They are allowed to keep the cash that they have accumulated and spend it in future years on revenue or capital, subject to the regulatory/legislative regime of their sector.

NHS foundation trusts

30. NHS foundation trusts are required to comply with licence conditions set by Monitor. Through the licence, Monitor will assess NHS foundation trusts' financial viability. Monitor's compliance framework sets out the approach that it takes to assess this compliance.[6]

NHS trusts

31. Each NHS trust's board is responsible for planning and controlling the activities, costs and income of the trust to ensure that it remains financially viable at all times. The board is accountable for financial control and for ensuring that the NHS trust meets its statutory duty to breakeven. Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 states that:

"Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account"

32. NHS providers are classified by the ONS as 'central government bodies,' meaning that their underspends, overspends and capital expenditure score to the Department's budget in the year that they occur. The Department's financial plans therefore have to include a forecast of these net underspends, overspends and capital expenditure.

Re-imagining care

The heart of the Committee's approach is that the care system should treat people not conditions. Services should adapt to people, not the other way round. (HC 651, paragraph 86)

6. See www.monitor-nhsft.gov.uk

33. The Government's White Paper on Care and Support set out a vision for a modern system which promotes people's wellbeing by enabling them to prevent and postpone the need for care and support, and puts them in control of their lives to pursue opportunities, including education and employment, to realise their potential.

34. The central principle of the newly published Care Bill is that people are at the heart of how services are shaped. This is reflected in the first clause of the Bill, which is about promoting individual wellbeing. This wellbeing principle underpins the entire care and support system, ensuring that the person's wellbeing should be at the heart of every decision made in the social care system.

35. The Government is aware that the care and support system is complex and difficult to navigate. The Bill states that every local authority must have an information and advice service so that people are able to understand how the care and support system works, what services are available locally, and how to access those services.

36. There is a duty in the Bill for local authorities to shape local care markets by promoting the diversity and quality of local services around what people want, so that there is a range of high-quality providers in all areas allowing people to make the best choice to satisfy their own needs and preferences.

37. The Bill captures in law for the first time the process of care and support planning. People will be central to determining what their own care and support plan looks like. Care and support plans will include personal budgets, which the Bill places on a legislative footing for the first time. Where a local authority is paying to meet a person's needs, the person will be able to request the cost of that care and support as a direct payment. Combined with the other provisions in the Bill, this will allow people to understand the options available to them and exercise control over how their care and support is provided.

38. Personal budgets are also being introduced in health. This follows the successful pilot programme, which demonstrated that they are more effective for people who are higher users of NHS services: such as people receiving NHS continuing healthcare, and those with long-term and substantial physical and mental health needs. They can improve quality of life, be cost effective and reduce the need for secondary care.

39. It is the Government's longer-term aim to introduce a right to have a personal health budget for all those who may benefit, with those receiving NHS continuing healthcare being the first to have a right to ask for a personal health budget by April 2014. The Mandate to NHS England sets out an ambitious objective that, ". . . patients who could benefit will have the option to hold their own personal health budget, as a way to have even more control over their care."

40. Integrated care and support means person-centred, coordinated and continuous care and support, tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to taking a whole person view of health, care and support needs.

41. Care that is 'integrated' offers the potential for genuine benefits for patients and service users and for health, care and support services to make measurable improvements in patient and service user experience, outcomes and system efficiency. The Government wants integrated care and support to become the norm for local working. This will support the delivery of truly personalised services focussed around individuals and not organisations.

42. There is a new duty in the Care Bill to promote integration of care and support with health services. This is a counterpart duty to the duties on NHS organisations created in the Health and Social Care Act 2012. It means that priority will be placed on integrating services to ensure they fit around what outcomes people want, rather than forcing people to fit around how the system is designed.

43. To be able to deliver integrated care and support we must have a shared understanding of what integration means. As part of the work on *Integrated Care and Support: Our Shared Commitment*, NHS England commissioned National Voices, a national coalition of health and care charities, to develop a person-centred narrative on integration that the whole system could adopt. The national partners have adopted this definition of what good integrated care and support looks and feels like and we expect all localities, including pioneers, to adopt it too.

The Government has accepted the key principles set out in the Dilnot Report with the key exception that it proposes that the cap on individual contributions should be set at £75,000 in 2017–18 prices (equivalent to £61,000 at 2010–11 prices). The Committee plans to review the implications of the Government's proposal to introduce the cap at a higher level than recommended by Dilnot, but it welcomes the Government's endorsement of the principles set out by Dilnot, and its commitment to introduce the necessary primary legislation. (HC 651, paragraph 88)

44. The Government is pleased that the Committee has welcomed the commitment to the principles set out by the Dilnot Commission. These historic reforms will give everyone more certainty and peace of mind over the cost of old age. This is the first time ever that a cap has been introduced to protect people from spiralling costs.

45. The Government's new measures will give everyone the assurance that they will get the care they need, and that they and their home will be protected from huge costs if they develop very complex care needs – such as dementia or a number of conditions that mean they need many hours of care a day.

46. This is crucial in the context of an ageing society. With the number of over 85s doubling by 2030 and cases of dementia expected to rise at a similar rate, it is vital that people are offered a clearer, fairer and more affordable way to plan for and manage their care costs.

47. At the Budget in March, the Chancellor announced that the Government would be bringing forward the start of the cap on care costs to April 2016, and will reduce the cap level to £72,000. The lower cap level of £72,000 in 2016 ensures that it is equivalent to the previous announcement of a £75,000 cap in 2017 prices. This means more people will benefit sooner from the reassurance and protection our reforms would bring.

48. Subject to the passage of legislation, the capped cost system will provide people with a new legal right to financial protection from very high care costs from the State. People will be more easily able to plan and prepare for their future, including the care and support they might need.

We recommend that the new health and wellbeing boards should be developed as the forum in which all interested parties should evolve the future shape of health and care services in their area. (HC 651, paragraph 95)

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. (HC 651, paragraph 100)

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. (HC 651, paragraph 102)

49. The Government agrees that health and wellbeing boards should be the forum for all interested parties to shape health and care services in their area. Our vision is for health and wellbeing boards to be the local system leader for health and wellbeing, bringing together local authorities, the NHS, public health and local communities to collaboratively develop a shared understanding of the health and wellbeing needs of the community, and a shared strategy to address those needs and improve outcomes.

50. The Government believes that CCGs and health and wellbeing boards should be required to deliver and promote integrated care and support, not simply to plan it. This is why these bodies are under clear duties to ensure and promote the integration of services and will be measured against their outcomes in delivering this, not their process in planning it.

51. We agree with the Committee that we should not be over-prescriptive as there are no 'one size fits all' blueprints for integrated care and support models. Each locality needs to develop the right solution for their local population and circumstances. We will explore ways to achieve the recommendation without resorting to primary legislation: for example, we will consider further with our partners how we can support the recommendation for health and wellbeing boards to demonstrate how they intend to deliver a commissioning process which provides integrated health, social care and social housing services in their area.

52. In addition to this, as part of our newly announced plan for vulnerable older people, which will look at aspects of the way older people most in need of support from the NHS and social care system are looked after, we will be looking into removing barriers to integration as well as improving primary care and the care provided by hospitals, including the role of emergency care.

53. We need to ensure care for patients is joined up across general practice and primary, secondary and social care starting with diagnosis. Work has already started to empower local health and care communities to improve integrated care and support for their populations, and to tackle the barriers to achieving this. We need to build on the good practice to make integration the standard approach. During summer 2013, we will be identifying integrated care 'pioneers' and their work will inform us about a range of issues, including commissioning integrated care. What matters most of all is the impact on patients and service users and their carers. By the end of 2013 we will have developed new ways of measuring people's experience of integrated care and support, which will be reflected in the health, social care and public health outcomes frameworks.

54. The Health and Social Care Act 2012 strengthens the duties to promote and enable integration between health, care and support, and 'health related' services such as housing on NHS England, CCGs, and health and wellbeing boards. If enacted, the Care Bill will place similar duties to cooperation and integration on local authorities. This will be reinforced through the NHS Constitution, the Mandate from the Secretary of State for Health to NHS England and through aligning the three outcomes frameworks. Further, we are developing a measurement of patient and service user experiences of integrated care to place in the three frameworks. Together these levers will work to ensure localities deliver integrated and joined up services.

55. Health and wellbeing boards are already placed under a duty to develop a joint understanding of current and future health and social care needs of the local population through Joint Strategic Needs Assessments (JSNAs) and to use the JSNAs to develop Joint Health and Wellbeing Strategies (JHWSs) to address identified needs. Health and social care commissioners, including local authorities, NHS England and CCGs must have regard to JSNAs and JHWSs. This means that in making any decisions to which JSNAs or JHWSs are relevant, for example a commissioning decision, they must take account of the relevant JSNAs and JHWSs, and must be able to justify any parts of their plans that are not consistent. In effect, JSNAs and JHWSs will lay the foundation for both local authorities' and NHS commissioning plans. Combined with the integration duties on each of these bodies this will ensure that integration is at the heart of the commissioning planning process.

56. 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.

57. 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. Health and wellbeing boards will be able to consider the use of NHS Act 2006 flexibilities, such as pooled budgets and lead commissioning, to support their JHWSs. Furthermore, local authorities will be able to commission on behalf of CCGs and vice versa.

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. (HC 651, paragraph 106)

58. 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.

59. Funding arrangements for 2015–16 will be announced in June 2013 as part of the current spending round, and arrangements for future years will be set at future Spending Reviews.

60. However, the Government does agree that integrated, flexible and responsive services that are built around the needs of patients and service users, carers and families, are an essential component of high-quality health and care.

61. The Health and Social Care Act 2012 introduces important duties in relation to integration, both nationally and locally. Local health and wellbeing boards will bring together commissioners and budget holders to deliver the best outcomes and the best use of resources.

62. Provisions in the Health and Social Care Act 2012 ensure that partnership arrangements and pooling of funding can continue in the new system architecture (under section 75, 76 and 256 of the NHS Act 2006).

63. These flexibilities allow for funding to flow across local authorities and NHS bodies, guided by health and wellbeing boards: for example, for joint commissioning and the social care transfer monies (almost £1 billion in 2014).

64. The 2010 Spending Review provided a challenging settlement to local authorities. In this context, the Government prioritised adult social care by providing substantial additional funding. The NHS provides a significant proportion of this funding to local authorities, for use on social care services with a health benefit. This arrangement promotes closer integration of health and social care by providing an opportunity for the NHS and local government to work together across organisational boundaries and deliver on shared objectives.

65. As set out above, the Department of Health is working across government to support local initiatives and identify what needs to happen to drive this integrated care at a national level. This is likely to include flexible and innovative funding arrangements, improving information sharing, harnessing technology, removing barriers where they exist and strengthening the evidence base for integrated care by learning from innovative models such as the Community Budget pilot sites, which are pooling public funding to make integrated services a reality for their communities.

66. All of this offers real potential to bring about a flexible, responsive health and care economy that will use the total budget provided across the NHS and local government more efficiently than is the case at present.

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