Government Response to the House of Commons Health Committee Report on Public Expenditure (Thirteenth Report of Session 2010–12)

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
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1 Introduction

1. On 24 January 2012, the House of Commons Health Committee published *Public Expenditure: Thirteenth Report of Session 2010–12* (HC 1499). The report followed an inquiry by the Health Committee which sought evidence from the Secretary of State for Health along with other witnesses, including the NHS Confederation, the Local Government Group and the King's Fund.

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.

2 Government response to the Committee's conclusions and recommendations

Meeting the challenge: the need for service redesign and integration

The evidence submitted to the Committee is … unambiguous. The Nicholson Challenge can only be achieved by making fundamental changes to the way care is delivered. (HC 1499, paragraph 9)

3. The Government agrees that the challenges facing the NHS, and the opportunities available to improve the quality and productivity of services, will mean that – in some instances – how and where care is delivered will change. Successive governments have shared a view that more care can and should be provided in community or primary care settings with secondary and tertiary services providing access to specialist care.

4. Where major service changes are required to achieve this, it is essential that this is determined and planned at a local level, where decisions can be clinically driven by clinical commissioners who understand the needs of their patients best. This is at the heart of the Government's reforms.

5. The aim of the reforms is very clear – to improve health outcomes, bringing them more into line with the best international comparisons, while the system successfully navigates a very challenging financial environment. The Government considers that this will be best achieved through a system which takes a far less top-down approach than previous incarnations of the health service.

6. Clinical commissioning groups (CCGs) will be responsible for securing high-quality health services to meet the needs of their local populations. CCGs will have the flexibility to collaborate with each other, with local government and with the NHS Commissioning Board in making decisions about the redesign and reconfiguration of services. In addition, there will be commissioning support mechanisms so that CCGs have access to any capacity and capability they require in order to carry out their commissioning functions, including service redesign. The NHS will also have a provider sector that has much greater freedom to innovate and respond to the needs of the market, as determined by the choices of patients.

7. The NHS should continue to consider the impact of changing any services for local patients and the public, and consider what engagement should take place with local patient groups and the relevant local authorities before any changes are made. Health and wellbeing boards will provide a forum where commissioners, local authorities, local HealthWatch and other key local leaders across health and social care can discuss the future shape of services, building on their assessments of local health and care needs and the overall health and wellbeing strategy for the local area.

While the separate governance and funding systems make full-scale integration a challenging prospect, health and social care must be seen as two aspects of the same service and planned together in every area for there to be any chance of a high quality and efficient service being provided which meets the needs of the local population within the funding available. We would like to see best practice in this rolled out across the Health Service and underperforming commissioners held to account for failure to engage in this necessary process of change.
(HC 1499, paragraph 13)

8. The Government recognises that the NHS and social care have different accountability and funding systems. Evidence from the field (brought together in the recent reports[1] from the NHS Future Forum, and from the King's Fund and Nuffield Trust) is that structural integration is not necessary to achieve the benefits of integration, the Government nonetheless agrees that every opportunity should be taken to promote the development of integrated approaches, services which are 'joined up' from the patients' perspective.

9. The Government wishes to encourage bottom-up, rather than top-down, approaches through local and sector-led initiatives. As the NHS Future Forum pointed out, there is no "silver bullet" and "one size does not fit all". To achieve the local ownership that the evidence suggests is essential to success, the Government will not want to be prescriptive about how integration should be achieved.

10. The new commissioning arrangements in the Health and Social Care Bill are designed to promote integration, through statutory duties and new ways of working. Commissioners will be held to account for commissioning high-quality services with good outcomes, within the resources available to them, and must seek to deliver services in an integrated way where doing so will achieve this. CCGs will be held to account by the NHS Commissioning Board ('the Board') against a Commissioning Outcomes Framework, while the mandate will be one of the primary means by which the Department of Health holds the Board to account. The mandate will include the NHS Outcomes Framework, which shares a number of outcomes indicators with the social care and public health outcomes frameworks.

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1 NHS Future Forum (2012) *Integration: A report from the NHS Future Forum*. www.healthandcare.dh.gov.uk/forum-report/; King's Fund/Nuffield Trust (2012) *Integrated care for patients and populations: Improving outcomes by working together*. www.kingsfund.org.uk/publications/future_forum_report.html

11. The Department is clear that existing joint commissioning arrangements between social care services and the NHS are maintained. Over and above this, the Bill is clear about the importance of greater service integration, with a statutory duty on the Board to exercise its functions with a view to securing that health services are provided in an integrated way, and that the provision of health services is integrated with health-related services or social care services where this would improve the quality of health and care services or reduce inequalities in outcomes or access. Furthermore, the Board will encourage CCGs to enter into section 75 agreements with local authorities where it considers that it would secure integration and deliver improved outcomes to patients. The Bill also places new duties on CCGs to promote integrated working by taking specific action to secure integration where it is beneficial to patients. CCGs will be best placed to promote integration given their knowledge of patient needs and the commissioning power to design new services around these needs.

12. One of the main aims of the reforms to NHS trusts, foundation trusts and the role of Monitor is to stimulate and enable new models of integration, recognising that providers are likely to develop some of the most innovative ideas for more joined-up services.

13. Health and wellbeing boards, under a duty to encourage integrated working between commissioners and to promote arrangements for integrated provision of services, will drive integrated commissioning and provision of services in their locality. They will provide the vehicle for local government to work in partnership with commissioning groups to develop robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of healthcare, social care and public health. CCGs will have to report annually to the Board on their contribution to the Health and Wellbeing Strategy in their locality.

14. There will also be an important role for the Board in supporting effective local approaches to joint commissioning and in spreading best practice. The Department agreed with the NHS Future Forum's recommendation that the Board should ensure that commissioning support for CCGs is provided in a way that helps to establish effective joint commissioning locally.

15. The Department will encourage lead and joint commissioning through statutory guidance and the Secretary of State's mandate to the Board. The NHS, social care and public health systems will ultimately be held to account for the outcomes they achieve, including outcomes delivered through greater integration, via the outcomes frameworks set by the Department.

Progress on Quality, Innovation, Productivity and Prevention (QIPP): setting and achieving targets

At a time when all NHS bodies are being required to make efficiencies and need to plan strategically to reshape services it is unhelpful for the Department of Health to require them to make bids for capital funding to … short deadlines and without adequate preparation.
(HC 1499, paragraph 39)

16. No such deadlines have been set by the Department. The Department identified capital funding from existing resources which could be made available to the NHS to the end of 2012–13. Discussions are now taking place with the NHS to see how it could best be spent. However, no decisions have been taken and no deadlines established at national level. Recent reports followed communications from one strategic health authority (SHA) only and were not instigated by the Department. Further announcements will be made when the best possible use of this capital funding has been identified.

It remains too early fully to assess the types of savings being made in 2011–12, the first year of the QIPP programme. The Government remains confident that savings are on track. Nevertheless, we have heard strong concerns from the NHS Confederation, the Foundation Trust Network and the King's Fund, among others, about the ability of NHS organisations firstly to meet their saving plans and second, to do so in a manner that is sustainable and releases further savings in future years. We are concerned that there appears to be evidence that NHS organisations are according the highest priority to achieving short-term savings which allow them to meet their financial objectives in the current year, apparently at the expense of planning service changes which would allow them to meet their financial and quality objectives in later years. (HC 1499, paragraph 40)

17. As set out in the edition of *The Quarter*[2] for quarter 2 of 2011–12, the NHS is broadly on track to deliver around £5.9 billion of efficiency savings in 2011–12 and, at a national level, quality continues to be maintained or improved. This represents good progress.

18. The QIPP challenge that the NHS faces covers a four-year period (2011–12 to 2014–15). That is why the NHS has been planning since 2009 to put in place proposals that cover the entire Spending Review period in order to meet that challenge. In the summer of 2011, the Department signed off the four-year integrated plans that were submitted by SHAs. In addition to monitoring the quality of, and efficiency savings generated by, NHS services throughout the year, the Department is also working with SHAs to ensure that they are clearly planning for and then delivering against the milestones required to produce savings in future years.

2 Department of Health (2011) *The Quarter: Quarter 2 2011/12*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131955

19. In some cases, this may mean that there is a good case for reorganising services to make sure that quality of care can be maintained or improved. But the Department has been very clear that any such decisions must include commissioners and must have a clear clinical evidence base, and that patients and the public must be involved in that process.

20. The NHS will benefit from non-recurrent, one-off savings in any one financial year, which will contribute towards the overall expenditure position in that year. However, the up to £20 billion QIPP challenge is a requirement for recurrent savings by 2014–15, and therefore NHS organisations recognise that efficiency savings must be sustained over this period.

Progress on QIPP: service reconfiguration

The Nicholson Challenge can only be achieved through a wide process of service redesign on both a small and large scale. These changes should not be deferred until later in the Spending Review period: they must happen early in the process if they are to release the recurring savings that will be vital in meeting the challenge. In the meantime, we are concerned that savings are being made through "salami-slicing" existing processes instead of rethinking and redesigning the way services are delivered. (HC 1499, paragraph 57)

21. The Government agrees that service redesign will play a significant role in helping the NHS to deliver the required improvements in quality and productivity. The Government has been clear that these savings will be weighted towards the later years of the Spending Review period to ensure that appropriate clinical leadership and local engagement take place.

22. Therefore, in 2011–12 while the NHS is preparing to deliver these redesigned services in future years, it is also generating significant savings now through quality and efficiency improvements that have shorter lead-in times. This could include changes such as incremental improvements to existing services or improving back office efficiency.

23. This was stated unambiguously in *The Operating Framework for the NHS in England 2012/13*:[3]

> "The NHS is on track in 2011/12 to meet QIPP objectives. Currently this is weighted towards central actions, including pay and administrative cost reductions and local efficiency programmes. For future years, delivering the additional efficiency savings and quality improvements will require the NHS to focus on delivering transformational change through clinical service redesign. For 2012/13, we need to build on the progress made in delivering efficient organisations and, through the reinvestment of those efficiencies, start to deliver transformational service change while maintaining the gains already made. Where cost improvement programmes are required, these must be

3 Department of Health (2011) *The Operating Framework for the NHS in England 2012/13*. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

agreed by Medical Directors and Directors of Nursing, involve patients in their design and include in-built assurance of patient safety and quality."

24. As the Secretary of State identified in his evidence to the Committee, where a large-scale service change or reconfiguration is required, these should be built on a foundation of support from commissioners, local authorities, patients and the public. This is why the Secretary of State introduced the 'four tests' during 2010 which current and future reconfigurations must meet. These tests set out that local plans must demonstrate:

    - support from GP commissioners;
    - strengthened public and patient engagement;
    - clarity on the clinical evidence base; and
    - support for patient choice.

25. The four tests provide important guiding principles to enable the development and implementation of service changes. Moreover, the reforms will enable commissioners to make the changes that will deliver real improvements in outcomes for patients and the public, and will incentivise providers to deliver higher-quality and more efficient services. This will be achieved through commissioning that is driven by clinical insight, patient choice and a focus on improving outcomes. It will strengthen the drive for provider efficiency through greater price transparency and increased competition. In addition, the Department is continuing to support the growth and uptake of assistive technologies that will enable more people to be cared for in their home and in the community. When combined, these reforms will provide much stronger incentives and opportunities to shift care from hospitals and closer to home.

26. The Government is clear that so-called 'salami-slicing' of savings, where savings are made through short-term, unsustainable measures that compromise the quality of care patients receive, are counterproductive. Savings made in this way will, in general, create additional cost for the NHS in the future, for example when unmet demand for services results in urgent or more serious medical intervention at a later date. QIPP is designed to ensure that the NHS makes savings in a way that is sustainable and improves or maintains quality.

The reduction of the tariff is intended to encourage service redesign. This link needs to be made much more explicit if there is to be a proper understanding in the NHS and among the wider public of the scale of service change which is needed to meet the Nicholson Challenge.
(HC 1499, paragraph 58)

27. The Committee received advice from the Department that improvements in provider efficiency have the potential to deliver 40% of the required QIPP savings. This estimate is based on national assumptions about gains that providers could make, including in areas such as improved staff productivity, procurement, introducing more talking therapies in mental health and improving the efficiency of community services.

28. The Department is taking a two-pronged approach to supporting the NHS to deliver these savings – offering providers support to make specific improvements, and driving improvements through contractual and financial levers which include, but are not limited to, the tariff.

29. The Department is pursuing new approaches to price-setting that promote best practice models of care which are also more efficient. For example, it is expanding the number of 'best practice tariffs' which promote changes in practice such as a shift of care from inpatient to day-case and outpatient settings where clinically appropriate.

30. The Government agrees with the Committee's view that tariff reduction is a tool and not a policy in itself, and that where reductions in tariff prices are linked to the promotion of service redesign that will benefit patients, this should be made explicit.

Progress on QIPP: the impact of the White Paper restructuring

The reorganisation process continues to complicate the push for efficiency gains. Although it may have facilitated savings in some cases, we heard that it more often creates disruption and distraction that hinders the ability of organisations to consider truly effective ways of reforming service delivery and releasing savings.
(HC 1499, paragraph 63)

31. As has been previously stated, the reform programme offers significant additional opportunities to support the NHS in its efforts to realise the required improvements in quality and efficiency. For example, in the short term the reforms allow more money to reach the front line where it can be used to directly care for patients with less being used for administration. In the medium term, by giving clinicians an even greater role and more freedom to design local services, they will help to ensure that patients get the care they need as quickly and conveniently as possible. That is the right thing for patients and taxpayers.

32. Given the scale of the changes being made across the health system, it is important that the transition to the new system is phased and carefully managed. The Department will continue to work on the design of the interfaces, roles and responsibilities of organisations in the new system as part of the wider transition process. The programmes of CCG pathfinders and health and wellbeing board early implementers will help to test these new ways of working before the new bodies are established formally.

33. The Government considers that the additional benefits the reforms will deliver will significantly outweigh the challenge of managing the changes, a challenge which the Government believes the NHS is handling well.

34. Recent activity growth is below 2010–11 levels but with no evidence of reduced access to care. Compared with the equivalent in 2010–11, year-to-date growth (up to the end of November 2011) in cost-weighted activity (a composite of elective, non-elective, first outpatient and accident and emergency attendances) is broadly flat at 0.1% (compared with 2.9% growth in 2010–11). The main

driver of the reduction is a 2.0% decline in non-elective admissions to hospital compared with growth of 3.6% in 2010–11.

35. To help to manage the transition, the 2011–12 Operating Framework set out how primary care trust (PCT) clusters should support and empower emerging CCGs by delegating budgets to groups ready to take on responsibilities. Almost half of available budgets have already been delegated to emerging CCGs and the rate of delegation is expected to continue to increase in 2012–13.

Social care: pressure on services

The overall picture of social care is of a service that is continuing to function by restricting eligibility, by making greater savings on other local authority functions and by forcing down the price it pays to contractors for services. In each case, the scope for further efficiencies is severely limited. The Government's response to the Dilnot Commission's proposals due in the first half of this year will, we hope, set out how a sustainably funded system will continue into the future. The challenge for local authorities and the Government is to continue to provide a meaningful service until a new system is in place. (HC 1499, paragraph 76)

ADASS [the Association of Directors of Adult Social Services] has found that 82% of councils are only providing care to those whose needs are assessed as significant or higher. The Permanent Secretary at the Department of Health told us that the settlement was intended to "hold the position steady" until a new funding system for social care was developed. The tightening of eligibility criteria demonstrates that the settlement is not sufficient to achieve this. (HC 1499, paragraph 86)

36. The Government has said that the Spending Review presented local authorities with a challenging settlement. However, it took steps to help protect adult social care, by allocating an additional £7.2 billion over the course of the Spending Review period.

37. The Government does not agree with the Committee's view that the system is only continuing to function by restricting eligibility. The Department has consistently said that the Spending Review settlement allows authorities to maintain access to care services if they can make ambitious efficiency savings. This was broadly corroborated by the 2011 King's Fund report *Social care funding and the NHS*[4] which said that, in its worst case scenario, local authorities would have to make efficiency savings of 3.5% each year in order to meet demand pressures on the social care system.

4 King's Fund (2011) *Social care funding and the NHS*. www.kingsfund.org.uk/publications/social_care_funding.html

38. It is the responsibility of local authorities to decide how to make these efficiencies. The Demos report *Coping with the Cuts*[5] found that the scale of cuts across an area has no real bearing on the extent to which disabled people are affected, highlighting a number of localities where local authorities are successfully making efficiencies through innovative service redesign, rather than tightening eligibility.

Social care: access to services

In spite of Government assurances, local authorities are having to raise eligibility criteria in order to maintain social care services to those in greatest need. (HC 1499, paragraph 84)

39. Tightening eligibility criteria is not a new phenomenon, and the vast majority of authorities are not having to raise their eligibility threshold to maintain services. In addition, most of the 13% of authorities that did raise their eligibility criteria last year were bringing their requirements into line with the median Fair Access to Care Services (FACS) level of provision.

40. Demos' recent report demonstrates that a number of local authorities are redesigning services to create the necessary efficiencies, and that this is often making services better for recipients. Furthermore, the Committee's survey of local authorities demonstrates that most authorities are prioritising a number of other efficiency-saving methods to protect services, ahead of tightening eligibility criteria.

41. It is disappointing that some local authorities have chosen to tighten eligibility thresholds, because the additional £7.2 billion allocated in the Spending Review by the Government to adult social care means that there is funding available to protect people's access to care, provided it is combined with a rigorous local authority focus on efficiency.

It is deeply concerning that £116m of the £648m intended to be spent through the NHS on improving the interface between health and social care is being spent on sustaining existing eligibility criteria. This suggests that this money (which was intended to support greater integration of services) is in fact being used to maintain the existing system. To the extent that this is true it is a lost opportunity to promote the necessary process of service integration. (HC 1499, paragraph 85)

42. This is the first time the Department has undertaken to transfer funding on this scale to local authorities. As the Committee acknowledged, this is a positive step and the Department knows that the agreements around the country have led to greater partnership working to support preventative services such as reablement or crisis response.

43. The Government does not agree with the Committee that using this funding to help maintain people's access to vital social care services is "deeply concerning".

5 Wood C, Cheetham P and Gregory T/Demos (2011) *Coping with the Cuts*. www.demos.co.uk/publications/copingwiththecuts

Using the funding in this way means that health and local authority commissioners have come together to agree that a shared investment in adult social care capacity would have a beneficial impact for both parts of the system. It is known that reducing access to care services can have consequences for the NHS, as people are more likely to go into hospital if they do not have support to live independently in their own homes. Ensuring that more people have access to this support is therefore a legitimate use of the funding.

44. In addition to the £648 million allocated this financial year to PCTs to support social care services, the Department recently announced an extra £150 million for PCTs to transfer to local authorities to spend on helping people to leave hospital more quickly and receive support at home. This will help to relieve pressures on the health system over the winter period.

Service integration: health and social care

A January 2012 joint report by the King's Fund and the Nuffield Trust, on the integration of health and social care, called on the Department of Health and the NHS Commissioning Board to "develop a consistent and compelling narrative that puts well-co-ordinated care for people with complex needs at the heart of what is required of local NHS and social care organisations" and to set "a clear, ambitious and measurable goal linked to the individual's experiences of integrated care that must be delivered by a defined date". (HC 1499, paragraph 94)

45. The Government agrees that care should be integrated around people, in particular those with complex needs. One of the key conclusions of the NHS Future Forum's report on integration was that services should be based around people and not disease pathways, and the Government welcomed the Forum's recommendation that the NHS Commissioning Board should produce commissioning guidance for CCGs which focuses on how to meet the needs of different groups of people who may have multiple problems, such as the frail elderly.

46. The Health and Social Care Bill is clear about the requirements on organisations to promote integrated care, with duties on the NHS Commissioning Board, CCGs, health and wellbeing boards and Monitor to encourage integrated working at all levels. The White Paper on adult social care, due to be published in the spring, will set out further details on the Government's ambitions for integrated care, as well as the roles of different parts of the health and social care systems in making this a reality.

47. The Department is also working to implement the recommendations made by the NHS Future Forum and the joint report by the King's Fund and Nuffield Trust on integrated care. This includes the development of measures that evaluate patients' experiences across whole journeys of care, and span transitions between services, for example discharge from hospital. By April 2012, the Department will put in place new metrics on patients' experience at the interfaces between services and, during 2012–13, the Department will work with the Care Quality Commission to ensure that its surveys cover the transition issues which it knows are important to patients and where things can go wrong.

The Department has also committed to exploring the scope for including these and other metrics of integration in future clinical audits.

48. The outcomes frameworks for the NHS, social care and public health will take an outcomes-based approach to holding these systems to account for delivering joined-up care. In designing the three accountability mechanisms, the Department has been careful to select outcome indicators that incentivise collaboration and an integrated approach, for example by replicating an outcome measure on the proportion of people 65 and over who are still at home 91 days after discharge into rehabilitation.

Although the Committee welcomes the continuing interest and support for the priority accorded by the NHS Future Forum to greater service integration, it found precious little evidence of the urgency which it believes this issue demands – on both quality and efficiency grounds. It is a question to which the Committee will return in its Report on Social Care. In the meantime it calls on the Government and local authorities to set out how they intend to translate this aspiration for greater service integration into the reality of patient experience.
(HC 1499, paragraph 95)

49. The Department will draw on the extensive levels of engagement carried out by the NHS Future Forum and on the analysis of the King's Fund and Nuffield Trust in its development of priorities for action for the adult social care White Paper planned for the spring. Integrating around the patient, not the system, is a key principle of the Government's reform agenda.

50. The Government does not share the view of the Committee regarding service integration; work is already under way to drive better integration around patients. As outlined above, the Department is aligning outcomes frameworks across the NHS, public health and social care systems to incentivise integration while balancing the need for clear and unambiguous accountability. The NHS Future Forum identified that data sharing is vital for integrated care, and the Government's information strategy for health and social care in England, to be published by April 2012, will set out the next steps for achieving the Forum's recommendations on standards for full electronic data sharing for all organisations delivering care in the NHS and social care.

51. Furthermore, ahead of publishing the White Paper, the Department is taking a number of steps to make more integrated care a reality for patients and service users. In addition to those outlined above, it has committed to:

- put in place by April 2012 new metrics on patients' experience at the interfaces between services and, during 2012–13, work with the Care Quality Commission to ensure that its surveys cover the transition issues which it knows are important to patients and where things can go wrong;
- agree with the NHS Commissioning Board and Public Health England 'baskets' of indicators that health and wellbeing boards can use to support the measurement of local shared goals, enabling them to assess the success of integration around the local population;

- explore new funding models to incentivise integrated services, as part of the approach it is taking to incentivise effective management of long-term conditions, particularly those with multiple co-morbidities and complexities; and
- boost its work with the NHS Institute for Innovation and Improvement to identify, promote and spread examples of best practice in local measurement and improvement of pathways of care. This will include work to help commissioners to improve patient experience along a whole journey of care.

52. This is in addition to the clear message to all primary care trusts in *The Operating Framework for the NHS in England 2012/13* to work with their local authority partners to ensure that a succession plan for existing pooled budgets and joint commissioning arrangements is in place. The Department has also set out that local variation on pricing is permitted where commissioners find that the rules prevent them from doing the best for patients, supporting the flexibility necessary for well-integrated services.

53. As the NHS Future Forum's report recognised, other organisations will have a key role to play in making integrated services a reality for patients and service users. The Department has committed to supporting these organisations in performing that role and in implementing the Forum's recommendations.

Service integration: investment of NHS funds in social care

Early reports from the Health Service are that the transfer of money from the NHS to be spent on social care has been effective. That effectiveness may be because there was a very straightforward control mechanism: the money had to be spent by agreement. We do not underestimate the importance of this transfer, but the fact remains that it represents just 1% of annual funding for the NHS. Clearly there is scope to extend transfers of this kind. (HC 1499, paragraph 101)

The Committee believes that, as a matter of urgency, the Department of Health should investigate the practicalities of greater passporting of NHS funding to social care. (HC 1499, paragraph 102)

54. The Government agrees with the Committee's conclusion that the additional funding streams from the NHS to support social care have been effective, and that they are encouraging a new partnership between the NHS and local authorities. This is expected to continue to 2014–15, when the level of funding will increase to £1 billion each year.

55. Under the ongoing reforms of the NHS sector, the Government wants to encourage further integration of services where it is effective to ensure better outcomes and user experience. The Health and Social Care Bill (subject to its passage through Parliament) requires the NHS Commissioning Board to encourage CCGs to use joint budget arrangements with local authorities where it would benefit patients, service users and carers. In addition, the creation of

health and wellbeing boards will facilitate further joint working and integration between local authorities and CCGs.

56. A further demonstration of the Government's commitment to integration of services came in January 2012, when the Department made an extra £150 million available to prevent unnecessary delays in hospital discharge. The funding was given to PCTs for transfer to local authorities to spend on social care capacity in order to get people settled back at home with the support they need and to help shorten their stays in hospital.

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