Government Response to the House of Commons Health Select Committee Report on Public Expenditure (Second Report of Session 2010–11)

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
January 2011

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Department of Health,
Customer Service Centre,
Richmond House,
79 Whitehall,
London SW1A 2NS.
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1 Introduction

1. On 14 December 2010 the House of Commons Health Committee published *Public Expenditure: Second Report of Session 2010–11* (HC 512). 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 British Medical Association, representatives from the NHS and local government, the Royal College of Nursing and UNISON.

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

2.1 The Spending Review settlement for social care

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

3. The Government accepts that the 2010 Spending Review (SR2010) will be challenging for local government. However, in recognition of the pressures on the social care system in a challenging fiscal climate, the Government has allocated an additional £2 billion by 2014–15 to support the delivery of social care. The £2 billion comprises:

- the allocation of £1 billion of additional funding through Department of Health grants to local authorities. This funding will be allocated on top of the Department's existing social care grants, which will rise in line with inflation. Total grant funding from the Department for social care will reach £2.4 billion by 2014–15. This funding will go through the general local government Formula Grant, and local authorities will therefore have the flexibility to use it to best support local priorities. However, the Government has been clear in SR2010 that social care is a crucial service, and that authorities should have the resources to protect people's care in their area; and
- up to £1 billion available within the NHS to support social care. Primary care trusts (PCTs) will work with local authorities to agree where the money should be spent, with a shared analysis of need and common agreement on what outcomes need to be met.

4. When taking the overall spending power of local authorities into account – central government grants, income from council tax and the NHS funding to support social care and benefit health – no authority will face more than an 8.9 per cent

reduction in spending power in either 2011–12 or 2012–13, and in fact the average reduction in 2011–12 is 4.4 per cent. The Department for Communities and Local Government has achieved this by making available a transition grant of £85 million in 2011–12 and £15 million in 2012–13. In addition, the Local Government Financial Settlement has been allocated in a way that directly reflects the relative reliance of individual local authorities on the funding from central government. The new banding approach means that those authorities that depend most on the grant from central government receive the smallest reduction in central government grant.

5. In line with their accountability to their local population, it is for local authorities to choose how best to use their available funding, not for Whitehall to prescribe how their funding should be used. However, the Government thinks that the extra investment, combined with a rigorous focus on efficiency, will mean that there is funding available to protect people's access to care and deliver new approaches to improve quality and outcomes.

Although we welcome the Government's identification of additional resources for social care, through the mechanism of the Personal Social Services [PSS] Grant, the fact is that this funding is now part of the general local authority revenue grant which will reduce from £28 billion this year to £21.9 billion in 2014–15. Given the pressures on local authority spending overall, the majority of our witnesses expressed serious concern that changes in the PSS grant will not be reflected in changes in actual spending in social care. The decision to end ring-fencing of PSS grants means that the total level of social care spending is now at the discretion of local authorities. Even though this may be welcome in principle it has the practical effect of introducing an additional element of uncertainty into the plan for meeting demand for health and social care. (Paragraph 16)

6. The Government has allocated £1 billion of additional funding through Department of Health grants to local authorities. This funding will be allocated on top of the Department's existing social care grants, which will rise in line with inflation. Total grant funding from the Department for social care will reach £2.4 billion by 2014–15.

7. In order to support local flexibility and to reduce administrative burdens, this additional grant funding will go to authorities through the general Formula Grant. This is in response to requests from local government. It will go to authorities responsible for social care, and has been welcomed by the local government sector.

8. Local authorities will have greater control over more than £7 billion of funding from 2011–12 which is moving into Formula Grant, not ring-fenced or new funding for the SR2010 period, so enabling them to better meet local communities' needs. This includes:

    - ending ring-fencing of all but a few revenue grants from 2011–12. This will give local authorities significant financial autonomy; and
    - very significantly simplifying and streamlining grant funding, by rolling around £4 billion of grants in 2010–11 into the unhypothecated Formula

Grant by 2014–15. The number of separate core grants for local government reduces from over 90 to fewer than ten.

9. Local authorities will therefore have the flexibility to use funding to best support local priorities. However, the Government has been clear in SR2010 that social care is a crucial service, and that authorities should have the resources to protect people's care in their area, in particular by prioritising the adult social care control totals. For example:

- The control totals for various services that are supported by Formula Grant will be set out at a national level. The control totals are a notional proportion of Formula Grant that are distributed for a particular service need. They cover the totality of funding for social care in the Formula Grant (i.e. not just the additional amount).
- The control totals for adult social care in 2011–12 show that the amount of Formula Grant notionally allocated for social care has remained steady – particularly when compared with other service areas.

10. Together, this means that it should be clear – at a national level – that the additional funding going into Formula Grant has been reflected in the final settlement, and sends a strong signal about the priority attached to social care within the overall local government settlement.

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

11. Government will continue to collect information about the level of spend on social care. As important as this information on spending is, the Department of Health will also gear its information collections to monitor outcomes and the quality of care. The consultation document *Transparency in outcomes: A framework for adult social care* proposes an enabling framework on how social care should approach quality as a sector and how it should seek to account for outcomes for local people.

Communicating expectations to the sector

12. Government is clearly communicating its expectations for social care to local government. The Secretary of State for Communities and Local Government said in his statement to Parliament (*Statement on the Local Government Finance Settlement*, 13 December 2010):

"This settlement also supports the Government's commitment to adult social care, providing councils with sufficient resources to protect people's access to care… The settlement directs more formula grant to authorities that deliver social care."

13. The Department has set out, in *The Operating Framework for the NHS in England 2011–12*, more detail about how the £1 billion funding that the Government has made available within the NHS to support social care should be used. This includes specific allocations for 2011–12, and indicative allocations for 2012–13. PCTs will

work with local authorities to agree where the money should be spent, with a shared analysis of need and common agreement on what outcomes need to be met.

2.2 The £1 billion from the NHS budget

We strongly support working towards an improved interface between health and social care, and we recognise the efficiencies and improvements in the quality of care that could result from this process (see Chapter 4). The distribution of this sum for social care from the NHS revenue budget is a key opportunity to drive positive change in this interface. The Secretary of State's description of a formal transfer of funds based on a jointly-agreed spending plan suggests an approach based on the provision of particular services in isolation. It will be an opportunity missed if this sum is not distributed with the primary aim of developing a better overall interaction between health and social care which could have a much wider impact on efficiency, prevention and reablement than the more limited funding of certain services. We expect that the distribution guidelines set out in the Operating Framework will grasp this opportunity. (Paragraph 20)

14. The Government agrees with the Committee that the NHS funding for social care as set out in SR2010 is a critical opportunity to make a step change in effective partnership working between the NHS and social care. It also comes at the same time as changes proposed in *Liberating the NHS: Legislative framework and next steps* and the Health and Social Care Bill 2011 are introducing stronger mechanisms such as health and wellbeing boards and strategies to drive better partnership working (see paragraphs 32–36).

15. On the specifics of the NHS funding to support social care, as announced in SR2010, the NHS will transfer some funding to health revenue, to be spent on measures that support social care, which also benefits health. This funding will rise to £1 billion in 2014-15.

16. *The Operating Framework for the NHS in England 2011–12* sets out that PCTs will need to transfer this funding to local authorities to invest in social care services to benefit health and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the National Health Service Act 2006.

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

18. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.

19. This demonstrates that the Government strongly supports working towards an improved interface between health and social care, and recognises the efficiencies and improvements in the quality of care that can result from this collaboration.

2.3 Making funding meet demand

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

20. In recognition of the pressures on the adult social care system in a challenging fiscal climate, the Government has allocated an additional £2 billion by 2014–15 to support the delivery of adult social care.

21. This funding is sufficient to allow local authorities to meet demographic pressures and continue to maintain access to services. This will only be possible if local authorities implement modernisation and efficiency with vigour. *A Vision for adult social care: Capable communities and active citizens* was published in November 2010 and sets out the key areas for modernisation and efficiency in social care.

22. The Government does not set efficiency targets for local government, or for specific services within local government. However, the Association of Directors of Adult Social Services and the Local Government Association have both said that a 3 per cent efficiency improvement per annum for adult social care would be challenging but realistic, and the Department of Health agrees that this is achievable.

23. To deliver this ambitious programme of efficiency local authorities will want to look at:

- helping people to stay independent for as long as possible, for example through reablement, reducing the need for care;
- ensuring that people receive care and support in the most appropriate and cost-effective way to meet their needs, for example through assistive technology and driving forward with personal budgets; and
- maximising spend on front-line services, for example by reducing back-office costs and making better use of the social care market.

24. The social care sector has entered into a new partnership agreement, *Think local, act personal*, which sets out the sector's approach to leading the delivery of the social care vision. This will include driving the delivery of the efficiency measures that were outlined in the vision.

25. The Government is removing burdensome central targets and large-scale central monitoring programmes run by the Department. Instead, the sector will take the lead in driving and monitoring progress – drawing upon expertise within the Local Government Association, Local Government Improvement and Development, the Social Care Institute for Excellence and others. The Department will continue to play a central role in monitoring sector-led delivery.

2.4 Interface between health and social care

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

26. To meet the challenge to deliver up to £20 billion in efficiencies over the next four years, it is crucial that local partners work together to deliver efficient, effective services that help people to keep healthy, maintain their independence and avoid the need for expensive treatments and care packages where possible. For example, integrated working across health and social care systems is particularly important following hospital discharge to support people to live independently at home. This includes good discharge planning and reablement services.

27. To strengthen and mainstream reablement services, the Department of Health will amend the payment by results tariff from April 2012 so that the NHS pays for reablement and other post-discharge services for 30 days after a patient leaves hospital. From April 2011, trusts will not be reimbursed for unnecessary readmissions.

28. To prepare for these changes, the Government has allocated £70 million in 2010–11 for PCTs to spend on reablement. This has been further supported by SR2010 with £300 million of the £1 billion NHS transfer being allocated for reablement services by 2014–15.

29. By investing in social care services, this should improve people's outcomes – supporting their independence, reducing unnecessary hospital admissions and easing discharges – which can also benefit the NHS.

30. And, by making efficiency savings in central spending, the Department of Health is able to make available for PCTs and local authorities an extra £162 million to spend this financial year (in 2010–11) on front-line services. The extra money will be spent on helping people to leave hospital more quickly and get settled back at home with the support they need, and to prevent unnecessary admissions to hospital.

31. In addition to the specific opportunities that the additional funding from the NHS for social care brings, there are also the forthcoming changes proposed by *Liberating the NHS: Legislative framework and next steps* and the Health and Social Care Bill 2011, introducing stronger mechanisms such as health and wellbeing boards and joint health and wellbeing strategies, to drive better partnership working (see paragraphs 32–36).

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

32. The Government is committed to creating a system that achieves better outcomes and delivers truly personalised services focused around individuals and not organisations. Partnership working across the NHS and local government is critical to delivering this vision.

33. A number of proposals outlined in the White Paper *Equity and excellence: Liberating the NHS* demonstrate how the Government will seek to support and encourage integrated working as a key element of the modernised system. These include:

- local authorities taking a key role in the future in joining up local NHS services, social care and health improvement via the health and wellbeing boards. Health and wellbeing boards will increase the local democratic legitimacy of NHS commissioning decisions and provide a vehicle for NHS and local authority commissioners, along with other key partners, to come together on a geographical basis to improve the health and wellbeing of the people in their area in a strategic and coherent way;
- strengthening the role of the Care Quality Commission as an effective quality inspectorate across both health and social care;
- extending the remit of the National Institute for Health and Clinical Excellence to social care to support the creation of effective quality standards for all those using health and social care services; and
- establishing HealthWatch to champion the voice of people using services and carers across both health and social care.

34. In future, the local authority and the GP commissioning consortia will be required to undertake a Joint Strategic Needs Assessment (JSNA) through the Health and Wellbeing Board. This will provide an objective analysis of local current and future needs for adults and children on which to base local commissioning plans.

35. Based on the JSNA, health and wellbeing boards will be required to develop a Health and Wellbeing Strategy for their area that will span the NHS, social care and public health, and could potentially consider wider determinants of health such as housing or education. They will need to have regard to this strategy when developing their own commissioning plans. Both local authorities and GP consortia will be required to consider the use of the Health Act flexibilities, such as pooled budgets or lead commissioning, in developing the joint Health and Wellbeing Strategy.

36. The Government believes that these measures provide a stronger statutory framework and stronger incentives for integrated working across health, social care and public health to improve services for local populations.

The allocation of £1 billion to social care through the NHS budget is a step in the right direction in that it formally recognises the interaction between health and social care, but we are concerned that it may be too tightly focused to bring about a genuine wider improvement in the interface between the two services. In general, there is a risk of the 'better interface' becoming a by-word for the health service seeking to achieve its own efficiencies by asking social care to take on more. The Government must do more to bring about improved relations and interaction more generally between the two sectors, as this could ultimately contribute to broader cooperation, more imaginative efficiencies, and more significant savings on both sides. It is not enough for the Government to exhort change in this area: there must be a formal policy infrastructure that recognises the importance of achieving this. (Paragraph 44)

37. The Government agrees that the £1 billion of NHS funding for social care will be an important catalyst for improving partnership working between health and social care. But more can be achieved with a stronger legislative and policy framework that enables better partnership working.

38. The policy framework and legislative intentions set out in *Liberating the NHS: Legislative framework and next steps* are intended to provide that enabling framework. The proposals include:

- health and wellbeing boards providing an important forum for commissioners across the NHS, public health, social care and children's services to come together with elected councillors and representatives of patients and the public through local HealthWatch organisations. In doing so, they can consider the total resource available and come to a joint understanding as to how the resources can be best invested to better the health and wellbeing of the people in their area. The statutory framework for health and wellbeing boards will provide a more robust basis and stronger incentives for integrated working and local democratic engagement which should already be taking place;
- a requirement to publish a JSNA and joint Health and Wellbeing Strategy. There will be a new legal obligation on NHS and local authority commissioners to have regard to the JSNA and Health and Wellbeing Strategy in exercising their own relevant commissioning functions; and
- development of the outcomes frameworks for the NHS, adult social care and public health so that they are aligned and complement each other. Recognising the synergies between sectors provides strong incentives for local services to work together, measure their progress on the same basis and develop whole-systems approaches to support better outcomes and increased productivity. The approaches of the three services to outcomes should not be as separate entities but as part of a single whole.

2.5 The Spending Review settlement for healthcare

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

39. The commitment to real terms growth for the NHS is good news, but it still leaves a massive challenge. The NHS has to make its contribution by extracting maximum value for money from all of this resource. The scale of challenge is recognised and well understood in the NHS.

40. Since early 2009, the Department has been challenging the NHS to prepare to deliver a quantum shift in NHS efficiency. The Quality, Innovation, Productivity and Prevention (QIPP) programme is designed to deliver savings of £15 billion to £20 billion over the next four years.

41. All of these savings will be reinvested in the NHS. Together with the guarantee to protect funding against inflation, the increased efficiency will allow the NHS to continue to deliver high-quality healthcare and keep pace with demographic pressures, medical advances and rising public expectations.

42. Alongside the commitment to maintain real terms funding, the Government is introducing changes that will reduce bureaucracy, cut management costs and put key decisions into the hands of the clinicians. By encouraging diversity of provision, increasing competition and ultimately putting more power into the hands of service users, the changes will drive continuous innovation and improvement.

The Government's commitment to a real terms increase in health funding throughout the Spending Review period will not be met. This emphasises the fact that the settlement, although generous when compared to other departments, represents a substantial challenge to the NHS. (Paragraph 51)

43. It is wrong to conclude before the spending review period has even started that the Government's commitment to a real terms increase in health funding throughout the SR2010 period will not be met.

44. The SR2010 settlement for the Department of Health increases total funding for the NHS from £103.8 billion in 2010–11 to £114.4 billion in 2014–15, a cash increase in funds of over £10 billion over the four years.

45. The SR2010 settlement met the Government's commitment to a real terms increase in health funding, with total NHS spending plans rising by 0.1 per cent per year, or 0.4 per cent over the four years. A full set of growth calculations covering all the main spending totals is included in table 1.

Table 1: NHS settlement – SR2010 settlement GDP deflators

£ million	Baseline	New plans				Annual average real growth	Cumulative growth over 4 years
	2010–11	2011–12	2012–13	2013–14	2014–15		
Resource DEL (RDEL)	99,760	102,621	105,170	108,158	111,059	0.34%	1.36%
Of which:							
Non-ring-fenced RDEL	98,659	101,480	103,988	106,934	109,791	0.33%	1.32%
Depreciation ring-fenced in RDEL	1,101	1,141	1,182	1,224	1,268		
Capital DEL	5,122	4,429	4,429	4,437	4,648	–4.66%	–17.38%
Total DEL(1)	103,781	105,909	108,417	111,371	114,439	0.10%	0.40%
Average annual real growth for the NHS in SR2010							
Resource DEL (RDEL)		0.90%	0.21%	0.22%	0.03%	0.34%	1.36%
RDEL (excluding ring-fenced depreciation)		**0.89%**	**0.20%**	**0.21%**	**0.02%**	**0.33%**	**1.32%**
Capital DEL		–15.18%	–2.22%	–2.38%	2.05%	–4.66%	–17.38%
Total DEL		**0.10%**	**0.10%**	**0.10%**	**0.10%**	**0.10%**	**0.40%**
	GDPs:	*1.95%*	*2.27%*	*2.62%*	*2.65%*		

Source: Financial Planning and Allocations, Department of Health

Footnote:

(1) Total DEL is calculated as RDEL plus capital DEL minus depreciation ring-fenced in RDEL (in accordance with HM Treasury guidance).

46. Two arguments are made by the Committee to support its conclusion that the Government's commitment to real terms increases in health funding will not be met. Each is discussed below.

Some NHS SR2010 settlement funding is earmarked for social care and so should be excluded from the calculation of NHS growth

47. The funding earmarked for social care of £0.8 billion in 2011–12 rising to £1.0 billion in 2014–15 will be allocated to the NHS via PCT allocations. In 2011–12, £150 million has been added to allocations to support reablement, and the remaining funds have been allocated to support joint working between health and social care. PCTs must jointly agree with local authorities the activities and outcomes for these funds, e.g. to support and maintain vulnerable people outside hospital in more appropriate non-acute settings.

48. The Government does not accept that this money should be excluded from the NHS spending totals. This funding supports the delivery of both health and social care outcomes. Social care plays a vital role in keeping people healthy and independent. This brings benefits across both the health and social care systems. The Government's view is that health and social care should therefore be complementary and integrated. Integrating health and social care funding will help to break down barriers and make that joining up a reality. PCTs and local authorities will have a shared analysis of need and common agreement on what outcomes need to be met.

Recent higher inflation forecasts cause growth over the period to dip below real terms

49. The measure of inflation used in calculating the real terms changes in spending totals is the Gross Domestic Product (GDP) deflator, which is a general measure of price increases across the whole economy.

50. Forecasts of the GDP deflator used in Government are now the responsibility of the Office for Budget Responsibility, which is independent of HM Treasury. The SR2010 settlement was calculated based on their latest available forecasts.

51. Projections of macroeconomic variables such as the GDP deflator are subject to change as forecasts are updated. The expected path of the GDP deflator is therefore likely to be revised in future Budgets and other forecasts. Outturn data for the GDP deflator will not be available until after the year in question.

52. Another factor that will influence the calculation is the actual level of expenditure in 2010–11, the base year. The SR2010 calculation uses a baseline that assumes full expenditure of resources in 2010–11, and corrects for temporary changes to spending totals.

53. Final growth rates of NHS spending will therefore only be known once there is outturn data for both spending and the GDP deflator.

2.6 The 'Nicholson Challenge'

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

54. The Government agrees that the protection afforded to the health budget in the SR2010 settlement means that the NHS is in a position where all of the efficiency improvements it makes will be available to reinvest in meeting rising demands and improving outcomes for patients.

55. The SR2010 settlement set out health funding for the next four years, which will rise by over £10 billion. This means that the budget for the NHS is rising, not being cut. In December 2010, the Department announced a 3 per cent cash terms increase in PCT revenue allocations in 2011–12.

56. *The Operating Framework for the NHS in England 2011–12* made clear that the efficiency challenge the NHS faces will best be achieved by improving the quality and effectiveness of services, not by cutting them. This is the principle underpinning the QIPP programme, through which the NHS response to the challenge is being developed.

57. The Government will continue to seek to ensure that these principles are communicated as clearly as possible to the NHS and the wider community.

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

58. The Government has set out a variety of broad areas that offer clear potential for improving efficiency. These include better management of long-term conditions, self-care, improving workforce productivity (including through the Productive Ward programme), more efficient procurement and reducing back-office costs.

59. However, this potential can only be translated into reality by local NHS organisations, according to their own individual circumstances and priorities. It would not be appropriate for the Department of Health to be prescriptive. Individual NHS organisations have been developing their own QIPP plans for some time. *The Operating Framework for the NHS in England 2011–12* set out the requirement for NHS organisations to bring together their planning for quality, efficiency, resources and modernisation into single, integrated plans that will be finalised ahead of the new financial year. The Government, in the Operating Framework, set out the revised challenge following SR2010 and what now needs to happen. The next step will be to publish a summary of regional assessments in the near future which will set out how NHS organisations are planning to deliver the efficiency improvements required.

The QIPP programme is the tool available to healthcare to make efficiencies, and represents a good starting point. However, the scale of the challenge is so immense that QIPP will need to demonstrate clear savings early in order to provide the savings programme with the momentum to proceed at a steady pace towards the £15–20 billion goal. Close monitoring and consistent reporting of performance against publicly available norms will be essential if these gains are to be seen as real improvements rather than accounting changes. (Paragraph 67)

60. The Government is committed to monitoring and reporting on progress towards delivering the QIPP challenge, as part of the single, integrated NHS planning process spanning efficiency, quality, resources and modernisation. *The Operating Framework for the NHS in England 2011–12* set out a number of key indicators for central monitoring. Draft technical guidance was published on UNIFY (the system for sharing and reporting NHS and social care performance information) in December 2010 to be finalised in collaboration with the NHS, and this final version will be published on the system by the end of January 2011.

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

61. The payment by results tariff accounts directly for over one-third of PCT budgets and additionally tariff price uplifts inform local contract prices for a variety of activities not directly covered by the tariff. Therefore, a significant proportion of total efficiencies will need to be delivered through services covered or informed by the tariff.

62. Changes to tariff prices do not, in themselves, deliver efficiency improvements and NHS organisations need to identify underlying efficiencies to enable them to live within tariff prices. These will depend upon local circumstances but may include improvements in workforce productivity, more efficient procurement and back-office functions, and reduced agency staff usage and staff sickness.

63. The Government agrees that the tariff needs to be revised to remove perverse incentives and encourage best practice. Best practice tariffs, first introduced in 2010–11, are designed both to improve patient outcomes and experience and to improve productivity. They will be expanded to cover a number of new service areas in 2011–12 and it is anticipated that their expansion will accelerate in 2012–13 and beyond.

64. To improve efficiency and remove perverse incentives, other changes to the tariff in 2011–12 will include:

- changing the way in which long hospital stays are funded to ensure that relatively short stays do not attract a long stay payment;
- hospitals will no longer be reimbursed for emergency readmissions within 30 days of discharge following an elective admission;

- the 30% marginal tariff rate for any emergency admissions above the 2008–09 level will continue; and
- providers will be able to offer services to commissioners at below the published tariff price, where both providers and commissioners agree and commissioners are sure that there is no detrimental impact on quality, choice or competition.

We welcome Sir David's recognition of the need for close financial oversight during this transition period. We believe there must be more detail in the Operating Framework and over the coming months on the exact nature of these controls and, in particular, how they will address the transitional arrangements from PCTs to commissioning consortia. (Paragraph 82)

65. *The Operating Framework for the NHS in England 2011–12* was published on 15 December 2010 and outlines the business and planning arrangements for the NHS over the transition year 2011–12. It describes the national priorities, system levers and enablers needed to build strong foundations set out in *Equity and excellence: Liberating the NHS*, and to maintain and improve quality, while keeping tight financial control and delivering the quality and productivity challenge at a time of significant change.

66. The Operating Framework sets out how tight financial control will be maintained during 2011–12. PCTs will continue to be required to invest 2 per cent of their budgets non-recurrently in order to create financial flexibility and headroom to support change. The marginal rate of tariff payment for emergency admissions above baseline thresholds will be maintained, incentivising commissioners and providers to work together in an area that is critical to delivering local QIPP plans.

67. These measures are critical for ensuring that the NHS maintains a strong financial position, to get the new system on the right footing from the outset.

68. As part of the single planning process set out in Chapter 6 of the Operating Framework 2011–12, the financial planning guidance will be issued in January 2011 and will include the detailed rules underpinning the financial strategy and the financial plans required for 2011–12.

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

69. The Department of Health published *Liberating the NHS: Legislative framework and next steps* in December 2010, setting out further detail on how the new system will work and how the modernisation programme will be implemented. The document fully recognises the importance of the transition period, and sets out further details for a phased and co-ordinated change process. The identification of GP pathfinders as well as local authority early implementers is complemented by departmental initiatives, such as the formation of PCT clusters, to allow flexibility and provide structure throughout transition.

70. *The Operating Framework for the NHS in England 2011–12* was also published in December and set out how modernisation will begin to be implemented in the coming year and how delivery will be maintained while the new system is being established. In order to communicate this growing narrative on modernisation, David Nicholson wrote to all NHS chief executives on the same day. This letter set out the vision for the new system, and a roadmap for transition which describes the characteristics of the approach that will be taken, key milestones in the transition process and critical elements of support for the transition programme. An update on the human resources (HR) strategy was also published in December. The HR strategy will help to support business continuity during transition, establish mechanisms to retain the knowledge and skill of people currently working in the affected organisations, encourage the development of new roles and skills for staff who will work in the new system, provide tools to help future leaders to manage the transition and future organisations, and seek to avoid compulsory redundancies, maximise redeployment and avoid unnecessary redundancy costs.

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

71. The figure of £1.7 billion was originally used in relation to the cost of the changes contained in the White Paper by the then Shadow Secretary of State for Health on 16 July 2010. It was also used in this respect by members of the Committee during questioning. The Government has never used this figure specifically to describe the costs associated with the changes contained in the White Paper.

72. The overall reorganisation cost (redundancy and non-redundancy) is estimated to be between £1.1 billion and £1.7 billion depending on how many existing PCT and strategic health authority staff transfer to future organisations.

73. The impact assessment for the Health and Social Care Bill 2011, published on 19 January 2011, includes estimates of redundancy and non-redundancy costs by sector. The low-end estimates are summarised in tables 2 and 3.

Table 2: Redundancy costs by sector

		£ million
Sector	**Baseline spend 2010**	**Total redundancy costs**
Strategic health authorities	353	59
Primary care trusts	3,588	541
Arm's length bodies	522	58
NHS leadership plus Department of Health	612	114
Total	**5,075**	**772**

Source: Financial Planning and Allocations, Department of Health

Table 3: Non-redundancy costs by sector

		£ million
Sector	**Baseline spend 2010**	**Total non-redundancy transition costs**
Strategic health authorities	353	26.6
Primary care trusts	3,588	323.0
Arm's length bodies	522	19.8
NHS leadership plus Department of Health	612	8.6
Total	**5,075**	**377.0**

Source: Financial Planning and Allocations, Department of Health

Footnote:

(1) Figures may not sum due to rounding.

74. The figures outlined in table 2 assume that all organisations experience a one-third real reduction in their baseline spending and that all the remaining staff transfer directly into the new organisations.

75. The non-redundancy cost estimates in table 3 include relocation, transfer of functions, estates and information technology associated with the reorganisation.

76. These cost estimates will be refined over time.

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