



Department  
of Health

# Government Response to the House of Commons Health Select Committee Report into Public Expenditure on Health and Social Care

(Seventh Report of Session 2013–14)

Cm 8836





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(Seventh Report of Session 2013–14)

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

April 2014

Cm 8836



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# Memorandum to the Health Committee

## 1 INTRODUCTION

1. On 12 February 2014, the House of Commons Health Select Committee published *Public Expenditure on Health and Social Care: Seventh Report of Session 2013–14* (HC 793). The report followed an inquiry by the Committee, which sought evidence from the Secretary of State for Health along with other witnesses, including the King's Fund, the Nuffield Trust and representatives of the NHS and local government.
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. We agree with the Committee on the very real financial challenge facing our health and care services, and recognise that maintaining both financial control and delivering efficiency savings are of paramount importance to ensuring the sustainability of our health and care system.
4. We believe that the reforms we have introduced, the steps we are taking to promote integration and our commitment to protecting the health budget in real terms, go some way towards creating this sustainable service. However, there is more that needs to be done, which is why we are continuing to focus on finance and efficiency through better procurement, productivity improvements and transformational changes to services.

## 2 GOVERNMENT RESPONSE TO THE COMMITTEE'S CONCLUSIONS AND RECOMMENDATIONS

### The efficiency challenge to date

**The conclusions that we draw from the evidence are that: the NHS has provided savings during the first two years of the programme, but that there is a question mark about how sustainable they are; the straightforward savings which are possible have now been made; and, the transformation of care that will be required to make the NHS sustainable in the future and able to deal with increasing demand has yet to take place. (HC 793, Paragraph 11)**

**On this final point, the key question, raised in evidence, is not 'what has been saved?' but rather 'what has the money "saved" been spent on?' That is currently not transparent, and more needs to be done to demonstrate what new activity has been possible because of the gains of the efficiency process. (HC 793, paragraph 12)**

5. We welcome the Committee's recognition of the substantial savings delivered so far, which are the results of hard and sustained work by staff throughout the NHS over the past three years. However, we do not agree that the sustainability of the savings so far is questionable: the National Audit Office (NAO) reported that 91% of the QIPP savings reported in 2011–12 were recurrent (i.e. represent a continuing saving for the NHS).

6. Nevertheless, the NHS continues to face a very significant efficiency challenge if services are to be maintained and improved within the available financial resources. We acknowledge that the positive progress

made over the last two years since 2011–12 includes a significant contribution from central savings, such as pay restraint, and that far greater transformational change in the way care is provided is now needed. The NHS is already making progress towards this goal: the figures which the Committee cites (HC 793, paragraph 5) projected that the NHS would achieve almost 80% of the planned transformational savings for 2013–14.

7. We do not underestimate the scale of the on-going financial challenge the NHS faces and a continued focus on efficiency across the service must be maintained, with more effort needed. Among other things, NHS England has:

- set out the scale of the challenge facing the NHS in the *Call to Action*,<sup>1</sup> to kick-start conversations about how to make the local NHS sustainable all over the country;
- given clinical commissioning group (CCG) commissioners more certainty by setting out allocations over two years instead of one;
- asked CCG and Area Team commissioners to work with partners in their local health economies to develop five-year strategic plans;
- set out a range of evidence-based interventions tailored towards rural, urban and suburban areas to give local commissioners a head start in thinking about their longer term plans; and
- included progress against targets for transformational change in monthly finance reporting.

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1 NHS England (2013) *The NHS Belongs to the People: A call to action* [www.england.nhs.uk/wp-content/uploads/2013/07/nhs\\_belongs.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf)



8. In addition, the Department of Health has taken a number of actions to reduce cost pressures on the NHS, including:

- Negotiating with the pharmaceutical industry to cap the NHS drugs bill at an affordable level.
- Ensuring that visitors and migrants pay for the services they use.
- Promoting efficiency in back office functions through NHS Shared Business Services.
- Transforming the way the NHS buys goods and services, to ensure greater value for money, through launching a Procurement Development Programme.<sup>2</sup>
- Establishing the £3.8 billion Better Care Fund providing the biggest ever financial incentive to transform and join-up services.

9. The Government recognises that improvements in workforce productivity are also essential to helping deliver the efficiency savings in this, and the next, Spending Review period. So far workforce productivity gains have contributed 12% of the total savings made in 2011–12 and 2012–13, compared with 23% which has come from pay restraint.

10. Despite improved productivity performance in the last two years, there still exists wide labour productivity variation at trust level.<sup>3</sup> Levelling up performance as well as shifting the average trust performance

upwards will help achieve the workforce productivity gains that are required. The level of resource assumed available for pay is predicated on an increased level of productivity in 2014–15.

11. We also recognise that there is further work to be done on delivering savings from procurement of goods and services, hence the aforementioned Procurement Development Programme. As the NAO and others have identified, there is a substantial opportunity for trusts to save money through better procurement. Making these saving real will require the engagement of NHS providers.

12. The savings to date have been spent on maintaining the quality of NHS services while delivering increased and more complicated activity as a result of a growing and increasingly elderly population. The NHS is doing more than even a few years ago: compared with 2009–10, the NHS is delivering 4.3 million more outpatient appointments; 590,000 more inpatient admissions; and, around 1.2 million more A&E attendances. At the same time, hospital-acquired infections have been reduced by half and the number of people waiting longer than 18, 26 and 52 weeks to start treatment has fallen. The efficiency savings delivered through QIPP have allowed the NHS to meet these demands without restricting the level of services available and with a budget which is broadly flat in real terms.

## NHS pay

**The Committee welcomes the Government's recognition that the future of the health and care system cannot be built on an open-ended pay freeze. If the health and care system is to be a good employer (which it needs to be if it is to deliver high quality care) it needs to undertake transformative change in order**

<sup>2</sup> Department of Health (2013) *Better Procurement. Better Value. Better Care: A procurement development programme for the NHS* [www.gov.uk/government/publications/improving-procurement-in-the-nhs](http://www.gov.uk/government/publications/improving-procurement-in-the-nhs)

<sup>3</sup> Nuffield Trust (2013) *The anatomy of health spending 2011/12: a review of NHS expenditure and labour productivity* [www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity](http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity)

**to ensure that its committed staff are better able to meet the needs of users of its services. (HC 793, paragraph 19)**

13. Pay restraint, beginning with a two-year pay freeze and followed by a 1% increase in 2013–14 has played an important part in enabling the NHS to meet the efficiency challenge. The Government's view is that pay restraint at this level needs to continue for a further two years from 2014 to 2016 with an expectation that average base pay rises should be no more than 1% in either year.

14. The pay review bodies recommended a 1% consolidated pay rise for all NHS staff and very senior staff employed by the Department's arm's-length bodies.

15. On 13 March, the Government rejected the pay review bodies recommendation on the grounds that the NHS could not afford the cost of incremental pay, nearly £1 billion every year. More than half of all employed medical and non-medical staff receive an average of over 3% in incremental pay. A 1% pay award would add a further £450 million to the NHS pay bill. The Government's written ministerial response on 13 March confirmed that:

***Employed NHS staff***

- In 2014–15, a 1% non-consolidated pay award will be paid to those employed staff that are not eligible to receive incremental pay. Staff that are eligible to receive incremental pay should receive at least 1%.
- In 2015–16, a 2% non-consolidated pay award will be paid to employed staff that are not eligible to receive incremental pay. Staff that are eligible to receive incremental pay will receive at least 1%.

***Very senior managers in arm's-length bodies***

- Government rejected the pay review bodies recommendation that very senior

managers in the NHS' arm's-length bodies should receive a 1% pay increase. Very senior managers who are already very well paid, must lead by example and demonstrate greater pay restraint than frontline NHS staff.

16. Pay rises for NHS staff from 2016–17 will be a matter for the next Parliament.

17. The Department is happy to speak to trade unions about how we can afford to make consolidated pay awards in this year and the next more affordable.

18. We and the NHS Pay Review Body agree with the Committee's observations on the need for transformative change. NHS pay systems have an important role to play in enabling such change. In our evidence to the pay review bodies in this year's round, the Department made clear that the current pay contracts, with in-built 2% per annum pay progression costs, are no longer fit for purpose.

19. NHS pay contracts need to change so that they reward most those staff who make the greatest contribution and end incremental pay rises based on time served. We welcome the March 2013 agreement made by the NHS Staff Council to close incremental pay gateways within the Agenda for Change (AfC) pay system so that progression is now based on meeting locally agreed appraisal and performance standards.

20. However, AfC needs to change further to reform and simplify progression arrangements and reward staff for what they do for patients in hospital or at home. There also need to be changes to out-of-hours pay arrangements to recognise that the NHS needs to provide the same quality of service over seven days. Negotiations are also underway to reform the consultant and junior doctor contracts again to end automatic

incremental progression based on time served and to support seven-day working.

21. The NHS pay bill is £43 billion; for most organisations pay represents around 70% of their entire expenditure. The pay bill will need to continue to be controlled. Reformed pay contracts can provide the basis for moving the focus from restraining headline increases to delivering value by making better use of the NHS pay bill.

### Allocation of resources

**The concept of target funding is as old as the NHS itself. Although the formula will continue to change, with the result that the day when all CCGs receive their target funding will never arrive, the Committee endorses the general approach while recognising that there will always be debate about how quickly actual funding should close the gap with target funding. It is clearly more difficult to make meaningful progress when the overall budget is largely stable in real terms. (HC 793, paragraph 28)**

22. We welcome the Committee's endorsement of NHS England's approach to allocations. In setting the allocations announced in December 2013 for CCGs and NHS England's direct commissioning responsibilities, NHS England sought to provide an appropriate balance between stability and action on underfunding.

23. NHS England remains committed to a transparent process for the distribution of funding. They carried out a Fundamental Review of Allocations to inform allocations for the 2014–15 and 2015–16 financial years, which drew on the expert advice of the Advisory Committee on Resource Allocation (ACRA) and has involved all partners, including representatives from CCGs. Following the Review, it was agreed to implement a new formula based on more

accurate, detailed data reflecting population changes and including a deprivation measure aimed specifically at tackling health inequalities.

24. The work of ACRA will continue, particularly in respect of gathering further research and evidence in relation to adjustments to reflect unmet need applied to CCG allocations, including considering the evidence on whether a further adjustment is needed to account for the cost of delivering services in more rural areas.

25. In relation to pace of change, the option agreed for CCGs reflected the challenge of directing additional funding to those CCGs most under target while managing the pace of any relative disinvestment required of others. This continues the policy of maximising growth for those furthest below target.

26. NHS England will continue to deliver an approach to future funding which is holistic and balanced with regard to the factors of population, age and deprivation which together define the need for healthcare.

### The provider sector (NHS trusts and NHS foundation trusts)

**This is the fourth report which the Committee has issued during this Parliament on the implications of the Government's spending plans for health and care. In each report we have drawn attention to the urgency of transformative change of the care model if the needs of patients are to be met. The fact that the number of NHS Trusts and NHS Foundation Trusts reporting underlying deficits continues to grow represents evidence that the pace of change has not been sufficient to meet the challenge. (HC 793, paragraph 38)**

### **Overall approach**

27. The Government has taken difficult financial decisions, allowing us to increase the NHS budget in real terms. However, we recognise the scale of the financial challenge that NHS trusts and foundation trusts are facing.

28. NHS England has adopted a more transparent, rules-based approach to provider support in 2013–14. This brings greater clarity with regard to providers' financial challenges and the recovery plans needed to restore them to a sustainable financial position.

29. We are clear that NHS organisations must meet their financial obligations, even where that entails making difficult decisions with commissioners around the organisation and delivery of their services, while ensuring patients still have access to the services they need. For NHS trusts this means continuing to meet their statutory break-even duty; for foundation trusts it means compliance with Monitor's licence conditions.

30. Where the Department of Health provides direct financial assistance to NHS providers who fail to achieve these basic financial requirements, the Department will attach conditions that specific actions are taken to address the underlying causes of the deficit. Where appropriate this might include: increased levels of financial and performance reporting; greater use of shared services; or, use of central procurement frameworks.

31. Where an NHS trust or foundation trust remains financially unsustainable, regulatory action may be taken against them, or the provider may be placed into special measures in order to ensure patients have access to the services they need, and that these are run on a sustainable basis. Where a foundation trust fails to comply with an additional licence condition imposed by Monitor as part of its

regulatory action; Monitor may use its powers to remove, suspend or disqualify one or more of the foundation trust's board members or governors. The NHS Trust Development Authority (NHS TDA) may also act to remove, suspend or disqualify board members in the case of NHS trusts.

### **Handling current deficits**

32. The Department of Health is working closely with partners including NHS England, the NHS TDA and Monitor in ensuring that the system is working collaboratively. This includes on-going analysis of the provider deficit position, including:

- The credibility of providers' recovery plans.
- The systemic or structural problems within individual providers which are contributing to their deficit.
- The reasons for provider deficits that have suddenly, or unexpectedly, appeared in year.

33. Actions being taken to address NHS provider deficits include:

- Challenging providers' recovery plans should insufficient progress be demonstrated, including regulatory intervention where appropriate.
- Identifying high-performing 'buddy organisations' to provide support and assistance.
- Making daily support available to trusts, so that they can call on a named professional lead from a range of different disciplines for guidance.
- Tailoring support to trusts from national bodies such as the Leadership Academy, the Foundation Trust Network and NHS Improving Quality.
- Identifying solutions to structural problems with the configuration of

services within individual local health economies.

34. Additionally, Monitor and the NHS TDA are working with trusts in deficit in drawing up action plans. Monitor can also take regulatory action to help trusts fix financial problems and regularly tracks the financial performance of trusts, encouraging them to work closely with other local organisations to provide sustainable, quality care.

#### ***Reducing pressures at the national level***

35. The Department is taking a number of actions to reduce cost pressures on the NHS and on NHS providers as detailed previously (see paragraph 8).

#### ***The five-year planning process***

36. The Government shares the Committee's concern regarding the increasing number of NHS trusts and NHS foundation trusts reporting deficits. We also recognise that, while significant progress has been made in some areas, service transformation takes time and will remain crucial in the years ahead. This is why NHS commissioners and providers are developing aligned, strategic plans for services over the next five years. As part of this planning, the £3.8 billion Better Care Fund will provide the biggest ever financial incentive to redesign and join-up services so that the health and care system is able to meet future challenges.

37. For 2014–15, the NHS TDA, NHS England and Monitor are establishing a package of joint support to assist some of the most challenged local health economies. This work is being done in advance of the relevant health organisations within those localities submitting their five-year plans in June 2014. This will be based on the approach of Monitor's Contingency Planning Team.

38. For many NHS trusts, it will be possible, if challenging, to produce a balanced five-year plan for high-quality care. However, a

minority of trusts have already decided that they are not sustainable in their current form and are therefore engaged in a transformation process through which they will either merge with, be acquired by, or be run by another organisation.

### **Integration of health and social care: Better Care Fund**

**The Committee welcomes the emphasis which the Government is now putting on service integration, both within healthcare services and between healthcare and social care. The Committee also recognises the logic of creating the Better Care Fund to provide an incentive for health and social care authorities to cooperate in new ways and facilitate the transfer of resources into community services which is a necessary part of the change process. (HC 793, paragraph 60)**

**The Committee remains concerned, however, that the pressures on available resources across the whole system, but in particular in social care, are now much greater than they were a few years ago, with the result that successful integration of high quality health and care services represents a substantial and growing challenge. The Committee does not believe that either the pace or the scale of the change which is necessary is sufficiently understood or that sufficient steps are being taken to explain the need for change to either the health community or the wider public. (HC 793, paragraph 61)**

**The Committee continues to believe that fragmented commissioning structures significantly inhibit the growth of truly integrated services. The Committee has recommended in previous reports that Health and Wellbeing Boards should**

**be encouraged to develop their role to provide an integrated commissioners' view of the transformative change which is necessary in our health and care system. It repeats that recommendation in this report and further recommends that NHS England and the Local Government Association should commission a review to establish the best practice method of consolidating the commissioning process through HWBs with minimum disruption of ongoing activity. (HC 793, paragraph 62)**

**The Committee also repeats the recommendation it made last year that the current level of real terms funding for social care should be ring-fenced. As we said in the corresponding report in 2013, this would "ensure that resources were no longer seen as 'belonging' to a particular part of the system but to the local health and care system as a whole." (HC 793, paragraph 63)**

**The Committee believes that in the absence of stronger commissioners and a commitment to ring-fenced real terms funding for health and social care, there is a serious risk to both the quality and availability of care services to vulnerable people in the years ahead. (HC 793, paragraph 64)**

39. In welcoming the Committee's support for the Better Care Fund, the Government shares the concern that demographic change will continue to place pressure on the health and social care system, making successful integration a growing challenge. This is why we have set up the £3.8 billion Fund of pooled budgets in health and social care from 2015–16.

40. Given the urgency to deliver transformational change, we believe the Fund is at the right scale and pace. The pooled fund is the biggest ever financial incentive for councils and local NHS organisations

to redesign services around the needs of service users in a way that has often been talked about in the past but never achieved. The fund equates to, on average, £25 million for each health and wellbeing board area. This is the minimum amount that will be pooled. Local areas have the flexibility to pool more funds locally and, if that is in the best interest of local people, we would encourage them to do so.

41. Every local area must have its two-year Better Care Fund plan signed-off by April 2014. Although the Fund is for 2015–16, £500 million of the pay for performance element will be tied to improved services and outcomes in 2014–15. Recognising that the integration of health and care services involves greater collaborative working and service redesign, an additional £200 million is being transferred from health to social care in 2014–15 to streamline the process.

42. The framework we have set up strikes the right balance between driving change at the right scale and pace and giving local areas the time and resources to develop and implement robust, sustainable plans that are genuinely transformative.

43. The 14 Health and Social Care Integration Pioneers<sup>4</sup> will be a key source of learning in how to make integration work at a local level, helping to drive change at the pace and scale required during 2014–15.

44. A strong quality assurance process has been developed with the Local Government Association (LGA) and NHS England, to ensure all local plans match the policy ambition envisaged by the Department of Health and the Department for Communities and Local Government (DCLG).

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<sup>4</sup> Department of Health (2013) [www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2](http://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2)

45. The Department of Health is communicating the need for change to both the health community and the wider public, but we agree that there is more to do.

46. The publication of *Integrated Care and Support*<sup>5</sup> by the national partners set out to the health and social care sector and the public the vision for integrated care and the commitments of different health and social care organisations. Since the publication of the Better Care Fund planning guidance in December 2013, the Government has worked with its partners to explain the Fund and integration policy by way of face-to-face events and other media, for example Health Service Journal press articles.

47. We accept there is more to do to explain the need for health and social care integration, in particular to the wider public. This could build on NHS England's *Call to Action* which set out many of the challenges facing healthcare, including the impact of an ageing population. To that end we will be working across government, with national partners and local organisations, to develop an effective communications strategy for 2014–15 and beyond.

48. Communicating the need for change cannot be done just from the centre of government, as it is at the local level where the changes will affect services for local people. Local professional, clinical and public engagement should therefore feature strongly in localities' work to implement their Better Care Fund plans.

49. Statutory health and wellbeing boards are playing an important role in developing more integrated commissioning approaches. Boards offer a forum that, because of their statutory responsibilities, promotes more coherent and coordinated commissioning

by local authorities and the local NHS, including the development of local health and social care integration. Local areas have the flexibility to decide the degree to which they wish to jointly commission services, and to develop locally determined mechanisms to do so. This could include developing a more formal role for the health and wellbeing board in overseeing joint commissioning.

50. Health and wellbeing boards have a specific role in respect of the Better Care Fund: all local plans must be approved by them, including the amount of money being pooled and plans for how this will be spent on health and care services. Boards also have a key role in ensuring Fund plans are part of a longer term strategy for improving the health and wellbeing of the local population, by ensuring plans are aligned with a local area's joint strategic needs assessment (JSNA) and its joint health and wellbeing strategy (JHWS). Boards can also influence NHS commissioning through their role in determining the basis on which the Quality Premium is paid to their local CCGs.

51. The Department is committed, along with colleagues in the DCLG and LGA, to ensuring that health and wellbeing boards continue to develop into their key role of leading and shaping the provision of health and social care in local areas.

52. The Department is funding a programme of developmental support for health and wellbeing boards, delivered in partnership with the LGA, NHS England, Public Health England, the NHS Confederation and Healthwatch. The programme provides peer support to local areas; intelligence and information sharing through regional networks; and, a range of resources and tools for use by local boards. These have included guidance on the development of JSNA and JHWS, and self-assessment tools to help boards assess their

<sup>5</sup> Department of Health (2013) *Integrated Care and Support: Our Shared Commitment* [www.gov.uk/government/publications/integrated-care](http://www.gov.uk/government/publications/integrated-care)

strengths and development priorities. The Department will also be working with partners to evaluate the role and impact of health and wellbeing boards in local systems throughout 2014–15.

53. The Government believes that by removing ring-fencing from local government grants we gave local authorities the freedom and flexibility over the money they received, allowing them to work with their residents to decide how best to make their spending decisions. It has enabled them to provide financial control to manage reductions in line with the priorities of their residents in order to protect key frontline services, protect the local taxpayer, reduce burdens and generate efficiencies.

### **Integration of health and social care: reconfiguration**

**Advocating service integration without recognising that the consequence of integration is reconfiguration of acute services is simply dishonest. (HC 793, paragraph 70)**

**The case for acute service reconfiguration is often presented as an economic necessity, but that is only half the story. It is certainly true that economic pressures mean that changes in acute services are necessary if the health and care system is to meet the demands placed upon it. The argument for reconfiguration, leading to reduced emphasis on acute services, is however supported by consideration of clinical quality as well as economic pressure. Our system currently places insufficient emphasis on identifying early symptoms and supporting normal life, with the result that it has provided reactive acute care to patients whose condition should never have been allowed to become acute. The challenge facing NHS policy makers, at both national and**

**local level, is to explain this underlying policy requirement to a sceptical public. (HC 793, paragraph 71)**

**Changes which lead to the closure of hospitals or remove services from hospitals are notoriously controversial with local communities. Too often this is because the first a community hears about proposed changes is when the acute facility is proposed for closure. If these proposals are notoriously controversial, it is too often because the case for change is notoriously badly made. Part of the benefit of involving Health and Wellbeing Boards in the commissioning decisions about health and care, with a single overview for a given community, should be to engage the local professional and lay communities in a greater understanding of the care quality issues which underlie the case for service reconfiguration, as well as the economic issues involved. (HC 793, paragraph 72)**

54. We agree with the Committee that significant service changes will be required in the NHS over the coming five years if it is to continue to deliver high quality and sustainable care to the public. In many cases, this will mean moving services out of a traditional hospital setting, and delivering them closer to people's homes and communities.

55. We also agree that it is important the consequences of integration are fully understood and planned for, including modelling the benefits and impact across all sectors of a local health and care system. NHS commissioners and local authorities should consider how services can be integrated holistically to deliver person-centred care, tailored around people's care needs. That may involve developing new services in the community and, as



these services come on stream, moving activity from existing acute-based services. NHS England's Better Care Fund planning guidance<sup>6</sup> specifically required that local areas should identify what the impact of local Fund plans would be on the acute sector. Health and wellbeing boards also have a key role locally in bringing together local health and care partners, so that changes can be planned effectively across local health economies.

56. It is important to note, however, that better integration is not the only reason for service change. NHS England's planning guidance set out the six characteristics of high-quality health systems which we expect local health economies and NHS England's direct commissioners to use as the basis for their five-year plans. These are:

- That they empower patients and include citizens in all aspects of service design.
- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- Achieving a step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.

57. NHS England expects that the strategic planning process due to conclude in June 2014 will make clear that, across the country, local areas need to change the services delivered by their health and care systems in order to deliver the high quality services which the public expects, sometimes very urgently. The Committee is right to highlight the need to communicate the reasoning for these plans to the public: in order to deliver

these plans successfully, they must be locally owned and championed.

58. In some cases, these service changes will need up-front investment. In 2014–15, CCGs and NHS England direct commissioners will set aside 2.5% of their spending for this sort of one-off investment, including 1% specifically to support service transformation. In 2015–16, the Better Care Fund will continue to support service change. NHS England will work with the Department on how best to meet the continuing requirement for investment to support service change from 2016–17.

59. At the same time, the Department is removing barriers to change that will both create and enable new models of care and solutions to emerge that are appropriate to their settings. This is the key to ensuring that healthcare providers can not only adapt to the current situation but can evolve alongside future changes in demographic trends and in the health economy. This will guarantee high-quality care and patient experience for the future.

60. We also agree with the Committee that considerations of clinical quality, and improving outcomes for patients, must be at the heart of any proposals to reconfigure services. The objective of service reconfiguration should be to achieve a transformation in care so that services are higher quality, improve the patient experience and are financially sustainable in the long term. As medicine and technology evolve, and the health needs of populations change, the NHS will continue to need to modernise the delivery of services. NHS England's *Call to Action* set out the significant challenges facing the health system but also that the solution to securing significant improvements in outcomes, in the face of a challenging economic climate, was the need to transform

6 NHS England (2013) *Better Care Fund Planning* [www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/](http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/)

care in partnership with patients and the public.

61. This includes commissioning and delivering more preventative services and early interventions, which aim to address health conditions before they become acute, and support people with one or more long-term conditions to manage these in the community and their own homes. It also includes concentrating specialist care in a smaller number of centres of excellence, where the evidence supports this.

62. We agree with the Committee that it is essential that proposed changes to health services have a robust and transparent evidence base, and that active participation of citizen and communities is a key part of the development of proposals throughout, and not just through formal public consultations. NHS England has produced best practice guidance on reconfiguration,<sup>7</sup> which sets out that proposals should build upon existing strong partnerships between commissioners and the public on local health and care priorities, and how best these can be met within available resources.

63. The guidance states that health and wellbeing boards should have a key role in helping to bring together leaders across the NHS, social care and public health locally, with local councillors and local Healthwatch – and where reconfigurations can build upon existing shared agreements through strategic commissioning plans, JSNAs and JHWSs. This approach ensures that reconfigurations are not considered as solutions to single parts of the local health system – such as an individual hospital service – but rather look across the potential opportunities for reshaping services broadly across the health

and care system, with partners working collaboratively to achieve the best outcomes for patients and the public.

### **Health and Social Care Act: system leadership**

**There is a real danger that, without a body which can take charge of decisions about reconfiguration and integration of services, change which needs to be made to maintain and improve services will not happen. As the Committee has noted earlier in this report, the evidence we heard in this inquiry confirms to us that, in the present system, this is the most viable approach to ensure continuity of and improvement in services. (HC 793, paragraph 79)**

**Health and Wellbeing Boards were established by Parliament to enable commissioners to take a view across the whole of a local health and care economy. In the light of the urgent need to increase the pace and scale of service reconfiguration in the health and care system, the Committee repeats the recommendation it has made in earlier reports that the role of Health and Wellbeing Boards needs to develop to allow them to become effective commissioners of joined-up health and care services. (HC 793, paragraph 80)**

64. The essence of the Government's approach to health and social care services is that they are person-centred, and designed around the needs of citizens and communities, not mandated by a top-down, remote body.

65. NHS England's planning guidance sets out that the reconfiguration of health services should, in most cases, be led by commissioners, but that the most effective plans are those built in partnership with commissioners, local authorities and

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<sup>7</sup> NHS England (2013) *Planning and delivering service changes for patients* [www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf)

providers working together across a local health and care system. Commissioners should be active in leading service design and change, corresponding with their responsibilities to identify high-quality services to meet local population needs, now and in the future. Where providers bring forward proposals, it is important that these align with commissioning intentions and reflect local commissioning plans. Commissioners should also work closely with local authorities, who have an important role, not just in scrutinising proposals, but in contributing to their development through health and wellbeing boards. This provides a firm foundation for more detailed development of plans that are in the best interests of local people.

66. At a local level, health and wellbeing boards bring together local authorities, the NHS, local Healthwatch, communities and wider partners, to share system leadership across health and social care. Boards are therefore the key forum for ensuring that local health and wellbeing systems meet the current and future needs of communities, including in respect of issues such as reconfiguration and the integration of services. Boards are responsible for developing JHWSs (based on JSNAs) that form the basis of NHS and local authorities' own commissioning plans across health, social care, public health and children's services. Local health and social care commissioners are expected to develop their commissioning plans in line with any relevant JSNA or JHWS, and must be able to justify any parts of their plans that are not consistent.

67. While health and wellbeing boards do not hold budgets or directly commission services themselves, they do offer a forum that, because of their statutory responsibilities, promotes more coherent and coordinated commissioning by local authorities and the local NHS. Local

authorities and the NHS also have the flexibility to develop local mechanisms to deliver integrated or joint commissioning. This could include developing a more formal role for the health and wellbeing board in overseeing joint commissioning, but might equally be delivered through other means such as through pooled budgets.

68. By involving local councillors and representatives of people using services through local Healthwatch, and through wider engagement with local communities, health and wellbeing boards also strengthen local democratic legitimacy of health and care services and increase the influence of local people over the services they use.

69. Health and wellbeing boards are also playing a significant part in health and social care integration by providing democratic and clinical oversight and approval of Better Care Fund plans for 2015–16, as part of their role in developing local health and wellbeing strategies for the longer term.

70. Health and wellbeing boards are relatively new organisations, having become fully established on 1st April 2013. The Department is therefore committed to working with its partners, both locally and nationally, to ensure they are able to meet the challenges of leading and shaping the provision of health care in local areas. As mentioned previously, the Department is funding a programme of developmental support for health and wellbeing boards, delivered in partnership with the LGA, NHS England, Public Health England, the NHS Confederation and Healthwatch.

### **Health and Social Care Act: competition**

**For reasons of both financial viability and quality of service, the Office of Fair Trading and the Competition Commission need to ensure that their decisions**

**on mergers are reached as quickly as possible. They should also have regard to the principle legislated for in the Act in respect of Monitor that it must allow ‘provision of services in an integrated way’ where this improves quality of provision or reduces inequalities in relation to access to services or to outcomes. (HC 793, paragraph 86)**

**The Secretary of State told us that he did not consider that there was a case as yet for seeking to change competition law. The Committee is concerned, however, that in the case of Bournemouth and Poole the competition authorities intervened to obstruct a proposed service reconfiguration on competition grounds without being able to substitute another proposal to deliver service change. The Committee has stated its view many times that there needs to be an increase in the pace and scale of service change. The Committee recommends that the Government should examine the background to the Bournemouth and Poole proposal in order to ensure that unnecessary impediments to necessary change are removed. (HC 793, paragraph 93)**

71. The Government agrees that where local health economies are pursuing service change, in the best interests of their patients, then this should be able to proceed at pace. The competition authorities and Monitor have stated their commitment to patient’s interests being at the heart of the merger review process.<sup>8</sup>

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<sup>8</sup> Joint statement from the Office of Fair Trading, the Competition Commission and Monitor (2013) *Ensuring that patients’ interests are at the heart of assessing public hospital mergers* [www.monitor-nhsft.gov.uk/sites/default/files/publications/131017\\_of\\_t\\_cc\\_monitor\\_merger\\_statement\\_final.pdf](http://www.monitor-nhsft.gov.uk/sites/default/files/publications/131017_of_t_cc_monitor_merger_statement_final.pdf)

72. However, it is also important that merger proposals are scrutinised effectively, to ensure that only cases that serve the patient and public interest proceed.

73. Review by the competition authorities is not automatic. Many changes to services will not involve a merger, and in other cases even where a merger is proposed, it may not result in reduced choice for patients and commissioners, or weakened incentives for a provider to maintain or improve the quality of their services. In these cases there will be no need to notify the proposed merger to the competition authorities.

74. In the case of notified mergers, in reaching a decision the competition authorities are required to weigh up the potential harm to patients’ interests against the expected benefits. This essentially follows the same principles that have been applied to NHS mergers since 2008. The competition authorities and Monitor’s aim is to ensure the process is well understood, and operates as quickly and predictably as possible. Where a merger is in the overall best interests of patients then it will proceed.

75. Monitor has committed to being more active in providing support, from an early stage, to those organisations that are planning to merge. The chief executive of Monitor wrote to all foundation trusts in January 2014, setting out a new three-stage approach that Monitor will roll out to help organisations achieve a robust merger proposal. In particular, Monitor will provide advice on the foundation trust’s strategic rationale for the merger, the identified benefits to patients and the plans to realise those benefits, and an assessment of any competition issues. Monitor will establish a dedicated team to provide this support and engage with any foundation trust planning a merger.

76. Should the competition authorities decide to investigate a merger, Monitor would provide them with its assessment of the relevant patient benefits identified by the foundation trust. This advice would cover whether a merger will result in the delivery of more integrated care to patients, otherwise improve quality of provision or reduce inequalities in relation to access to services. Monitor would also share its assessment of the potential scale and impact of any reduction in competitive pressure. The competition authorities have agreed to place significant weight upon Monitor's advice.

77. Overall, we expect this will mean that in future, where a review of a merger is necessary, the process will be quicker and less costly.

### **Payment by results: the tariff system**

**It is important that payments to providers reflect the costs of treatment, and that the payments system is able to distinguish accurately between different types of case. It should be a priority for NHS England and Monitor to work to develop a payments system which reflects this requirement. (HC 793, paragraph 97)**

78. We agree with the Committee that it is important that payments to providers accurately reflect the relative cost of treatment in relation to the achievement of the best practice in terms of outcomes, including incentives to deliver improving quality.

79. One of the issues that will be fundamental to that system will be the quality of the data underpinning the system and, in particular, the quality of the cost data used to set prices. The cost data used to underpin prices needs to be as accurate as possible so that prices reflect the cost of treating different patients and of achieving optimum outcomes.

80. NHS England are also reviewing the payment system to ensure that it takes into account the cost of treating different patients as much as possible by looking at the way the system takes into account the number and severity of conditions of individual patients.





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