



Government response to the Lords Select Committee report on Long-Term Sustainability of the NHS and Adult Social Care

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

February 2018



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Foreword

I welcome the Committee's report, and would like to thank the Chair, Lord Patel, and the Committee for their thorough and thoughtful approach. It is right that questions about the long-term sustainability of health funding are openly discussed, and my Department welcomes the opportunity to debate these crucial issues about the long term sustainability of our health and care services in England further. We have already acted to address some of the recommendations made in the report, and we intend to consider the others in the longer-term. As the NHS celebrates its 70th birthday this year, we want to make sure that it is supported in continuing to provide excellent care well into the future.

This Government is deeply committed to the founding principles of the NHS. We want to make sure that the service meets the needs of everyone, no matter who they are or where they live, that care is based on clinical need, and is free at the point of use.

We know that the NHS and adult social care systems face unprecedented challenges due to an ageing and growing population, with increasing expectations and demands on services. For example, more people than ever are going to A&E – last year 23.4 million people went to A&E, 2.9 million more than in 2010, and the overwhelming majority of patients continue to be seen within 4 hours (90.5%). Last year the NHS saw 61.5 million outpatients - 10.5 million more than in 2010. It carried out 11.6 million operations - 1.9 million more than in 2010.

This Government is committed to making sure that these systems are sustainable for the long term so that NHS treatment remains free at the point of delivery. That is why, through the 2015 Spending Review, the Government committed to a real terms increase of £10 billion in NHS funding by 2020-21, compared to 2014/15. We know the NHS is facing many challenges and that there are increasing pressures on the health and care system. The Government has now gone further, with the Chancellor announcing a further £2.8 billion of additional resource funding over 2017-18, 2018-19 and 2019-20 for the NHS in England at the Autumn Budget. This will help our ambition to deliver performance targets on waiting times in A&E and after patients are referred to treatment. It will ensure that more patients receive the care that they need more quickly. In addition, for other core NHS services, such as mental health and primary care, the Department of Health and Social Care is making a further £540 million available through the NHS Mandate over the coming financial year. The Autumn Budget also announced £3.5 billion of capital investment for buildings and facilities in the NHS in England by 2022-23, and a commitment to fund pay awards as part of a pay deal for NHS staff on the Agenda for Change contract, including nurses, midwives and paramedics.

In the Spring Budget 2017 we announced an additional £2 billion for councils in England to spend on social care. In addition, the Secretary of State for Housing,

Communities and Local Government has recently announced £150 million to continue the Adult Social Care Support Grant – which was due to end - in 2018-19. This means that councils have access in total to £9.4 billion more dedicated funding for social care over the period 2017-18 – 2019-20, as a result of measures introduced by the government since 2015. This funding will allow councils to support more people and sustain a diverse care market. It will also help to ease pressures on the NHS, by supporting more people to be discharged from hospital and into the right care as soon as they are medically ready. We have attached conditions that ensure the additional funding goes towards social care provision.

Delivering our commitment to long-term sustainability of health funding depends in part on ensuring that services are planned and delivered in a more effective and sustainable way. I am pleased that we have the opportunity to achieve this via the *NHS Five Year Forward View* and subsequent *Next Steps on the Five Year Forward View*, which we will continue to support wholeheartedly and hold the NHS leadership to account for its delivery.

We know that the *NHS Five Year Forward View* provided consensus about why and how the NHS should change, with a greater emphasis on keeping people well and independent for longer, as well as reducing the fragmentation patients often experience by delivering more integrated care and services. I am pleased to say that since its publication, substantial progress has been made in terms of better health, better care, and financial sustainability.

The *Five Year Forward View* set out a clear vision around closing the gaps around the health and wellbeing of the population and the quality of care provided. The NHS has chosen to use Sustainability and Transformation Partnerships (STPs) to support the delivery of the transformation required to deliver this vision and make sure that health and social care services in England are developed around the needs of local populations now and for the foreseeable future. My Department supports local STPs where they are clinically led and locally supported.

We are also committed to STPs working closely with the partners in their areas, including local authorities, while developing their plans. NHS England has issued guidance to the system to support this, and our expectations about local involvement and engagement have been clear.

On health and social care integration, the Better Care Fund (BCF) has been implemented since the beginning of 2015-16 to provide a mechanism for local authorities and clinical commissioning groups to pool budgets for the purposes of integrated care.

As the Committee's report makes clear, significant efficiencies will need to be delivered and I do not underestimate the scale of this challenge, even with achievements made by the NHS to date. We will continue to ensure every pound of

NHS spend has the greatest possible impact on patient care, building on an unprecedented five consecutive years of productivity improvements in the NHS.

One of the purposes of the £2 billion we announced in the 2017 Spring Budget for social care is reducing pressure on the NHS, including delayed transfers of care. We set clear expectations for delayed transfers of care reductions for each local area reflecting that reducing such delays must be a shared endeavour across the NHS and social care. In addition, we introduced greater transparency through publishing a dashboard showing how local areas in England are performing against metrics across the NHS-social care interface, including delayed discharges.

To address the long-term challenges facing the social care system, the Government is committing to publish a Green Paper on care and support for older people by summer 2018 setting out its proposals for reform.

Finally, on 8 January 2018, the Department was renamed Department of Health and Social Care, taking on responsibility for the forthcoming social care green paper which will set out the Government's proposals to improve care and support for older people and tackle the challenge of an ageing population.

The Committee's report has identified many of the key issues which need to be addressed in order to make the NHS and social care system sustainable for the long term. Our immediate focus is rightly on the next five years and, within this, delivering the *Five Year Forward View* to deliver improvements for patients while managing demand and planning to achieve financial balance.

I look forward to working with our partners to deliver on the range of recommendations included in the report.

Lord O'Shaughnessy
Parliamentary Under Secretary of State for Health (Lords)

Introduction

On 5 April 2017, the Long-term Sustainability of the NHS Select Committee published its report into the issues relating to the sustainability of the NHS and adult social care.

The Committee was appointed on 25 May 2016 and ceased to exist upon publication of its report. The Committee took evidence from 36 hearings involving 99 witnesses.

The Committee itemised a number of conclusions and made 34 recommendations in relation to a wide range of areas including service transformation; funding the NHS and adult social care; innovation, technology and productivity; public health, prevention and patient responsibility; and towards a lasting political consensus.

Our response is set out in the same order as the conclusions and recommendations in the Committee's report. Wherever the word 'we' appears in the recommendations it refers to the Committee and the paragraph numbers at the end of the recommendations refer to paragraphs in the Committee's report. Wherever the word 'we' appears in the response sections, it refers to the Government.

Service Transformation

Recommendation 1

Most people agree that key aspects of the service delivery model for the NHS need to change. There is also broad agreement on how this should happen. The general direction of NHS England's Five Year Forward View commands widespread support and, if fully realised, will place the NHS on a far more sustainable footing, especially if greater public support can be achieved (Paragraph 43).

The Five Year Forward View appeared to be the only example of strategic planning for the future of the health service. This is clearly short-sighted. Without a longer-term strategy for service transformation, which goes beyond 2020, any short-term progress achieved through the Five Year Forward View will be put at risk (Paragraph 44).

The Department of Health and NHS England, in partnership with the Department for Communities and Local Government, the Local Government Association and the Association of Directors of Adult Social Services, should agree a medium-term plan that sets out the action required to deliver sustained service transformation at a local level. This plan should cover the period up to at least 2025, be supported by dedicated funds and be implemented following a full public consultation (Paragraph 45).

Response:

The Government is deeply committed to the long-term sustainability of the NHS and has put in place steps to ensure the health and care system is well placed to prepare for the future.

We support the NHS England report, *Next Steps on the NHS Five Year Forward View*, published in March 2017 ^[1]. This set out practical steps for ensuring that the NHS is able to adapt and transform to meet our priorities for the future. This includes 'helping frail and older people stay healthy and independent, avoiding hospital stays where possible' and 'better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes'. We are actively working with NHS England and national partners to use the period covered by the *Five Year Forward View* to put in place the necessary steps for the future.

This includes providing funding to back the Five Year Forward View, with a £10 billion a year real terms increase in the NHS budget by 2020-21. At Autumn Budget 2017, the Government committed to backing the NHS in England further so that by 2019-20

^[1] NHS England, *Next Steps on the Five Year Forward View*, March 2017

it will have received an additional £2.8 billion of revenue funding for frontline services than previously planned over the period. A further Spending Review will occur during 2019, which will provide further certainty for the NHS.

At Autumn Budget 2017, the Government also made available an additional £3.5 billion of capital investment in the NHS by 2022-23. This includes £2.6 billion for locally-led Sustainability and Transformation Partnerships (STPs), which are designed to bring about more joined-up services and real improvements to patient care. Many local STP plans focus on increasing local capacity to treat patients out of hospital, where that best suits their needs; and enabling the NHS to meet future demand more sustainably. Our capital investment also includes £200 million to support efficiency programmes that will allow more staff time to be directed towards treating patients.

Health Education England published a draft workforce strategy for health and care in December 2017 and will publish a final strategy that sets out a long term vision for workforce, as well as action to increase the number of students training to be doctors and nurses. To protect frontline services in the NHS, the Government is also committing to fund pay awards for NHS staff on the Agenda for Change contract that are agreed as part of a pay deal with the unions to boost productivity. This includes nurses, midwives and paramedics.

On social care – we have set out our plans to publish a green paper by the summer, and will engage with parliamentarians and other interested parties as part of that open consultation process.

We are pursuing our ambition to become the safest healthcare system in the world. This includes the draft Bill published this year to establish a new independent Health Service Safety Investigation Body to take forward and embed a culture of learning within the NHS.

The health and care system is therefore well placed to plan for the future on this basis. We will continue to support and champion new, innovative ways of working and delivering care that improves outcomes and focuses on prevention, so more people avoid needing care in the first place. In doing this, we have sent a clear message that change should be clinically and locally led, and it is vital that local people have a role in shaping the needs of the future of their local services; where there is significant system reconfiguration, there should be regular engagement with the public and stakeholders.

Recommendation 2

We applaud the move towards more place-based commissioning which delivers integrated health and social care services. At this early stage it would be premature to make a judgement about the current effectiveness of Sustainability and Transformation Plans but we doubt the ability of a non-statutory governance structure to secure sustainable change for the medium and longer term. NHS England, with the support of the Department of Health and Social Care, should ensure that all 44 Sustainability and Transformation

Plan areas have robust governance arrangements in place which include all stakeholders, including NHS organisations, local government, the voluntary sector and the public (Paragraph 58).

We are concerned by the reported lack of engagement with either local authorities or the wider public in the preparation of Sustainability and Transformation Plans. This will deter buy-in at a local level and jeopardise ongoing political support (Paragraph 59).

The evidence was mixed on the contribution of devolution to the long-term sustainability of health and social care. There are undoubtedly lessons to be learnt from devolution, but the evidence was not clear on how well the model in Greater Manchester could be replicated nationally especially as many, if not most, of the Sustainability and Transformation Plans (STPs) are for much smaller populations than that of Greater Manchester (Paragraph 63).

The traditional small business model of general practice is no longer fit for purpose and is inhibiting change. NHS England, with the help of the Department of Health and the profession, should conduct a review to examine alternative models and their contractual implications. The review should assess the merits of engaging more GPs through direct employment which would reflect arrangements elsewhere in the NHS (Paragraph 76).

Response:

The Government recognises the incredibly positive and fundamental contribution that general practice makes within the NHS, including the significant benefits to local communities that GP practices across the country provide.

We are working in partnership with NHS England to continually monitor and review emerging data and evidence on how general practice is delivered in order to understand the issues fully and consider what they mean for the future of general practice. In partnership with the profession, NHS England and Health Education England published the 2016 *GP Forward View*¹, setting out the ambitions for general practice and committing to an extra £2.4 billion per year investment for improvements in capability and capacity.

We are working with NHS England, the National Association of Primary Care and the BMA to explore ways in which GP practices can move to new models such as GP federations and Primary Care Homes/Hubs. This is supported by work being taken forward by the NHSE New Care Models team, exploring models that can deliver the *Five Year Forward View* while also supporting the improvement and integration of services.

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

Two really positive examples of new models of primary care are Primary and Acute Care Systems, which join up GP provision with hospital, community and mental health services; and Multispecialty Community Providers, as set out in the *GP Forward View*, where specialist care is being moved out of hospitals into the community.

Recommendation 3

We acknowledge that over-reliance on the acute hospital inpatient sector is a serious threat to the financial sustainability of health and care services. This sector should be radically reshaped in terms of service provision but changes to the number, size and distribution of secondary care services should always reflect the needs of the local population. Any changes should take place following a broad consultation (*Paragraph 80*).

Response:

Transformation in the acute sector has been key in delivering positive and lasting changes and improvement to health and care over the past fifteen years.

Nevertheless, challenges remain and the needs and expectations of the public are also changing. People are living longer, and often require different, more complex care. New treatment options are emerging, and patients rightly expect better care closer to home.

There is broad consensus that, in order to create a better future for the NHS, we need to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care – quite the opposite. It means more preventative care; finding new ways to meet people's needs, and identifying ways to do things more efficiently. Any significant service change should involve proper local engagement and consultation.

Where this is done successfully, transformational improvements in quality and in outcomes can be achieved. Juliet Bouverie, Chief Executive of the Stroke Association, said recently (July 2017) that “the reconfiguration of stroke services is a topic that continues to drive public and political debate. But the evidence is clear that centralising stroke treatment at a much smaller number of hospitals has considerable benefits. The London Hyper Acute Stroke Unit (HASU) model, which operates 24 hours a day, seven days a week, saves £5.2 million each year. That's equivalent to £811 per NHS patient. Evidence from the National Audit Office also suggests that faster access to tests and specialist treatment, and the associated efficiencies, have improved outcomes for stroke patients and helped to save the NHS an estimated £456 million between 2007 and 2014”. The challenge for all involved in service design – clinicians, commissioners, patients, local and national government – is to

make the case that reconfiguration in the best interests of the health service needs to be supported.

Recommendation 4

The drive to consolidate specialised services is a necessary part of overall service transformation. However, as with primary care, we were left with no clear picture of how specialised service consolidation will be delivered in the medium and the longer term (Paragraph 85).

Although recent efforts to promote joined-up health and social care services have delivered mixed results, integrated health and social care with greater emphasis on primary and community services still presents the best model for delivering patient-centred, seamless care. Although there is disagreement on the financial gains to be derived from this integration, the benefits to patients are a clear justification for continuing to pursue this agenda (Paragraph 94).

The Health and Social Care Act 2012 has created a fragmented system which is frustrating efforts to achieve further integration and the service transformation aims of the Five Year Forward View (Paragraph 99).

NHS England and the Department of Health should launch a public consultation on what legislative modifications could be made to the Health and Social Care Act 2012 which would remove the obstacles to new ways of working, accelerate the desired service transformation and secure better governance and accountability for achieving system-wide integrated services (Paragraph 100).

Response:

The Department of Health and Social Care has an ongoing role to review regularly health and social care legislation and regulation to ensure that national bodies and local systems are best supported to achieve our shared objectives for integrated, high quality care. At this stage we do not consider a change in primary legislation is necessary to drive forward further integration.

Considerable progress towards integration of health and social care is being made within the current legislative framework. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund, the mechanism by which local authorities and clinical commissioning groups pool budgets to support integrated care, which has been implemented since 2015-16.

The BCF requires local areas to pool budgets, helping to join-up health and care services so that people can manage their own health and well-being and live independently in their communities for as long as possible. In 2015-16, 90% of local health and care system leaders said that the BCF had already had a positive impact on integration locally.

Integration is therefore being led locally and different parts of the country are already pressing forward with their own approach, according to their own local needs and context. In Greater Manchester for example, the ten Health and Wellbeing Board localities are pooling health and care budgets, while certain services will be commissioned jointly across the Greater Manchester area, on behalf of local authorities, clinical commissioning groups and NHS England. North East Lincolnshire is pursuing a lead commissioner model, in which the CCG exercises adult social care functions on behalf of the local authority.

Recommendation 5

Service transformation is dependent on long-term planning, broad consultation, appropriate systems of governance and local accountability. The model of primary care will need to change, secondary care will need to be reshaped and specialised services consolidated further. Importantly, a renewed drive to realise integrated health and social care is desperately needed. However, the statutory framework is frustrating this agenda and in order for real progress to be made the national system is in need of reform to reduce fragmentation and the regulatory burden (Paragraph 101).

With policy now increasingly focused on integrated, place-based care we see no case for the continued existence of two separate national bodies and recommend that NHS England and NHS Improvement should be merged to create a new body with streamlined and simplified regulatory functions. This merged body should include strong representation from local government (Paragraph 102).

Response:

NHS England and NHS Improvement are actively working together under their different statutory functions to monitor and support trusts and CCGs to deliver the *Next Steps on the NHS Five Year Forward View*. We are supportive of their efforts to work more closely together to provide joined-up national leadership, within the legal framework – and will continue to look for opportunities to go further here, to ensure that their regulatory functions are as streamlined and aligned as possible. They have made a number of joint appointments to provide strategic leadership across the NHS including the Chief Information Officer for health and care a joint national lead to support Trusts and CCGs to make improvements in urgent and emergency care. They are also improving integration between regional teams who work with Trusts and CCGs on a day to day basis through the appointment of shared regional managing directors between NHS England and NHS Improvement, and regional chief nurse appointments in the south region.

Workforce

Recommendation 6

We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years. In our view this represents the biggest internal threat to the sustainability of the NHS. Much of the work being carried out to reshape the workforce is fragmented across different bodies with little strategic direction from the Department of Health. Although we recognise that Health Education England has undertaken some work looking at long-term planning for the workforce, this is clearly not enough. Health Education England has been unable to deliver (*Paragraph 119*).

We recommend that, as a matter of urgency, the Government acknowledges the shortcomings of current workforce planning. Health Education England, both nationally and through the network of local education and training boards, should be substantially strengthened and transformed into a new single, integrated strategic workforce planning body for health and social care. This will enable it to produce and implement a joined-up place-based national strategy for the health and social care workforce, and it should always look 10 years ahead, on a rolling basis. Consideration should be given to its name to better reflect its revised function (*Paragraph 120*).

Response:

HEE are leading the development of a cross-system workforce strategy for the NHS, which was published as a draft for consultation in December.

The strategy is positive, forward-looking, and reflects the joint positions of all Department of Health and Social Care ALBs, including NHS England, NHS Improvement and Public Health England. It focuses on policy priorities for the coming five years and starts a national discussion about the changes needed into the 2020s and beyond in order for the NHS workforce to deliver and ensure it has the productivity levels required to deliver safe, compassionate and effective care.

The strategy announced independent reviews to assess the impact of these changes on all clinical professionals and on how best to support the informal workforce, made up of family, carers and patients themselves, in the future.

The consultation provides an opportunity for stakeholders and the public to engage with Government on how future challenges for the NHS workforce can be best addressed.

Recommendation 7

Health Education England’s independence should be guaranteed and supported by a protected budget with greater budgetary freedom. It will need enhanced skills and a board that includes representation from all parts of the health and care system (Paragraph 121).

Response:

Health Education England is a Non-Departmental Public Body, and operates with a level of independence as set out in the Care Act 2014 and associated regulations. HEE is accountable, through the Secretary of State, to Parliament for the efficient, economic and effective expenditure of nearly £5 billion public spending.

We will keep the make-up of HEE’s board under review following the recruitment of a new Chair.

As with other bodies in central government, HEE must still adhere to the same HMT budgetary regime applied to all central government bodies.

Recommendation 8

Workforce strategy has been poor with too much reliance on overseas recruitment. The Government should outline its strategy for ensuring that a greater proportion of the health and care workforce comes from the domestic labour market and should report on progress against this target (Paragraph 122).

Response:

Staff trained in the European Union and from across the globe make a vital contribution in delivering high quality care across the health and care system.

We recognise that the NHS should seek to become more self-sufficient by maximising the supply of domestically trained staff in the United Kingdom. The Department of Health and Social Care is taking a number of practical steps to increase the supply of health and care professionals trained in the United Kingdom. For instance:

Expanding nurse training places and broadening routes into nursing

The Department of Health and Social Care is increasing the number of available clinical placements for nurse degree courses by 5,000 from 2018 – an increase of 25 per cent. This will mean that NHS employers, as well as those in the independent and care sectors, will have a larger pool of highly qualified home-grown staff available.

Developing new routes into nursing is a priority for the Department. That is why in November 2016 we announced the new Nursing Associate role and the Nurse Degree Apprenticeship. Once established, up to 1,000 apprentice nurses could join the NHS each year.

In October we announced an expansion of the Nursing Associate training programme through the apprentice route. Health Education England is establishing a national programme to train up to 5,000 Nursing Associates in 2018, and up to 7,500 Nursing Associate in 2019, through the apprentice route.

The new routes into the nursing profession will allow thousands of people from all backgrounds to pursue careers in the Health and Care sector and allow employers to grow their own workforce.

Expanding Medical Education

An additional 1,500 student places in medical schools each year are being funded. 500 places have been allocated to medical schools for students commencing courses in 2018. The remaining 1,000 places are being allocated through a competitive bidding process and will be available from September 2019.

Social Care

The Department of Health and Social Care continues to fund their delivery partner Skills for Care and are working closely with them to improve the level of domestic recruitment and retention of staff within adult social care.

Programmes of work include:

- an apprenticeship programme for adult social care which has been highly successful in attracting people to the sector with 87,800 apprentices starting in 2016/17.
- a Care Ambassadors programme supports those working in a variety of care roles, to promote a positive image of the sector. Employers see this scheme as a valuable tool in improving the image of the sector and increasing workforce capacity.
- resources and guidance to improve the skills of the social care workforce and support employers to recruit and retain their staff.

Recommendation 9

In the light of the result of the EU referendum, we recommend that the Government takes steps to reassure and retain overseas-trained staff working in the NHS and adult social care who are now understandably concerned about their future (Paragraph 123).

Response:

We agree totally. The Government recognises and values the enormous contribution that staff trained in the EU, and elsewhere globally, make across the health and care system. The Prime Minister has publically reassured the three million EU citizens, who have chosen to make their homes and livelihoods in the UK, that she wants them to stay.

On 8 December the UK and EU Commission reached an agreement which delivered on the Prime Minister's number one priority, to safeguard the rights of people who have built their lives in the UK and EU, following the UK's exit from the EU. The agreement will guarantee the rights of the 150,000 EU nationals working in our health and care system. It means that EU citizens living lawfully in the UK and UK nationals living lawfully in the EU by the specified date will be able to stay and enjoy broadly the same rights and benefits as they do now. On 7 November 2017 the Government published a technical document setting out how EU citizens will be supported through an application process which is streamlined and easy to use.

The Government has commissioned the Migration Advisory Committee (MAC) to gather evidence on patterns of EU migration and the role of migration in the wider economy, ahead of our exit from the EU. The MAC's advice will inform our decisions on our future immigration arrangements. As we design the future immigration system, we won't do it in a way that is contrary to the national and economic interest, because nobody wants to see labour shortages in key areas, such as the NHS and adult social care.

Recommendation 10

A transformed Health Education England should use its greater budgetary freedom to review current commissioning and funding mechanisms to explore how initial and ongoing education and training might achieve a more multi-professional skill mix among the workforce and be underpinned by a place-based approach (Paragraph 134).

Response:

HEE and NHS employers are supporting the growth of a flexible NHS workforce ready to deliver services as part of multi-disciplinary teams. HEE are piloting new roles such as the Nursing Associate and Physician Associate which are designed to

reduce the burden on nurses and doctors across a range of health and care settings. Employers themselves have developed new roles responding to local workforce needs. For example, Advanced Clinical Practitioners (ACPs) and Specialist Clinical Practice give existing nurses or Allied Health Professionals the opportunity to develop their skills further and provide more expert service to patients. Health Education England recognise the benefits from the ACP role and are working with NHS Improvement systematically and safely to support expansion of the role to deliver benefits in high priority areas such as A&E, cancer care and elective services.

As with other bodies in central government, HEE must still adhere to the same HMT budgetary regime applied to all central government bodies.

Recommendation 11

There has been too great a reluctance by successive governments to address the changing skill mix required to respond to a changing patient population and too little attention paid to workforce planning, education and training, all of which are necessary for delivering efficiency, productivity and overall value for money (Paragraph 135).

Health Education England should take the lead on changing the culture of conservatism which prevails among those who educate and train the health and social care workforce. It should convene a forum of the Royal Colleges, the General Medical Council, the Nursing and Midwifery Council, higher education institutions, other education providers, social care providers and local government representatives to investigate how medical and social care education and ongoing training courses can be reformed. Many are too lengthy, involve unnecessary repetition and do not meet the needs of a workforce which will have to be more flexible, agile and responsive to changing need (Paragraph 136).

Response:

Alongside our arm's length bodies, we are in regular contact with professional regulators and the Royal Colleges with regard to future curricula. For example, working with the General Medical Council in taking forward its recent work on Outcomes for Graduates and what the future medical curriculum needs to look like. Work is also ongoing via the Nursing and Midwifery Council on the future nursing curriculum and what the future skill sets of nurses and midwives should look like. Through Health Education England we have on-going discussions with Royal Colleges about modernisation of curricula and ensuring that this keeps up to date with the future skill sets the NHS needs. For example, Health Education England (HEE) has already increased to 50 per cent the proportion of doctors undertaking a four month psychiatry post during their foundation programme training and the Royal College of Psychiatry will complete the review of this expansion with a view to HEE

commissioning a further expansion from 2019. In addition to this, HEE is to ensure that from 2018 all foundation programme doctors not undertaking the four month training post will be required to complete a two week 'taster' attachment in psychiatry.

Recommendation 12

Given the move to a more localised and place-based approach to the provision of health and social care, a more flexible approach to the makeup of the workforce is required. Professional bodies, education providers and regulators should embrace the opportunities for different ways of working made possible by emerging, often non-medical, workforce roles and should not be afraid of challenging the traditional allocation of responsibilities within professions (Paragraph 137).

Response:

In addition to new roles described above, Health Education England is leading a programme to embed a National Framework for Multi-professional Advanced Clinical Practice to maximise the potential of the nursing and Allied Health Professional (AHP) workforce. The National Framework was launched in November 2017. The programme will formalise the use and development of extended roles for nurses and AHP through the roll-out of a national framework to develop their skills, knowledge and deployment in the NHS. Advanced Clinical Practice (ACP) across the multi-professional workforce will enhance capacity and capability within teams as part of the continuing drive to provide safe, accessible and high quality care for patients. Health Education England and NHS Improvement are working to systematically and safely to support expansion of the ACP role which can make a demonstrable impact in high priority areas such as accident and emergency, cancer care and elective services.

Recommendation 13

There is an indisputable link between a prolonged period of pay restraint, over burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade (Paragraph 153).

We recommend that the Government commissions a formal independent review with the involvement of the Department of Health, the pay review bodies and health and care employers to review pay policy with a particular regard to its impact on the morale and retention of health and care staff (Paragraph 154).

Response:

NHS staff do a fantastic job in delivering world-class care and we want to recognise their hard work and make sure that the overall pay package is fair and also affordable to hard working taxpayers.

The Government confirmed that the across-the-board 1% public sector pay policy will no longer apply to pay awards for 2018-19. It recognises that for some public sector workforces greater pay flexibility in return for improved productivity may be needed to address recruitment and retention problems.

In the Autumn Budget the Chancellor confirmed that, in order to protect patient services, he is committing to providing additional funding for a multi-year pay deal above the 1% per annum if ongoing discussions among NHS trades unions, NHS Employers and the Department on reforming the Agenda for Change contract bear fruit. Any multi-year pay deal will only apply to staff employed under Agenda for Change such as porters, domestic staff, nurses, midwives, paramedics. Any agreement will be on the condition that the pay award enables smarter working in the NHS, and is justified on recruitment and retention grounds.

For all NHS staff, the independent Pay Review Bodies will, as is usual practice, consider written and oral evidence about the recruitment, retention, motivation and productivity from a range of stakeholders, not just from the Government. This includes for example, NHS Employers and NHS Providers which represent NHS trusts, NHS trades unions, NHS Providers, NHS Improvement, and Health Education England.

Recommendation 14

The current regulatory landscape is not fit for purpose. In the short term, we urge the Government to bring forward legislation in this Parliament to modernise the system of regulation of health and social care professionals and place them under a single legal framework as envisaged by the 2014 draft Law Commission Bill. The Government should also introduce legislation to modernise the system regulators to take account of our recommendation that NHS England and NHS Improvement be merged and to reflect the clear move towards place-based care (Paragraph 155).

Response:

As set out in the response to recommendation 5, NHS England and NHS Improvement are working jointly under their different statutory functions to monitor and support trusts and CCGs to deliver the Next Steps on the NHS Five Year Forward View. We are supportive of their efforts to work more closely together to provide joined-up national leadership, within the legal framework. They have made a number of joint appointments to provide strategic leadership across the NHS

including the chief information officer for health and care and a joint national lead to support Trusts and CCGs to make improvements in urgent and emergency care. They are also improving integration between regional teams who work with Trusts and CCGs on a day to day basis through the appointment of shared regional managing directors between NHS England and NHS Improvement, and regional chief nurse appointments in the south region.

On 31 October 2017, the Government, along with the Governments of Scotland, Wales and Northern Ireland, published a consultation on the reform of the regulation of health and social care professionals in the UK. The UK's model of professional regulation for healthcare professionals has become increasingly complex and outdated. It needs to change to protect patients better, to support our health services, and to help the workforce meet future challenges. This consultation is a major step towards developing a modern system of regulation for healthcare professionals. The Government is already taking forward elements of this reform agenda in setting up Social Work England as the new regulator of social workers in England. Social Work England will have a range of powers which will enable it to take a proportionate approach to the regulation of social workers and to do more to promote the professional standards of all registrants. This is consistent with our broader approach to the reform of professional regulation.

Funding the NHS and adult social care

Recommendation 15

International evidence shows that a tax-funded, single payer model of paying for healthcare has substantial advantages in terms of universal coverage and overall efficiency. There was no evidence to suggest that alternative systems such as social insurance would deliver a more sustainable health service. Sustainability depends on the level of funding and, crucially, how those funds are used (Paragraph 169).

We strongly recommend that a tax-funded, free-at-the-point-of-use NHS should remain in place as the most appropriate model for delivery of sustainable health services both now and in the future (Paragraph 170).

Response:

The Government agrees with this recommendation, recognising the advantages of the current model as highlighted in the report. This is a key principle of the NHS constitution and the Government has no plans to revisit this principle.

Recommendation 16

We received some detailed analysis of how hypothecation might work for the NHS. Given the far-reaching implications of hypothecation for systems and services beyond the remit of our inquiry, we were not well-placed to make a firm conclusion on the issue. We recommend that hypothecation be given further consideration by ministers and policymakers (Paragraph 182).

Response:

As the Committee has noted, it is already the case that a significant portion of National Insurance contribution receipts – approximately 20 % (£20 billion in 2016-17) – is allocated to the NHS to fund its expenditure. The Committee has also outlined in its report some of the arguments for and against hypothecation of taxation. As with all aspects of government policy, we keep tax rates and NHS funding under review, and any decisions on future changes will be taken in the context of the wider public finances.

Recommendation 17

The reduction in health spending as a share of GDP seen over this decade cannot continue beyond 2020 without seriously affecting the quality of and access to care, something which has not been made clear to the public or widely debated (Paragraph 192).

To truly protect the sustainability of the NHS the Government needs to set out plans to increase health funding to match growing and foreseeable financial pressures more realistically. We recommend health spending beyond 2020 should increase at least in line with the growth of GDP and do so in a predictable way in that decade (Paragraph 193).

Response:

The Government is committed to protecting the NHS budget and devoting a significant share of national resources to the NHS. That is why annual NHS spending will increase by £10 billion in real terms in the six years following the publication of *Five Year Forward View*, reflecting the priority that we have put on properly supporting the NHS. Looking forward, the Conservative Party Manifesto committed to increase NHS spending by a minimum of £8 billion in real terms over the next five years. The government made a significant first step towards delivering this commitment with the £2.8 billion of additional resource funding provided at Autumn Budget 2017. In addition, the Department of Health and Social Care is making a further £540 million available through the NHS Mandate over the coming financial year. We will set out further plans in due course, with a Spending Review due to take place in 2019.

Recommendation 18

The additional funding for social care announced in the 2017 Budget is welcome and means funding for social care will increase by more than 2% a year for the next three years. This is more than the increase for NHS funding. However it is clearly insufficient to make up for many years of underfunding and the rapid rise in pressures on the system (Paragraph 206).

In order to stem the flow of providers leaving adult social care, meet rising need and help alleviate the crisis in NHS hospitals, the Government needs to provide further funding between now and 2020. This funding should be provided nationally as further increases in council tax to fund social care do not allow funding to be aligned with need. Beyond 2020 a key principle of the long-term settlement for social care should be that funding increases reflect changing need and are, as a minimum, aligned with the rate of increase for NHS funding (Paragraph 207).

Response:

We recognise the Committee's concerns about care providers leaving acute social care and the interactions between social care and NHS services. That is why, at Spring Budget 2017, additional national funding was agreed and is now being paid to local authorities. In addition, on 6 February 2018, the Government announced £150 million to continue the Adult Social Care Support Grant – which was due to end - in

2018-19. Taken together with other measures introduced by the Government since 2015, including a new social care precept and new 'improved' Better Care Fund, councils have had access to £9.4 billion more dedicated funding for social care over the next three years. Councils can now afford to tackle these issues, by using the funding to purchase care packages for more people, support social care providers, and relieve pressures on the NHS locally.

However, in addition to this funding we have been active in introducing targeted measures to ensure the funding delivers the necessary improvements. These include:

- publishing a performance dashboard showing how local areas in England are performing against metrics across the NHS-social care interface including delayed discharges
- plans for Local Government to deliver an equal share to the NHS of the expectation to free up 2,500 hospital beds, including a breakdown of delayed days per 100,000 of the population and the indicative reduction levels required by each Local Authority and local NHS, which included flexibility to be shared out differently at local level if agreed by both organisations
- we have also asked the Care Quality Commission to carry out 20 targeted reviews of local areas to consider how well they are working at the health and social care boundary, each review leading to a tailored response to ensure that those areas facing the greatest challenges can improve rapidly. The CQC has published an interim report setting out emerging findings and,
- in November 2017 we reviewed 2018/19 allocations of the additional social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.

We regularly update our understanding of future needs for social care, working closely with leading academics. This will feed into decisions about funding for social care beyond 2020 including the Green Paper on social care reform.

Recommendation 19

Funding over the past 25 years has been too volatile and poorly co-ordinated between health and social care. This has resulted in poor value for money and resources being allocated in ways which are inconsistent with patient priorities and needs (*Paragraph 216*).

The budgetary responsibility for adult social care at a national level should be transferred to the Department of Health which should be renamed the 'Department of Health and Care'. This should allow money and resources to be

marshalled and used more effectively as part of an integrated approach to health and care (*Paragraph 217*).

Response:

We agree that the Department of Health should be renamed.

On 8 January 2018, the Department was renamed Department of Health and Social Care, taking on responsibility for the forthcoming social care Green Paper which will set out the Government's proposals to improve care and support for older people and tackle the challenge of an ageing population.

The Department of Health and Social Care continues to be the responsible department for social care policy nationally, working closely with the Ministry of Housing, Communities and Local Government (MHCLG), which remains responsible for the financial framework for local government. Local Authorities are best placed to know the needs of their communities and therefore the Department will not be taking on adult social care budgets.

Recommendation 20

We acknowledge the difficulties with integrating budgets at a local level but this is achievable. The Government should undertake a review and bring forward changes in order to make this happen (*Paragraph 218*).

Response:

We support the local integration of health and social care budgets, which is why we introduced the Better Care Fund. The first mandatory pooled health and social care budget was announced in 2013 and implemented in 2015-16. In 2015-16, 90% of local health and care system leaders said the Better Care Fund had already had a positive impact on integration locally. In both 2015-16 and 2016-17, local areas voluntarily pooled more than the minimum required taking the total to £5.3 billion and £5.9 billion respectively.

In July 2017, the Secretary of State for Health asked the Care Quality Commission (CQC) to undertake reviews in 12 of the most challenged systems. The systems were identified from the bottom quartile of the dashboard of performance metrics for 150 areas in England, also published in July. The purpose of the reviews is to understand the pressures and challenges faced by these systems and identify any areas for improvement in the provision of health and social care. The reviews are focused on services provided at the interface of health and social care, including the interface between social care and general primary care, and acute and community health services.

The dashboard was refreshed and published in November and a further 8 areas for review have been identified - Cumbria, Hampshire, Liverpool, Northamptonshire, Sheffield, Stockport and Wiltshire, along with Bradford as a high performing area to support learning from good practice. All reviews will take place by the end of March 2018. CQC has published an interim report of its finding, with a final report to follow in the summer of 2018.

Each area reviewed is expected to produce an action plan; support is available from the Social Care Institute for Excellence as well as the Local Government Association, NHS England and NHS Improvement. We have put in place an agile and supportive improvement infrastructure and been clear on priorities, including the need to reduce delayed transfers of care.

Recommendation 21

Regardless of this further work on integrating budgets, the Government should commit to (1) securing greater consistency in the allocation of funding to health and social care at least in line with growth in GDP and (2) reducing the volatility in the overall levels of funding allocated to health and care in order to better align the funding of both services (Paragraph 219).

Response:

The Government absolutely agrees that stability and certainty in funding is desirable for health and social care.

This level of certainty has been provided through long-term settlements for the NHS and local government. We aim to take decisions on health and social care funding in a joined-up way, taking account of the impact of decisions in one area on the other; and we regularly update our understanding of future needs for social care, working closely with leading academics.

Decisions about future funding for the entire health and social care system will be made at the next Spending Review.

As for the Better Care Fund, the *Integration and Better Care Fund Policy Framework 2017-19* sets out the national conditions for its plans. One of the conditions stipulates that the contribution from NHS to adult social care is maintained in line with inflation.

Recommendation 22

We recommend that the current Government and any successive governments should agree financial settlements for an entire Parliament to improve planning and ensure the effective use of resources. 'Shadow' ten year allocations should also be agreed for certain expenditures, such as medical training or significant capital investment programmes that require longer-term planning horizons (Paragraph 220).

Response:

The Government agrees that it is important that the NHS, local government and social care providers have certainty over health and social care funding.

That is why the 2015 Spending Review provided a five year settlement for the Department, including the NHS – with budgets set for the 2016-17 to 2020-21 financial years.

In addition, at Autumn Budget 2017, the Government provided the NHS with an additional £3.5 billion of capital investment to 2022/23. This provides certainty to Sustainability and Transformation Partnerships and trusts allocated capital allowing them to take forward long-term capital schemes.

The Department and its arms' length bodies also undertake long-term planning to ensure the effective use of resources. For example, Health Education England has launched a 15-year strategic framework for the training of the NHS workforce to ensure that it is fit for the future and adapts to changing demographics, service delivery patterns, technology and culture.

Recommendation 23

Social care should continue to be underpinned by a means-tested system. Where possible, people should be encouraged to take personal responsibility for their own care. We support a funding system that enables those who can afford it to pay for the social care they need but with the costs falling on individuals capped in the manner proposed by the Dilnot Commission (Paragraph 239).

The Government should also implement as quickly as practicable, and no later than the first session of the next Parliament, new mechanisms which will make it easier for people to save and pay for their own care. The Government should, in the development of its forthcoming green paper on the future of social care, give serious consideration to the introduction of an insurance-based scheme which would start in middle age to cover care costs (Paragraph 240).

Response:

An ageing society means that we need to reach a longer-term sustainable settlement for social care. The Government has committed to publishing a Green Paper by summer 2018 setting out its proposals for reform. The Government has started a process of initial engagement through which it will work with experts, stakeholders and users to shape the long-term reforms that will be proposed in the Green Paper.

The Government will look more broadly than social care services alone, and will not focus narrowly on questions of means-testing, important though these are. Our

vision for care must also incorporate the wider networks of support and services which help older people to live independently, including the crucial role of housing and the interaction with other public services. It must consider how care is provided at present and challenge the system to embrace new technology, innovation and workforce models which can deliver better quality and value.

The Prime Minister has been clear that the consultation will include proposals to place a limit on the care costs individuals face. To allow for fuller engagement and development of the approach, with reforms to the care system and the way for which it is paid considered in the round, the Government will not be taking forward the previous Government's plans to implement a cap on care costs in 2020. Further details on the Government's plans will be set out after it has consulted on the options.

Innovation, technology and productivity

Recommendation 24

There is a worrying absence of a credible strategy to encourage the uptake of innovation and technology at scale across the NHS. It is not clear who is ultimately responsible for driving innovation and ensuring consistency in the assessment and the adoption of new technological approaches. The provision of appropriate training and development of strong leaders to support this agenda within the NHS will be critical to its success (Paragraph 250).

The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for driving this overall agenda. It should also identify the bodies and areas within the NHS which are falling behind in the innovation and technology agenda and make it clear that there will be funding and service delivery consequences for those who repeatedly fail to engage. This could involve relocating services to places that prove to be more technologically innovative (Paragraph 251).

Response:

The Government agrees that leadership is critical to drive this agenda. New leadership arrangements for technology across the whole of the health and care system were announced in July 2016, establishing for the first time a system wide national Chief Clinical Information Officer (CCIO) and Chief Information Officer (CIO).

The CCIO, supported by the CIO, provides strategic leadership across the system and is chief commissioner of information and technology services for the NHS and Social Care system under delegated authority from the Department of Health and Social Care.

Last year, the Government announced the launch of the Global Digital Exemplar (GDE) program to champion NHS digital excellence. There are currently 16 Acute and 7 Mental Health (MH) Trust Global Digital Exemplars, receiving up to £10 million and £5 million respectively, to be matched by investment by the Trust.

Global Digital Exemplars are partnered with fast follower trusts, so that GDEs can share their experience of implementation and Fast Followers can learn from this and support the spread of best practice and innovation. Acute Fast Followers can access up to £5 million and MH up to £3 million on a matched basis.

We are also investing £6 million in an NHS Digital Academy to train the aspirant digital leaders of the future, who will be critical to successful local implementation of digital technology. The first cohort is expected to start by early to mid-2018.

We are also working with our partners to catalyse the adoption of the best cost-effective innovations across the system through a number of initiatives. This is a complex issue and requires multiple approaches. The Life Sciences Sector Deal demonstrates our ambition and commitment to making the UK a global hub for clinical research and medical innovation. Successful delivery of the Deal is now crucial and we are working with Sir John Bell and key sector representatives to take this forward with a Life Sciences Council responsible for delivery of this deal and subsequent deals.

Our response to the Accelerated Access Review (AAR) sets out how we will improve adoption and uptake of innovation at both national and local levels.

At a national level, we have established a new Accelerated Access Collaborative (AAC) chaired by Sir Andrew Witty. The AAC will develop and own the Accelerated Access Pathway (AAP), an expedited route to market which will bring breakthrough products to patients as quickly as possible by streamlining regulatory and market access decisions.

Underpinning this, Government has already committed up to £86 million to support implementation. For example, we are supporting Academic Health Science Networks (AHSNs) to provide specialist advice to industry, patients and NHS trusts, aimed at tackling adoption issues and they have extensive partnership arrangements and networks at local, regional and national levels.

At a local level, we are incentivising the adoption of best practice through the established Commissioning for Quality and Innovation (CQUIN) programme. Every provider of care in the NHS has the opportunity to earn additional income each year as a financial incentive to spread best practice in Quality and Productivity.

We are also using clinical and patient ‘pull’ to identify and spread the best innovations through the Test Bed programme which has industry-NHS partnerships to test how combinations of technologies and service delivery can be used to improve patient care at the same or lower cost.

A good example of the adoption of innovation and technology by the NHS is in the field of genomics. The NHS has been working closely with Genomics England to deliver the 100,000 Genomes Project. NHS England is establishing the Genomics Medicine Service which will mean that the NHS is one of the first to introduce whole genome sequencing into mainstream healthcare.

Recommendation 25

The failure of the care.data project illustrates the inevitable consequences of failing to grapple with important issues relating to personal privacy. NHS Digital and all those responsible for data sharing in the NHS should seek to engage the public effectively in advance of any future large-scale sharing of

personal data. Public engagement on data sharing needs to become a priority at a local level for staff in hospitals and the community, and not be left to remote national bodies (Paragraph 262).

Response:

We recognise that it is important for organisations to have access to the data and information they need to deliver high quality, integrated health and social care. They should be confident to share information where it is appropriate and ensure it is done safely, securely and legally. The National Data Guardian (NDG) Review of Data Security, Consent and Opt-Outs was published in July 2016 and the Government response, *Your Data: Better Security, Better Choice, Better Care*² was published in July 2017. The Government is committed to implementing all the recommendations from these reports.

Making greater use of information and data enables health and care professionals to provide quality and safe care that improves our lives. It helps researchers unlock new treatments and make medical breakthroughs, and it means our health and social care system runs effectively and efficiently.

Recognising the breadth and complexity of current data sharing activity, a new Ministerial Data Strategy Board has been established to ensure a coordinated and aligned approach across key health and care data initiatives.

Recommendation 26

The Government should require a newly unified NHS England and NHS Improvement to work with commissioners to achieve greater levels of consistency in NHS efficiency and performance. Greater levels of investment and service responsibility should be given to those who improve the most (Paragraph 270).

Response:

NHS England and NHS Improvement are actively working jointly under their different statutory functions to monitor and support trusts and CCGs to achieve greater efficiency and performance.

The Government's mandate to NHS England for 2017-18 includes an objective that NHS England, "Through better commissioning, [NHS England should] improve local and national health outcomes, particularly by addressing poor outcomes and inequalities." This includes overall goals to deliver "consistent improvement in performance of Clinical Commissioning Groups (CCGs) against the CCG

² <https://www.gov.uk/government/consultations/new-data-security-standards-for-health-and-social-care>

improvement and assessment framework, increasing the proportion of CCGs that are rated ‘Good’ or ‘Outstanding’” by 2020.

The Next Steps on the Five Year Forward View published by NHS England and NHS Improvement in March set out a joint NHS 10 Point NHS Efficiency Plan which shows the activity the NHS has underway to deliver this, to ensure it lives within its means. We will measure progress against a clearly defined set of metrics for the programmes with a robust governance and assurance process to track delivery.

The NHS Shared Planning Guidance recently published to support commissioners and providers finalise their plans for 2018/19, set out details for the new Commissioner Stability Fund that will look to support those clinical commissioning groups (CCGs) that would otherwise be unable to live within their means for 2018/19.

Recommendation 27

The testing and adoption of new health technologies should be formally integrated into medical and non-medical NHS leadership, education and training at all levels (*Paragraph 278*).

Response:

The Government agrees that the NHS should invest in and adopt new technologies where they will benefit the people who use services.

To ensure that such technology is successfully rolled out across the NHS, all clinical leaders and managers need to have had the right education and training to allow them to evaluate emerging technologies and disseminate best practice widely. Clinical education and leadership development prepares doctors, nurses and managers for this role already and we will continue to ensure that this is the case. Additionally, there are a range of training programmes available to all NHS staff which cover quality improvement and the adoption of new health technologies. Health Education England’s draft strategy announced an important, system-wide review to assess the impact of technological changes on clinical professionals. This review will report to the Secretary of State for Health and Social care at the end of 2018.

As part of the Personalised Health and Care 2020 portfolio, work is in hand to improve digital readiness and capability in the workforce so that, by 2020, there will be:

- an improvement in the health and care workforce’s use of data, information, knowledge and technology;
- accredited, skilled clinical and practitioner informaticians who are valued because their presence influences improvements in health and care; and

- through the establishment of the NHS Digital Academy, health and care leaders, and aspirant leaders, who will champion data, information, knowledge and technology, and their workforce, as core enablers of better health and care.

This work is led by NHS Digital, Health Education England and NHS England, working closely with bodies such as the medical Royal Colleges, the NHS Leadership Academy and social care leads, as well as professional and academic bodies across the country.

Recommendation 28

NHS England should develop a system to identify and financially reward organisations and leaders who are instrumental in driving the much needed change in levels of productivity, the uptake of innovation, the effective use of data and the adoption of new technologies (*Paragraph 279*).

Response:

The current financial approach to this is mainly via the operation of the national tariff, as well as via the sustainability and transformation fund and the ten point efficiency plan. NHS England recognises and is actively supporting NHS leaders to drive the necessary changes in levels of productivity including the use of best practice.

The current financial approach to this is the operation, by NHS England and NHS Improvement, of the national tariff. The national tariff comprises a set of prices and rules used by providers of NHS care and commissioners to deliver the most efficient, cost effective care to patients. It is designed to help providers and commissioners work together to manage demand and deliver services more efficiently.

NHS England has launched the Innovation and Technology Tariff (ITT) which aims to remove the financial and procurement barriers to the uptake of approved innovations. NHS England has agreed national prices with suppliers and is centrally funding the costs of technologies under 6 innovation themes. The ITT was officially announced in November 2016 and went live in April 2017. This tackled areas such as obstetric injury and pneumonia prevention.

On 14 June 2017, the Innovation and Technology Payment (ITP) was announced. The ITP aims to extend the scope of the ITT by supporting a wider range of innovations and unlike the ITT is not limited to secondary care. The ITP is specifically focussed on low cost innovations which can deliver significant patient outcomes and savings to the NHS. ITP themes will be available from April 2018.

Both the ITT and ITP are breaking new ground and working closely with the changing procurement landscape including the new supply chain arrangements (future operating model for procurement).

Public health, prevention and patient responsibility

Recommendation 29

We welcome the greater prominence that mental health has received in recent years and we are encouraged by the Government's commitment to a five-year strategy for mental health. Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators (Paragraph 295).

There is still widespread dissatisfaction with the prevention agenda. We share the views expressed by many of our witnesses of the need to realise the long-awaited ambition to move from an 'illness' to a 'wellness' service. The NHS must shift the rhetoric to reality and make genuine progress on refocusing the system towards preventative care (Paragraph 303).

We recommend that the Government urgently embarks on a nationwide campaign to highlight the many complications arising from the obesity epidemic, including its links with many chronic diseases. Such a campaign must be a cross-departmental effort, target the entire population and involve those who sell food and drink to the public, especially those whose products are consumed by children (Paragraph 304).

Response:

Obesity is one of the top public health challenges for this generation. Obese children are much more likely to become obese adults, and younger generations are becoming obese at earlier ages and staying obese for longer. That is why the Government has made reducing childhood obesity one of our key priorities.

We published the *Childhood Obesity: A Plan for Action*³ in August 2016, setting out our plans to reduce levels of childhood obesity, improve the health and wellbeing of children, and contribute towards reducing future pressures on the NHS.

The policies in the plan are informed by the latest research and evidence and focus on the areas that are likely to have the biggest impact on preventing childhood obesity. These measures are estimated to reduce childhood obesity rates by around a fifth over the next ten years.

³www.gov.uk/government/uploads/system/uploads/attachment_data/file/546588/Childhood_obesity_2016_2_acc.pdf

Key measures include the soft drinks industry levy being implemented from April 2018 and sugar reduction and wider reformulation programme which give companies strong incentives to reduce added sugar and reformulate their products. There have been a number of early successes as some in the food and drinks industry have committed to reducing sugar in their products and we now expect almost half all drinks that would otherwise have been in scope to have been reformulated by the introduction of the levy. As a result, children and adults alike will consume less sugar and fewer empty calories.

The childhood obesity plan also sets out a package of actions to continue to improve healthy eating and nutrition standards in schools including encouraging Academies and free schools to sign-up to the School Food Standards. From September, a new voluntary healthy rating scheme for primary schools will be introduced to recognise and encourage their contribution to preventing obesity by helping children to eat better and move more. This scheme will be taken into account during Ofsted inspections.

Alongside our work with the food and drinks industry and schools, the UK's national healthy eating model, the Eatwell Guide⁴, ensures consistency with the latest dietary recommendations and key public health messages. The guide is suitable for everyone over the age of 5 years and shows the proportions of the different types of foods and drinks to have a healthy, balanced diet to meet government dietary recommendations.

Public Health England promotes the Eatwell Guide through its social marketing campaigns such as Change4Life and One You, as well as through the NHS Choices website.

We will monitor change in the prevalence of childhood obesity through various schemes including the National Child Measurement Programme and Health Survey for England. In addition, Public Health England will publish detailed assessments in spring 2018, March 2019 and March 2020 to determine, and advise the Government on, progress against delivering the category specific sugar reduction and portion size guidelines and overall reduction targets.

All reports and data published on progress in delivering our plan will be open to scrutiny. We will use this to determine whether sufficient progress has been made and whether alternative levers need to be considered.

Recommendation 30

We are of the opinion that a continued failure to both protect and enhance the public health budget is not only short-sighted but counter-productive. Cuts already made could lead to a greater burden of disease and are bound to result

⁴ www.gov.uk/government/publications/the-eatwell-guide

in a greater strain on all services. The Government should restore the funds which have been cut in recent years and maintain ring-fenced national and local public health budgets, for at least the next ten years, to allow local authorities to implement sustainable and effective public health measures (Paragraph 315).

Response:

Public health is about far more than the services funded through the grant. The transfer to local government provided the opportunity to join up public health with decisions on other local services such as housing and economic regeneration in the interests of improving the health of the local population.

We have to take tough decisions to ensure that public finances are sustainable, and that our economy can support the essential public services on which we all rely.

We are aware that many councils have redesigned services, taking a holistic place-based approach and are demonstrating real innovation, which we welcome. Local authorities themselves are best placed to decide their spending based on assessment of local need, and many councils are re-tendering contracts and achieving better value for money than in the past.

Local authorities will still receive more than £16 billion for public health over the 2015 spending review period. This is in addition to what the NHS spends on prevention, including well over £1 billion a year on our world-leading immunisation and screening programmes, and the world's first national diabetes prevention programme.

The NHS also has an integral role to play too. This is reflected in the Five Year Forward View commitment to prevention, and in Next steps on the NHS Five Year Forward View. Prevention is a core theme of local cross-system Sustainability and Transformation Plans.

We are performing well on a number of public health indicators; for example,

- over the five year period 2012 to 2016, smoking prevalence among adults has decreased by about 1 percentage point each year, from a survey estimate of 19.3 % of the population in 2012 to 15.5 % in 2016.
- Over the last five rolling three-year periods 2010-2012 to 2014-2016, the proportion of HIV cases that were diagnosed 'late' showed a decrease in each successive period, from 48.5 % in 2010-2012 to 40.1 % in 2014-2016. This corresponds to a reduction of about 2 percentage points each year.
- Over the last five year period 2012 to 2016 the STI new diagnosis rate has reduced from 812.2 per 100,000 population in 2012 to 749.7 in 2016. Most of the progress was made during the last two years 2015 and 2016.

- Over the 5 year period 2011 to 2015 the under-18 conception rate reduced each year from 30.7 per 1,000 females in 2011 to 20.8 in 2015. This was a reduction of about 2 percentage points per year.

Recommendation 31

The Government should be clear with the public that access to the NHS involves patient responsibilities as well as patient rights. The NHS Constitution should be redrafted with a greater emphasis on these often overlooked individual responsibilities. The Government should relaunch the Constitution as part of a renewed and sustained drive to improve health literacy and educate the public about their common duty to support the sustainability of the health service, with children, young people, schools, colleges, further education institutions and employers forming a major part of this initiative (Paragraph 320).

Response:

The Government agrees that patients and the public need to be more aware of the steps they should take to safeguard their health and wellbeing, so the NHS can focus on providing sustainable, responsive and high quality services to all those who need them, when they need them.

The NHS Constitution sets out (in section 3b) responsibilities that patients have for helping the NHS to work effectively and to ensure that its resources are used sensibly. These include taking steps to safeguard their and their family's health and wellbeing and participating in important public health programmes.

The handbook that is published alongside the NHS Constitution suggests that patients talk to their local health professional or visit NHS Choices⁵ for advice on how to stay healthy, on making lifestyle changes, and on support available for this. We shall update the handbook in 2018 and will take this opportunity to look at how the wording on patient responsibilities can be strengthened further, making clearer the links with NHS sustainability.

Also as set out in the Act, we will be publishing a report on the effectiveness of the NHS Constitution in 2018. A decision on when to review and republish the NHS Constitution itself will be made in light of this.

In the meantime, Public Health England has already put in place a number of initiatives to raise awareness of the importance of healthy lifestyle and of seeking early advice when experiencing symptoms of ill health. These are included in the well-established national Starting Well, Living Well, and Ageing Well campaigns.

⁵ <http://www.nhs.uk/pages/home.aspx>

Towards a lasting political consensus

Recommendation 32

We look forward to the publication in the near future of NHS England's delivery plan for what the NHS will look like for the rest of the Parliament. This will be a positive development in the short term. We are extremely concerned, however, that the Department of Health is failing to plan for the long-term (*Paragraph 325*).

The historic political failure to take a long-term approach to the provision of health and adult social care has been a major stumbling block to longer-term sustainability. Efforts should be made to encourage cross-party consensus. If this consensus is to be accepted by the public it should emerge as a result of committed cross-party talks and a robust national conversation. The Government should seek to initiate these immediately (*Paragraph 334*).

Recommendation 33

We recommend the establishment, before the end of this Parliament, of an independent standing body named the Office for Health and Care Sustainability to assist the Government in safeguarding the long-term sustainability of an integrated health and adult social care system for England. It should play no part in the operation of the system, or make decisions, but should be given the independence to speak freely about issues relating to its remit. It should report directly to Parliament (*Paragraph 344*).

Recommendation 34

The new body should be given a clear remit to advise on all matters relating to the long-term sustainability of health and social care. Initially it should focus on three key issues: (1) the monitoring of and publication of authoritative data relating to changing demographic trends, disease profiles and the expected pace of change relating to future service demand; (2) the workforce and skills mix implications of these changes; and (3) the stability of health and adult social care funding allocations relative to that demand, including the alignment between health and adult social care funding. It should continually look 15–20 years ahead (*Paragraph 345*).

Response:

The following response covers recommendations 32-34.

The Government is absolutely clear that the long term sustainability of the NHS and adult social care is a key priority, and we are keen to consider ways of promoting and achieving greater consensus across parties on this aim.

The Committee recommended establishing an Office for Health and Care Sustainability. We believe that the functions of the proposed body would replicate existing mechanisms. For instance, much of the information referred to in recommendation 34 is publicly available, with the Office for National Statistics publishing information on demographic trends (<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration>) and the Office for Budget Responsibility publishing health spending projections in their annual fiscal sustainability report (<http://budgetresponsibility.org.uk/fsr/fiscal-sustainability-report-january-2017/>).

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