



Department
of Health

Government Response to the
House of Commons Health
Select Committee Report into the
Impact of the Spending Review
on Health and Social Care
(First Report of Session 2016–17)



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

December 2016



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Print ISBN 9781474136815

Web ISBN 9781474136822

ID 2905634 12/16

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

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1 Introduction

1. On 19 July 2016, the House of Commons Health Select Committee published, *Impact of the Spending Review on health and social care* (HC 139). The report followed an inquiry by the Committee, which sought evidence from the Secretary of State for Health along with other witnesses, including NHS England, NHS Improvement, think tanks such as the King's Fund and various representatives from both 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 to each of the conclusions and recommendations.

3. The report correctly identifies the significant challenges facing the NHS over the next few years. There is a clear plan for responding to these challenges, which is made up of four key components:

- Extra investment in the Spending Review for the NHS (see section 2.5), and freeing up local government to spend more on adult social care (see section 2.4).
- Restoring financial discipline in the short term, including the publication of *Strengthening Financial Performance & Accountability in 2016/17*¹ which sets out a wide-ranging, seven-point set of actions (see section 2.3).

- Reducing demand for acute care in the longer term as set out in the *Five Year Forward View*². NHS England and NHS Improvement are working with local areas as to how they can moderate activity growth by about 1% on a sustainable basis (see section 2.6).
- Promoting efficiency and productivity in the provider sector – building on the work of Lord Carter³, which has identified large variations in efficiency across non-specialist English acute hospitals, and controlling cost pressures, for example, by applying the 1% pay cap, renegotiation of the community and pharmacy contract, and controls to cull spiralling agency spending (see section 2.6).

4. Section 2 of this paper responds to the overall conclusions of the Committee then considers in more detail the individual recommendations contained in the wider report.

1 NHS England and NHS Improvement (2016) *Strengthening Financial Performance & Accountability in 2016/17* www.england.nhs.uk/publications/performance/

2 NHS England (2014) *Five Year Forward View* www.england.nhs.uk/ourwork/futurenhs/

3 Lord Carter of Coles (February 2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations* www.gov.uk/government/publications/productivity-in-nhs-hospitals

2 Government response to the Committee's conclusions and recommendations

New models of care and the measures to achieve demand reduction which are crucial to the achievement of the Five Year vision are not being embedded across the whole system. These changes are not happening at sufficient scale and pace across the wider NHS and social care. The integration of health and social care – not just the integration of funding, as in the Better Care Fund, but getting commissioners and service providers in each sector to work more closely together to deliver a service to their local population – is not proceeding at the required pace. Furthermore, there is a risk that cuts to funding outside NHS England, such as public health and social care, will put the achievement of the Five Year vision at risk. (HC 139, Paragraph 170)

5. The Government agrees that demand reduction is vital if the NHS is to move onto a sustainable footing. NHS England has published the modelling agreed for the Spending Review (SR) which set the efficiency challenge to be achieved by demand reduction: activity savings at £4.3 billion by 2020–21. NHS England and NHS Improvement are working with local areas as to how they can moderate activity growth by about 1% on a sustainable basis.

6. We recognise that investment in public health and social care are essential to the success of the *Five Year Forward View*. For public health, local authorities will receive more than £16 billion over the SR period. This is in addition to what the NHS and

wider health system spends on prevention, including: over £1 billion in 2016–17 mainly on immunisation, vaccination and screening; £340 million in 2016–17 on vaccine stocks; and, the £400 million capital investment in the new national Science Hub.

7. We also recognise the link between the health system and social care. We have introduced the Social Care Precept to support local areas to protect funding for social care services. This is not a decision that we have taken lightly and it is a very clear recognition of the importance that we place on social care. The precept has been implemented by 95% of local authorities and raised over £380 million in 2016–17. This could raise up to £2 billion by 2019–20. From April 2017 additional social care funds will be made available to local government, rising to £1.5 billion by 2019–20, to be included in the Better Care Fund. Recent local authority budget data demonstrates that this has supported local areas to increase adult social care budgets in 2016–17 compared with 2015–16. The impact of this additional funding and the overall social care settlement will be closely monitored for its impact on the NHS over the current parliament.

The Forward View needs to be accompanied by strategic thinking from Ministers about what priorities will best support achievement of the vision when resources are constrained. They should be prepared to set out the evidence as it develops on the value delivered by seven-day services and how that compares

with other priorities such as action on prevention and public health. (HC 139, Paragraph 171)

8. The *Five Year Forward View* articulated the care and quality gap and an ambition to close that by 2020. We know there are variations across the week in urgent and emergency care. By the end of the parliament anyone admitted as an emergency to hospital should receive the same high-quality care, regardless of whether they are admitted during the week, or at the weekend. The NHS is expected to rollout the four clinical priority standards in all relevant specialties to 25% of the population in 2016. The learning from this early rollout will be shared across the NHS to ensure delivery can be achieved within available resources.

9. The *Forward View* also highlighted the health and wellbeing gap. It called for a radical upgrade in prevention to improve peoples' lives and achieve financial sustainability of the health and care system. Further detail on public health funding, seven-day services and mental health can be found at sections 2.8, 2.11 and 2.12 respectively.

Given the scale of rising demand and costs we are not confident that the efficiency challenge is achievable. We are concerned about the failure to plan for the consequences if the current plan for savings is not achieved. (HC 139, Paragraph 172)

We believe it is time for the Government and NHS England to set out how they will manage the shortfall in NHS and social care finances and the decline in services to patients if the measures proposed in the *Forward View* fail to bridge the funding gap. If the funding is not increased, there needs to be an honest debate about what that will mean for patient care. (HC 139, Paragraph 173)

10. The scale of the efficiency challenge is ambitious. The *Forward View* outlined a vision for how the NHS could deliver £22 billion of efficiency over the course of this parliament. We have committed to this vision and embedded it in the mandate to NHS England. NHS England has published the details of the efficiency challenge including how £6.7 billion of this target will be delivered through national action, including implementing our 1% public sector pay policy to 2019–20, and renegotiating the community pharmacy contract. This leaves £14.9 billion to be delivered locally.

2.1 Payments to providers

The financial situation in the NHS has become increasingly tight. Health spending rose at an historically low rate of 1.1% in real terms between 2009–10 and 2015–16. NHS provider deficits have become so widespread that there is a risk that running a deficit is no longer taken seriously as a sign of poor financial management. The need to manage deficits also risks skewing attention and draining resources from other NHS priorities. (HC 139, Paragraph 26)

11. The Department of Health (the Department) and its arm's-length bodies (ALBs) are taking a wide-ranging set of actions in 2016 to support providers achieve financial sustainability and improve operational performance in 2016–17. In particular, new programmes of financial special measures for providers that are unable to ensure sufficient financial discipline have been introduced, alongside financial control totals linked to access to the Sustainability & Transformation Fund (S&T Fund).

12. NHS England and NHS Improvement's 'reset' document, *Strengthening Financial*

Performance & Accountability in 2016/17, sets out the actions being taken by the national bodies to stabilise NHS finances in 2016–17, including access to the S&T Fund; a proposed basis for assessing the financial performance of provider organisations; and, the introduction of new programmes of financial special measures for trusts and CCGs that are not meeting their financial commitments. The measures announced, as well as wider actions with individual organisations and local health and care systems, are designed to give us the best opportunity to bring the NHS back onto a sustainable footing. The document shows the provider sector significantly improving on performance from 2015–16, with combined provider plans for 2016–17 showing a deficit of £580 million and an ambition to go further and achieve £250 million.

13. This document also describes the agreed legal responsibilities of individual NHS bodies to live within the funding that Parliament has made available for the NHS in 2016–17. A wide-ranging, seven-point set of actions is being taken. The Department and its ALBs have:

- Allocated an extra £1.8 billion to trusts, with the aim set by NHS Improvement of cutting the combined provider deficit to around £250 million in 2016–17 and the ambition that, in aggregate, the provider position commences 2017–18 in run-rate balance.
- Replaced national fines with trust-specific incentives linked to agreed organisation-specific published performance improvement trajectories, so as to kick-start a multi-year recovery and redesign of A&E and elective care.
- Agreed 'financial control totals' with individual trusts and CCGs, which represent the minimum level of financial performance against which their boards,

governing bodies and chief executives must deliver in 2016–17, and for which they will be held directly accountable.

- Introduced new intervention regimes of special measures which will be applied to both trusts and CCGs who are not meeting their financial commitments.
- Set new controls to cap the cost of interim managers and to fast track savings from back office, pathology and temporary staffing.
- Published the 2015–16 performance ratings for CCGs.
- Launched a two-year NHS planning and contracting round for 2017–18 and 2018–19, to be completed by December 2016.

14. The Sustainability and Transformation Plans now being developed in communities across England will also play a part in this work. Locally led, and first announced in December 2015, these plans will ensure NHS resources are directed to the places where the community needs them so services work more closely together and, most importantly, patient care is improved. These plans are yet to be finalised and local residents will have further opportunities to make their views known.

We have heard compelling evidence that the current payment system does not drive greater efficiency or support the transformation that is required across the system. The payment system needs to be reformed, so that it does not continue the perverse incentives which can drive inappropriate hospital admissions. It must however ensure that hospitals are paid a fair price, and that the system encourages them to manage their costs appropriately, with care being carried out in the right settings. Whilst we recognise that reforms

of this scale cannot be rushed, we note that we and our predecessor Health Committees have been hearing concerns about the payment system for many years. We therefore recommend that NHS England and NHS Improvement set out a clear timetable for reforms to the payment system, and clarify the underlying problems that the changes will address. (HC 139, paragraph 27)

15. In relation to the financial situation of the NHS, NHS Improvement and NHS England set an efficiency rate of 2% for the 2016–17 national tariff. This is considerably lower than previous years and more in line with historical achievement. With an uplift of 3.1% for inflationary factors, this meant that the 2016–17 national tariff prices increased. This increase in tariff prices, plus a continuation of the payment currency, formed part of our approach for the 2016–17 national tariff, which was focused on providing the sector with a year of stability to support a return to financial balance. While under-delivering the 2% efficiency requirement in any one year implies a need for a higher efficiency in the subsequent year, it also implies that the unaddressed opportunity in that year is also higher by virtue of not having met the 2% goal in a prior year.

16. The *Five Year Forward View* describes new models for the organisation of integrated, collaborative care, supported by new approaches to payment and contracting. These new approaches, including the Multispecialty Community Providers, Primary and Acute Care Systems, Urgent and Emergency Care Networks and Enhanced Health in Care Homes, are currently being developed through a programme of 50 Vanguard sites across England.

17. NHS England and NHS Improvement are working with Multispecialty Community Providers and Primary and Acute Care

Systems to develop a ‘whole population budget’ approach for implementation from April 2017. This will support service and financial sustainability and incentivise prevention, service integration and effective risk management across the system. During 2016, new payment models, contracts and procurement processes for Multispecialty Community Providers and Primary and Acute Care Systems will be developed in conjunction with a number of Vanguard sites and documented. This learning and support will be available to local health economies to utilise in implementing new payment and contracting arrangements to enable the development of new models of care. A whole population budget will be the first step to a full capitation payment model. We are also focused on developing approaches that allow for risk to be better managed and shared across local health and care systems.

18. NHS England and NHS Improvement are also working with the sector to develop and implement new payment approaches for mental health services. They will also both continue to develop currencies and support improvements in costing as ‘building blocks’ for any future payment system.

19. The continued development of currencies has supported greater consistency in care, service efficiency and information, and provides a key building block for the payment system. NHS England continues to develop currencies for acute and non-acute care including mental health and community services. In the medium term, this will help commissioners and providers to make more informed decisions on behalf of local populations and in the longer term support the shift to the new care models.

20. NHS Improvement launched the Costing Transformation Programme (CTP) in 2015 to deliver a step change in both the quality and use of costing information. Lord Carter’s

review of hospital efficiency noted that the Programme will help address inconsistency in costing approaches across the NHS, and therefore will be used to support quality and efficiency improvements.

21. Better information has both national and local benefits. Nationally, the information will help to improve the development of payment systems, benchmarking and assessments of efficiency. Locally, the information will enable healthcare providers to make the best possible use of resources, evaluate clinical practice and support better ways of working.

22. The Programme is developing new costing standards for NHS providers of acute, ambulance, mental health and community services. Standards development version 2 will be issued in January 2017, including revised Acute Standards following trial implementation together with the first version of Mental Health and Ambulance Standards. NHS Improvement is working closely with partners at the Department, NHS England and Health Education England to develop a single annual cost collection.

2.2 NHS workforce planning

There is no doubt that spending on agency staff on the scale seen since 2009–10 has been a major contributor to provider deficits. The cap on agency costs and rates has helped to turn the corner, but this may be undermined by the widening gap between NHS pay and that for comparable jobs outside the NHS. Over the previous Parliament, much of the efficiency gain was achieved thanks to a pay freeze, but a long-term pay squeeze has unintended consequences for recruitment and retention, which may drive higher costs. The problems with agency spending are likely to remain until the underlying issues of workforce

supply and staff shortages are addressed. We therefore call on the Government to set out its plan for how it will recruit and retain the NHS future workforce, including by making working as a permanent member of staff a more attractive option. (HC 139, paragraph 36)

23. The Department is taking action to increase the supply of trained staff available to work in the NHS and wider health and care system. In conjunction with Health Education England (HEE) and NHS England, it has taken a range of actions to boost the supply of domestically trained staff and to increase the efficiency and productivity of the existing workforce through better use of technology and changing the skill mix.

24. There has been an increase of over 25,000 more professionally qualified staff working in the NHS since May 2010 combined with over 50,000 nurses and over 50,000 doctors currently in training. We will continue to make sure there are sufficient staff available to give patients high quality, safe and sustainable care 24 hours a day, seven days a week.

25. HEE has increased the number of key professional groups being trained. For example, the numbers of nurse training places being commissioned each year has increased by 15% since 2013. Additionally, the reforms to funding of training for nurses and allied health professionals would further boost supply by removing restrictions on the number of training places universities can offer, which is estimated to result in 10,000 more training places by the end of the parliament.

26. Furthermore, almost £5 million has been provided to support the Return to Practice scheme, aimed at encouraging and supporting experienced nurses who have left the profession to return. This scheme has already seen 2,344 returners on the

programme to date with over 700 now back in employment.

27. Employers are encouraged to recognise the benefits of adopting flexible working patterns such as shift or part-time working to accommodate personal commitments, thereby improving retention and making the NHS an attractive option for a permanent career.

28. In relation to the out-of-hospital workforce, we are committed to ensuring 10,000 additional primary and community care staff by 2020, including an extra 5,000 doctors in general practice. As set out in the *General Practice Forward View*⁴, NHS England and HEE are working together with the profession on measures to increase recruitment, retention and return to practice. As part of this work, HEE has a Mandate commitment to increase the number of GP training places to 3,250 each year from 2016.

Agency staff

29. We have taken a series of measures to cut the cost to the NHS of agency staff while improving frontline care. All NHS trusts and foundation trusts are required to stay within a specified annual expenditure ceiling for total spending on agency staff (expressed as a percentage of staff costs) and to use only approved frameworks to procure all agency staff. Price caps have been introduced which limit the amount a trust can pay to an agency for the provision of temporary staff.

30. Agency controls have had a significant impact. Between April and August 2016 the NHS has spent £188 million less than in the same period in 2015 (spending is £555 million less than projected spending before controls were introduced). However, we recognise that there is still more to do to drive down spending and are working in partnership with NHS Improvement to further curtail

agency spending. The intention behind the introduction of caps on the prices paid for agency staff is to reduce the incentive for staff to work via an agency and to encourage a return to substantive roles.

31. Action on the agency supply side will also be mirrored by action to reduce demand for temporary staff. The Lord Carter review identified savings opportunities estimated to be around £2 billion from better management of the existing permanent workforce. Implementing the Carter Review recommendations, such as better use of e-rostering, will help to limit demand for temporary staffing.

Pay policy

32. We have made it clear that the 1% pay policy in the public sector continues to be a crucial part of government plans for the continued prudent management of public finances to help support long-term workforce planning, and to help protect jobs. The NHS is one of the few public sector employers which operates a progression pay system. Around half of the employed NHS workforce receives progression pay of over 3% on average in addition to annual pay awards. Over the last parliament and at the start of this one, independent Pay Review Body's reports confirm that recruiting and retaining staff is not just about pay and that NHS employment remains an attractive prospect because of the total reward package which includes pay and non-pay benefits.

33. The Government's 2015–2016 evidence to the NHS independent Pay Review Bodies acknowledged that prolonged pay restraint could become challenging as the wider economy improves. However, the NHS workforce must be affordable, with annual pay awards set at a level that enables the NHS to continue to recruit, retain and motivate the staff it needs.

4 NHS England (2016) *General Practice Forward View* www.england.nhs.uk/ourwork/gpfv/

Attractive careers

34. We have already introduced a 'total reward' policy, to encourage trusts to develop more innovative reward solutions to help improve local recruitment and retention as well as strengthening staff engagement to support improved services for patients.

35. There are encouraging signs with some trusts developing alternative offers for staff using existing pay and pension flexibilities and greater uptake and use of staff total reward statements (TRS). TRS have been introduced to provide staff with a better understanding of the benefits they have or may have access to as an NHS employee and provide personalised information about the value of staff employment packages including details about remuneration and the benefits provided locally by employers.

2.3 Managing the financial situation

We are concerned that the Government has resorted to short-term measures to deal with the financial situation. Capital was transferred to revenue for the second year running in 2015–16 and trusts were encouraged to review their accounting estimates for savings. We are concerned that these measures are masking the true scale of the underlying financial problems facing the NHS. We are also concerned about the consequences of repeated raids on the capital budget to meet current spending, especially as that budget is already set to reduce in real terms over the spending review period. (HC 139, paragraph 42)

36. We have made tough decisions and have had to prioritise restoring financial discipline in the short term over transformational investment. For example, the

Department released resources from areas where there were no clear plans for spending in 2015–16 (including capital) and reinvested these resources in supporting frontline services.

37. The best providers have shown that financial discipline is possible, and over three-quarters of organisations are meeting their control totals at Q1 2016–17 so are eligible for the STF payments. We need all to be doing as well as the best.

38. We have taken decisive action to make sure the NHS balances its books in 2016–17 and will be providing intensive support to the most challenged NHS organisations through the new special measures programme.

39. We make no apology for making sure that taxpayers' money is used as efficiently and effectively as possible and is properly accounted for. All adjustments are properly audited by the National Audit Office (NAO).

40. Accurate accounting and effective budget management and control were of paramount importance in 2015–16, given the financial pressures present in the health and social care system and because inaccurate accounting entries have the potential to vary the level of funding available for frontline services.

41. Our capital funding includes an agreed level of flexibility for transferring budget to support the revenue position. Our announced SR capital budget includes funding for a shift in the way urgent and emergency care services are provided and improving out of hospital services to deliver more care closer to home. New investment of £1 billion in technology will support this transformation and integrate patient records across health and social care by 2020. Over the next five years, at least £500 million will be invested in building new hospitals.

The conclusion we draw from the evidence we have heard is that the proposed strategies for reducing costs – cutting the tariff price (albeit at a lower rate), strict pay restraint, imposing agency price caps and reducing capital spending – are not sustainable ways of securing long-term efficiencies. The NHS will need a new approach if it is to adapt to increasing patient demand and funding constraints. (HC 139, paragraph 44)

42. It is clear that the NHS faces a significant challenge, due to the increasing demand for health services as a consequence of the ageing and growing population, new drugs and treatments and safer staffing requirements.

43. The financial strategy for 2016–17 and beyond is not just about “. . . cutting the tariff price [. . .] strict pay restraint, imposing agency price caps and reducing capital spending [. . .]”. Our approach is set out in *Strengthening Financial Performance & Accountability in 2016/17* discussed previously in more detail at section 2.1.

44. Additionally, there are other areas where we are looking to reduce costs and make savings. Private finance initiative schemes are a particular example where we provide help and support by sharing best practice and ideas for savings. The last time data was collected – via HM Treasury’s Operational Projects Efficiency Programme – it was reported that trusts had negotiated validated savings worth over £250 million on their contracts. A further data collection is about to be undertaken.

45. Furthermore, as a result of the Pharmaceutical Price Regulation Scheme, savings of over £1 billion have been made to the branded medicines health service medicines bill since the beginning of 2014, which have been reinvested in the NHS. The

Department is continuing to work closely with NHS England to deliver better value from our investment in medicines.

2.4 The impact of pressures in social care funding on health

We are concerned about the effect of reduced access to adult social care as a result of the cuts to funding and the impact of this on the NHS. Given the evidence of the linkages between health and social care, we were concerned that none of the senior officials giving evidence from the Department of Health, NHS England or NHS Improvement were able to quantify the financial cost of one of the most visible interfaces between health and social care, namely delayed transfers of care as a result of not having adequate social care packages in place. The supplementary evidence sent to us by the Department, NHS England and NHS Improvement following the session was able only to refer us to estimates from a recent National Audit Office report. (HC 139, paragraph 53)

We recommend that the Government urgently assess and set out publicly the additional costs to the NHS as a result of delayed transfers of care, and the wider costs to the NHS associated with pressures on adult social care budgets more generally. That assessment should be accompanied by a plan for adult social care which demonstrates that the Government is addressing the situation in social care and dealing with its effect on health services. (HC 139, paragraph 54)

46. We recognise the challenges facing the health and social care system and so introduced the Social Care Precept to support local areas to protect funding for

social care services. This is not a decision that we have taken lightly and it is a very clear recognition of the importance that we place on social care. The precept has been implemented by 95% of local authorities and raised over £380 million in 2016–17. This could raise up to £2 billion by 2019–20. From April 2017 additional social care funds will be made available to local government, rising to £1.5 billion by 2019–20, to be included in the Better Care Fund. Recent local authority budget data demonstrates that this has supported local areas to increase adult social care budgets in 2016–17 compared with 2015–16.

47. We recognise the importance of the interface between health and social care services. We took the long-term decision to introduce the Better Care Fund to support the integration and joint commissioning of services between local authorities and CCGs. The financial modelling behind the *Five Year Forward View* assumed that access to social care services was maintained at current levels relative to need.

48. The funding and performance of both services will have a direct impact and consequences for the other. Any difficulties faced by social care services in meeting their efficiency challenge will cause pressures on health services. We welcome the contribution from the NAO, and the Carter report, into understanding the costs associated with delayed discharges. As the NAO has acknowledged within their report⁵, there are numerous challenges associated with developing an accurate estimate of these costs; the Department is therefore working together with NHS England and NHS Improvement to further refine the data and information around delayed discharge, to

support a more accurate estimate of the cost to hospitals of delayed discharges, as well as the costs of caring for these people in the community.

2.5 The Spending Review announcements on health

Health spending will not increase by as much as expected from official pronouncements. In previous years, spending reviews have defined health spending as the entirety of the Department of Health's budget, but the 2015 spending review defines spending in terms of NHS England's budget, which excludes, for example, spending on public health, education and training. Excluding these aspects of spending – which are being cut over the spending review period – is misleading, as these organisations play a vital role in providing front line services to patients, reducing demand through prevention and in training the future workforce. We call on the Government to set out the rationale for changing the definition of health spending. Until there is a clear case for the change, we will continue to use the previous definition of health spending, and we call on the Government to do likewise. (HC 139, paragraph 61)

Using the original definitions, and taking 2015–16 as the base year, total health spending will increase by £4.5 billion in real terms by 2021. This is a welcome increase, particularly in the context of the financial constraints faced by other Government departments, but is clearly far less than the £8.4 billion implied by the Spending Review announcements and does not in our view meet the commitment to fund the Five Year Forward View. (HC 139, paragraph 62)

5 National Audit Office (May 2016) *Discharging older patients from hospital (HC18)* www.nao.org.uk/report/discharging-older-patients-from-hospital/

49. The SR provided the NHS in England with £10 billion per annum additional funding in real terms by 2020–21 compared with 2014–15, with £3.8 billion real terms growth in 2016–17. This will help stabilise current pressures on hospitals, GPs and mental health services, and support the *Five Year Forward View's* fundamental redesign of care. In the context of constraints on overall public spending, the case for the NHS has been heard and actively supported.

50. We are not only backing the NHS plan but enabling it to go further – by investing £2 billion more than the £8 billion the NHS asked for – delivering government objectives, including seven-day services and improved access to cancer treatments and mental health services.

51. The SR settlement delivers on this Government's promise of real terms increases in the NHS budget – with an increase for NHS England of £3.8 billion over and above inflation in 2016–17. Overall resource funding to the Department is £115.6 billion.

52. This settlement means a growth in total funding of over £16 billion in cash terms in 2020–21 compared with 2015–16. This represents a real terms increase of nearly 4% across the period. It also means that in real terms, NHS funding will be £10 billion a year more by 2020–21 than 2014–15, and £8 billion higher than 2015–16.

53. We will be giving the NHS £3.8 billion more this year above inflation, which means it will have received around £6 billion of the £10 billion in the first two years of the six-year period.

54. Table 1 sets out the detail of the Department's budget for the SR 2015 period, while table 2 shows the funding for the NHS allocated through NHS England. Funding for non-NHS England programme budgets have all now been agreed for 2016–17 as part of the normal business planning cycle.

55. These figures differ from the NHS TDEL figures announced at SR 2015 due to a number of technical adjustments, including transfers of functions. The main transfer of function is the move of 0–5 public health services from NHS England to local government. There are a small number of other transfers including the move of the Leadership Academy to Health Education England. To ensure comparability of numbers, in this table £500 million has been removed from the 2015–16 baseline, representing six months of funding for 0–5 public health services between 1 April and 30 September 2015 and these other planned transfers.

56. It is absolutely the case that an extra £10 billion is being provided to NHS England, supporting the *Five Year Forward View*. We are though making significant savings to non-NHS England budgets, by far the most

Table 1: Department of Health budget for Spending Review period

£ million	2015–16 baseline	2016–17	2017–18	2018–19	2019–20	2020–21
RDEL ⁽¹⁾	111,560	115,611	118,718	121,308	124,085	128,241
CDEL ⁽²⁾	4,810	4,810	4,810	4,810	4,810	4,810
TDEL	116,370	120,421	123,528	126,118	128,895	133,051

(1) Resource DEL excludes depreciation.

(2) Capital DEL includes funding for: key priority schemes (Proton Beam Therapy, PHE Science Hub and Advanced Well Being Centre); major new hospitals planned at Brighton and Sandwell Birmingham; and, Disabled Facilities Grant monies.

Table 2: NHS budget for Spending Review period

Revenue and capital combined	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Total (£ million)	100,500	105,975	109,337	111,824	114,929	119,035
Real terms increase on previous year (%)		3.7%	1.3%	0.3%	0.7%	1.3%
Real terms increase on 2015–16 baseline (£ billion)		3.8	5.3	5.8	6.7	8.4
Real terms increase on 2014–15 baseline (£ billion)	2.0	6.0	7.0	8.0	9.0	10.0

significant of which is replacing grants with loans for non-medical students. This does mean the overall increase in the Department's budget is less than £10 billion. However, the reform of student funding does not put the *Five Year Forward View* at risk. Overall the settlement is tough in some areas, but fair in the context of constraints on overall public spending.

2.6 The impact of the Spending Review on future efficiencies

We welcome the Five Year Forward View, which provides NHS England's assessment of the challenge and proposes a way forward for the NHS to be able to meet the widening funding gap. (HC 139, paragraph 74)

NHS England published further details of where the £22 billion of savings will come from on the day of our final oral evidence session, but we consider that it falls short on detail. It is still not sufficiently clear how or when the stated efficiencies will be achieved, or the contribution that individual organisations and sectors are expected to make. (HC 139, paragraph 75)

The Department and NHS England now need to set out a detailed plan for realising the savings and demand reductions that are needed to realise

the aspirations of the Five Year Forward View, so that bodies understand the contribution they need to make. The plan needs to be seen to be realistic, show the profile of savings and include metrics and milestones for monitoring progress against a trajectory. We will return to this subject on a regular basis through the spending review period to monitor progress against achieving the plan. (HC 139, paragraph 76)

We are encouraged by the progress that has been made to build on good practice in the NHS, including through the work of Lord Carter and Professor Briggs. We heard mixed views on whether addressing unwarranted variation can realise sufficient efficiency savings but we are hopeful about what might be achieved with the engagement of providers and clinicians. The NHS must now set out how it will tackle variation within community, mental health, ambulance, primary care and specialist acute services. We recommend that the NHS publish details of the profile of saving targets within each sector so that we can assess progress when we next return to this subject. (HC 139, paragraph 84)

57. We welcome the Committee's support for the *Five Year Forward View*, delivery of which is crucial to placing the NHS on a

sustainable footing for the future. We have always been clear that while we would protect investment in the NHS, there would still be a need for the system to make significant efficiencies as considered in the *Forward View*.

58. In May 2016, NHS England set out a further breakdown of the savings against the modelled £22 billion. This showed that total efficiencies of £21.6 billion are expected to be delivered by 2020–21.

59. Of this, £6.7 billion of efficiencies against the *Forward View* counterfactual cost growth could be nationally delivered. These include:

- Implementing the 1% public sector pay policy to 2019–20;
- Renegotiating the community pharmacy contract with the pharmacy sector, and a variety of other nationally delivered cost efficiencies;
- Implementing income generating activities overseen by the Department as agreed in the SR; and,
- Reducing NHS England central budgets and administration costs.

60. Local health economies need to find around £15 billion in efficiencies. There is already a line of sight to £1 billion of efficiencies from non-NHS provider contracts and CCG running cost reductions. This leaves £14 billion of savings to find over the period, the vast majority of which will be delivered through reducing secondary acute provider reliance on costly agency staff; improvements in secondary care provider productivity; and, moderating levels of activity growth.

61. The Department, NHS England and NHS Improvement have taken significant steps, with further work ongoing, to set out the contribution that local health bodies need to make in these areas and how they can achieve this. This includes:

- **Agency spending:** NHS Improvement has introduced tough controls to bring down spiralling agency costs. This action includes requiring trusts to procure from frameworks, and introducing price caps and expenditure annual ceilings. These are expected to reduce the growth in agency costs back to 2013–14 levels of £2.5 billion during this financial year (2016–17).
- **Acute sector productivity:** Lord Carter's review identified at least £5 billion worth of efficiency opportunities by 2020–21 through reducing variation in efficiencies across workforce, estates and facilities, hospital pharmacy and procurement in non-specialist English acute hospitals. The Department and NHS Improvement have been working closely to scale up and accelerate implementation of the recommendations throughout the NHS, by transitioning to NHS Improvement work currently sitting with the Department. A new directorate in NHS Improvement will take up the 15 projects led by professional experts who will continue to work closely with trust Model Hospital experts to continue building its capability, metrics and analysis and; more regional expertise to support trusts. By fully transitioning the programme into its structure across central and regional offices, NHS Improvement will continue close engagement with the original cohort, now comprised of 46 trusts, as well as providing additional support for all 136 acute trusts and over time to all providers. Robust governance processes already exist between the Department and NHS Improvement and the appointment of Lord Carter as non-executive to ensure oversight of the programme of work will further strengthen this and give us greater assurance over delivery. The Department is working to

ensure these arrangements continue to operate effectively as responsibility for implementation transitions fully to NHS Improvement, in order to track progress and ensure delivery of efficiency savings. Lord Carter will be reporting back progress made to date to the Health Secretary by spring 2017.

- **Moderating activity growth:** NHS England is working with the system to reduce demand for NHS care by improving the public's overall health, introducing new ways and places to care for patients that mean they don't always need to go to hospital, and reducing inexplicable variation in care. This is being delivered through the development of new models of care through the 50 Vanguard sites. These are the blueprints for the NHS moving forward and enable wider roll out of the New Care Models programme, which will re-design health and care systems to provide the best possible models of integrated care for patients at the most efficient cost for the taxpayer. Other work in this area includes: Right Care, supporting commissioners to spend the NHS pound wisely; self-care, supporting patients to manage their health; and, a range of interventions in urgent and emergency care.

62. However, change on this scale can only be delivered if it is locally led – in order to be realistic and meaningful, plans need to be developed bottom-up and take account of local needs and context. It is only right that local health economies determine what their ambition should be that would meet the needs of their local populations but also realise the efficiencies required.

2.7 Opportunities for efficiencies in social care

Cuts to social care funding over a number of years have now exhausted the capacity for significant further efficiencies in this area. We have heard that the savings made by local councils in the last parliament have gone beyond efficiency savings and have already impacted on the provision of services. Based on the evidence we have heard we are concerned that people with genuine social care needs may no longer be receiving the care they need because of a lack of resource. This not only causes considerable distress to the individuals concerned but results in significant additional costs to the NHS. (HC 139, paragraph 86)

63. The 2016 ADASS (Association of Directors of Adult Social Services) budget survey⁶ states that the recent Spending Review recognised the pressures facing adult social care. However, it also demonstrated an overview of the challenges faced by local government. Local authority budget data⁷ published by the Department for Communities and Local Government shows that, in the context of a challenging funding settlement, local authorities have increased the amount budgeted for adult social care services. Government measures such as the adult social care precept were put in place to protect these budgets, and we are pleased to see that 95% of councils chose to implement it in 2016–17.

6 Association of Directors of Adult Social Services *ADASS Budget Survey 2016* www.adass.org.uk/adass-budget-survey-2016-full-report/

7 Department for Communities and Local Government (2016) *Local Authority Revenue Expenditure and Financing: 2016-17 Budget, England* www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing

64. The ADASS survey shows that over half of savings required in 2016–17 can still be achieved through efficiencies and 97% of directors are either fully or partially confident of being able to make the required savings this financial year. Almost all respondents identify efficiency improvements such as increased prevention and early intervention or integration of health and social care services as ‘quite’ or ‘very’ important in achieving savings. We recognise the importance of these approaches. To help people to stay well in their own homes for longer, the SR included over £500 million for the Disabled Facilities Grant by 2019–20 when it is expected to pay for over 85,000 home adaptations and prevent around 8,500 people from needing to go into a care home. The Better Care Fund continues to support the integration between health and social care, helping improve the efficiency and effectiveness of integrated services.

65. The Local Government Association (LGA) has delivered a sector-led adult social care efficiency programme over a two-year period to support participating authorities to refine and develop the comprehensive efficiency approaches required to deliver savings authorities needed to make to meet the challenges of reduced funding, demographic pressures and personalisation. Savings are being made through taking a systematic approach to transformation, including managing admissions to residential care, making more efficient use of social work time and improving procurement. The Programme has helped councils to take forward their efficiency and transformation agendas and deliver savings of up to 7%.

66. The Department is continuing to work in co-operation with the LGA on this programme in 2016–17 through the sector-led Care and Health Improvement Programme (CHIP). A stated deliverable of the CHIP is for the LGA to work with a cohort of councils to

rapidly progress efficiency and transformation in the core areas of the programme (integrated commissioning, market shaping and mental health and learning difficulties). Learning and new approaches from this work will be shared within the year so that councils can use it to inform the 2017–18 and beyond financial cycle.

2.8 Funding for public health

Cuts to public health budgets threaten to undermine key parts of the vision set out in the Five Year Forward View, which are predicated on, among other things, a “radical upgrade in prevention and public health”. Failing to promote prevention with sufficient vigour will mean increasing operational and financial pressure on the NHS. The overwhelming view amongst our witnesses is that the public health cuts will turn out to have been a false economy. (HC 139, paragraph 102)

Given that even greater responsibility for public health has been transferred to local authorities, monitoring what is spent, how it is spent, and what it has achieved is of great importance. The Government needs to analyse and closely monitor the effects of the public health cuts on the aspirations set out in the Five Year Forward View. The Government should set out clearly, with measurable objectives and milestones, what it expects public health spending to achieve over the next five years, in terms of improved health and savings in NHS expenditure. We will return to this issue in future consideration of the financial situation in health and social care. (HC 139, paragraph 103)

By the time this report is published, a new Prime Minister will have taken office. We are concerned about the future of the childhood obesity strategy. We call on

the Government under Theresa May as Prime Minister to publish and implement the strategy at the earliest possible opportunity, and on the Chancellor of the Exchequer to implement the existing plans for a levy on the manufacturers of sugary soft drinks. (HC 139, paragraph 104)

67. We agree that improvements in public health and prevention remain essential, and – without underestimating the challenges – believe that they are achievable within the resources that were announced in the SR.

68. Our written evidence to the Committee described how local authorities will still receive more than £16 billion for public health over the SR period. This is in addition to what the NHS spends on prevention, including: over £1 billion in 2016–17 mainly on immunisation, vaccination and screening; £340 million in 2016–17 on vaccine stocks; and, the £400 million capital investment in the new national Science Hub.

69. Within the SR settlement the NHS is increasing its investment in prevention – for example the NHS Diabetes Prevention Programme, which is delivering an evidence-based behavioural change intervention to support people at risk of developing type-2 diabetes. By 2020, SR funding will be able to support at least 100,000 people through the programme each year. Investment in other preventative interventions will increase through the *Five Year Forward View*.

70. The NHS Prevention Programme Board has brought together key partners in the health and care system to provide strategic direction on prevention. The Board supports longer term planning to deliver on the *Five Year Forward View* commitment for an upgrade in prevention and public health. This includes action identifying efficiencies for the NHS through preventative interventions.

71. This emphasis on prevention is also consistent with our commitment to investment in NHS primary care. Much primary care activity has a preventative element, for example mitigating clinical risk factors like high cholesterol or pre-diabetes, and reducing avoidable complications for people with an underlying health condition.

72. Directors of Public Health (DsPH) also have a key role in influencing local authority budgets associated with the wider determinants of health. This was at the core of the rationale for returning health improvement responsibilities to local government in 2013, a move which was widely welcomed. As more functions are devolved to local government in areas such as Greater Manchester the opportunities available to local authorities, and the potential influence of DsPH in applying knowledge and expertise to local health challenges, can only grow.

73. We also agree that we need to be able to identify and monitor variations in public health outcomes, and to understand the relationships between outcomes, investment and the economic return on investment – not just for the NHS, but for society as a whole. Public Health England (PHE) has a key role in advising local and central government and promoting evidence-based commissioning and policy-making. In terms of objectives and milestones, the refreshed Public Health Outcomes Framework (PHOF)⁸ will continue to provide the most important mechanism for transparency and accountability across the whole public health system. It contains 66 measurable indicators of public health and PHE monitors and publishes data against each one for every local authority in England. The PHOF's two overarching priorities have

8 Public Health England (May 2016) *Public Health Outcomes Framework* www.gov.uk/government/collections/public-health-outcomes-framework

remained constant and clear since its original publication in 2012:

- increased healthy life expectancy; and,
- reduced differences in healthy life expectancy between communities and groups.

74. The PHOF will be reviewed again in 2019. While all local authorities must have regard to it, their primary duty requires them to identify local needs and their own priorities for action. They remain accountable to their local electorates for the decisions they make and the outcomes they achieve. Local authorities lead locally on population health improvement, but to do that effectively they must work in conjunction with their local partners, including CCGs.

75. NHS England, NHS Improvement and PHE have worked with other key bodies to set out a single framework for local areas that has a clear focus on prevention. PHE has provided evidence to DsPH to help them develop bold and practical plans for preventing ill health. PHE assesses draft plans and supports their further local development.

76. While many of the most innovative and effective opportunities to improve health can be realised by local agencies working in partnership, we have been clear that we will not shy away from our responsibility to take strong national action where this is necessary and supported by evidence.

77. For example, tobacco use remains one of the leading causes of inequalities in healthy life expectancy. Building on our clear track record on protecting children from the harmful effects of tobacco, we are committed to publishing a new tobacco control plan.

78. We have been working with a broad range of stakeholders, to develop a Government-wide tobacco control plan which co-ordinates the many levers held

across government. These include duty rates, enforcement activity and prison management as well as opportunities within the NHS.

79. The plan will include proposed new ambitions and a range of commitments to reduce smoking prevalence, in particular focusing on groups experiencing greater health inequalities as a result of smoking. A series of stakeholder ‘roundtables’ have helped inform the development of the plan, its commitments and ambitions.

80. Furthermore, our recently launched childhood obesity plan⁹ will help children and families to recognise and make healthier choices and be more active – supported by schools and the NHS. Through the soft drinks industry levy we are doubling the Primary PE and Sport Premium to £320 million from September 2017 and putting a further £10 million a year into school healthy breakfast clubs to give more children a healthier start to their day.

2.9 Transformation, integration and devolution

We expect the Government to clarify the situation for CCGs wanting to adopt integrated commissioning with local authorities including through “most capable provider” approaches. During the passage of the Health and Social Care Act, the then Secretary of State assured our predecessor committee that integration would trump competition where that was in the best interests of patients. All those working towards the goal of providing an integrated service need clarity about the legal avenues

9 HM Government (August 2016) *Childhood Obesity: A Plan for Action* www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

open to them in order to do so. (HC 139, paragraph 116)

81. The National Health Service Act 2006 already supports local health and care organisations to work together in various ways. For example the legislation enables NHS England to delegate to or share with CCGs the responsibility for certain health functions, such as commissioning of GP services. It also enables local authorities and NHS bodies to agree voluntary arrangements to work together and pool budgets for particular functions and for CCGs to work together and pool funds.

82. The Cities and Local Government Devolution Act 2016 also introduced additional flexibilities to support joined up, place-based approaches. It is an enabling Act which permits the transfer of a range of functions, including health and social care functions, to a combined or local authority. Functions can be exercised solely by the receiving authority, or jointly or concurrently with the original holding organisation. The Act does not in itself transfer or devolve any powers or functions – any future transfer of functions would be achieved through an Order made by the Secretary of State and passed by affirmative procedure in both Houses of Parliament.

83. The Devolution Act also amended the NHS Act 2006 to enable combined authorities to work with CCGs and for NHS England to enter into joint or delegated arrangements with groups of local commissioners including CCGs and combined and local authorities. Unlike devolved arrangements, these local voluntary arrangements would not require the Secretary of State to make an Order in Parliament.

84. Legislation therefore now offers a broad menu of flexible options available to local partners and NHS England as they seek to

take collective steps towards better health and care and greater financial sustainability.

85. We are committed to the view that health and social care services in any area, whatever devolution arrangements are entered into, must remain firmly part of the NHS and social care system, that all existing accountabilities and national standards for health services, social care, and public health services will still apply, and that the position of NHS services in the area in relation to the NHS Constitution and Mandate cannot change. The Secretary of State for Health will continue to be bound by relevant duties set out in the National Health Service Act 2006 and in relation to the NHS Constitution.

Competition

86. This Government's policy is that patients should receive healthcare services from the providers that are most capable of meeting their needs. During the passage of the 2012 Act the Coalition Government committed that, in order to demonstrate continuity, the existing competition rules would be put on a statutory footing. For commissioners this was done by the *National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (PPCCR)* so that they could continue to apply to the new commissioning organisations. The Cooperation and Competition Panel was retained then transferred to Monitor.

87. Monitor's (now operating under the name of NHS Improvement) role as the health sector regulator is to make sure that the rules are applied taking into account the specific circumstances of health, and to ensure that they achieve their objective of meeting the needs of patients. Monitor has powers to investigate breaches of the rules and in cases where there has been a serious breach can set aside a commissioners' contract. The purpose of the regulations and their enforcement is to make sure choice

and competition operate in the best interests of patients, that procurement decisions by commissioners achieve the best results and, that all providers are treated fairly.

We heard some impressive evidence of the work going on to integrate health and social care services, and to incorporate other public services in ways that meet the needs of patients better and improve the local population's health. These initiatives for integration have great potential. In many areas, patients are already benefitting from better integration and other transformation initiatives. This will however not necessarily save money in the short term, as this approach also identifies more individuals who could benefit from services. (HC 139, paragraph 126)

Integration and devolution do not offer a quick solution to the financial problems facing the NHS and social care services. Such projects require substantial investment in preparation and during the early years of operation, and may in some cases add to costs in order to deliver long term savings. The Government needs to take a long term view in assessing their financial benefits and should define how the success of the vanguards will be evaluated. (HC 139, paragraph 127)

88. In many respects, health and care services are currently fragmented, reactive and designed to respond to single episodes of care. In order to provide people with person-centred and co-ordinated services that deliver the right care in the right place at the right time, we need to integrate health and social care services.

89. Implemented from the beginning of 2015–16, the Better Care Fund (BCF) is the first national, mandatory integration policy, helping clinical experts and local leaders in every part of the country to join up and

improve health and care services through the establishment of pooled budgets.

90. It is clear from the fact that areas voluntarily pooled an extra £1.5 billion in the BCF in 2015–16 that there is an enthusiasm for the policy and its aims. Feedback from local areas regarding the BCF has generally reported that it has had a positive impact on their relationships at the commissioning level, using words such as ‘catalyst’ and ‘enabler’ to describe its effect on local health and care systems.

91. It is too early to formally evaluate the BCF, but this deliberately ambitious programme has helped to create greater momentum for a necessary step change in the way that care is delivered across the whole of England.

92. Integrating health and social care will take time. Local areas are already making excellent progress in delivering their plans, and the benefits are now being seen by those who work in health and social care, and those local people who require health and social care services.

93. The intention is that by 2020 health and social care are integrated across England. The BCF is a building block towards this and many areas are looking at ways to further integration aims, including through devolution deals and new care models. We need to enable people to live independent and healthy lives in the community for as long as possible, relieving the pressure on acute services.

With much of the upfront investment in the Spending Review being used to plug deficits, there is a real danger that greater integration and the move to the new models of care set out in the Five Year Forward View will be jeopardised by the shortage of transformation funds across the wider NHS outside the vanguards. At present the Sustainability and Transformation Fund is being

used largely to 'sustain' in the form of plugging provider deficits rather than in transforming the system at scale and pace. If the financial situation of trusts is not resolved or, worse, deteriorates further, it is likely that the overwhelming majority of the Fund will continue to be used to correct short-term problems rather than to support long-term solutions. We call on the Government to set out how it will protect the Transformation element of the Fund to ensure that the ambitions of the Five Year Forward View are realised. (HC 139, paragraph 128)

94. We agree with the importance of protecting funding for transformation and service improvement in the NHS. NHS England established a Sustainability and Transformation Fund of £2.14 billion for 2016–17. Of this, £1.8 billion will be deployed on sustainability to stabilise NHS operational performance, and £340 million for transformation to continue the new care models programme and invest in other key *Five Year Forward View* areas.

95. The Fund will grow from £2.1 billion in 2016–17 to £2.9 billion in 2017–18, rising to £3.4 billion in 2020–21, with an increasing share of the growing fund being deployed on transformation including the new care models, and mental health parity of esteem. The recent financial reset by NHS England and NHS Improvement provides further actions to deliver sustainability which are essential to protect the transformation elements of future funding.

2.10 Health education funding

The failure to train and retain an adequate supply of clinical staff is causing great strain in many parts of the NHS. This is undermining patient care, driving up the use of more expensive agency staff

to fill rota gaps and diverting resources away from other important priorities. We expect Health Education England to set out their strategic plan and state whether they expect it to be achievable, and whether it will deliver the staff needs of the NHS, within their current budget. As we return to this subject through the spending review period we intend to examine the progress which HEE is making in improving workforce planning and effecting the transformation of the workforce at the heart of achieving the aims of the Five Year Forward View. (HC 139, paragraph 139)

We have heard concerns about the potential impact of the proposed abolition of NHS bursaries on the supply of nursing staff and other allied health professionals. We recommend that the Government review the impact on those training as a second degree and examine a transitional approach to support this section of the future workforce. We welcome the introduction of new routes to Associate Nurse and degree level nursing for those working as Health Care Assistants. We plan to return to this issue. (HC 139, paragraph 140)

96. Health Education England (HEE) published its workforce plan for 2016–17¹⁰ setting out future supply forecasts and confirming the investment HEE will make in education and training throughout 2016–17. HEE proposes to again increase the overall volume of staff entering education and training, with in excess of 38,000 new training opportunities for nurses, therapists and scientists, and over 50,000 doctors and dentists in training.

10 Health Education England (2016) *Investing in People for health and healthcare: workforce plan for England 2016* www.hee.nhs.uk/our-work/planing-commissioning/workforce-planning

97. Currently two-thirds of people who apply to university to become a nurse are not offered a place – the health education funding reforms could create up to 10,000 more nursing, midwifery and allied health professional training places by the end of this parliament, with those in training getting around 25% more financial support while they study. This will open up opportunities for applicants turned down under the current system and ultimately increase domestic workforce supply so reducing NHS demand for expensive agency workers or staff from overseas.

98. HEE has established Local Workforce Action Boards (LWABs) as a mechanism through which local partners can meet to agree and discharge their collective workforce responsibilities in a co-ordinated manner.

99. A small number of nursing, midwifery and allied health professional students may already have a degree in another discipline. Under the current student support system, these potential students would not be eligible to access student support for a second time.

100. To support students who are planning to undertake nursing, midwifery and allied health professional subjects as a second degree, the Government will put in place an exemption to enable these students to access the standard student support system, just like students studying for a first degree. The rates of repayment will be the same as for students who take out student loan borrowing for the first time: 9% of income over £21,000 per year. At present, newly qualified nurses earning £21,700 will pay back around £5.25 a month.

101. As set out in our reply to the Public Accounts Committee¹¹, the effects of bursary reform will continue to be monitored and evaluated. The Department will work with delivery partners such as HEE, the Higher Education Funding Council for England, the Student Loans Company and the Universities and Colleges Admissions Service to assess the effects of bursary reform, particularly for mature students.

2.11 Service improvement: seven-day services

The Government and NHS England have now produced a clearer account of their intentions for seven-day services in hospitals and GP surgeries. We welcome the more realistic vision for seven-day hospital services, focussing on urgent and emergency care. We will continue to monitor progress on seven-day services across the Spending Review period, with the aim of assessing whether the Government's ambitions are achievable and delivering value for patients given the constraints on available resources and the risk of displacing measures which would be more cost effective. (HC 139, paragraph 153)

102. We welcome the Committee's comments and the opportunity presented by this inquiry to clarify our objective for seven-day services in hospitals. We know that there are variations in the quality of urgent and emergency hospital care provided across the week. This is why we have set the NHS the objective that, by the end of the parliament,

¹¹ HM Treasury (July 2016) *Treasury Minutes Government responses on the Thirty Fourth to the Thirty Sixth; the Thirty Eighth; and the Fortieth to the Forty Second reports from the Committee of Public Accounts: Session 2015-16 Cm 9323* www.gov.uk/government/publications/treasury-minutes-july-2016

anyone who is admitted to hospital in an emergency should have access to the same high-quality standard of care at the weekend as during the week. The Department is working with NHS England and other relevant organisations to progress the phased implementation of the four key standards for seven-day services in hospitals in a cost-effective way.

103. The Government has said that by 2020, everyone will be able to access routine GP appointments at evenings and weekends, as part of our commitment to a seven-day NHS. The *General Practice Forward View* announced an investment of a further £2.4 billion a year by 2020–21 into general practice services, which represents a 14% real terms increase. As part of this proposed increase, NHS England will provide additional funding, on top of current primary medical care allocations, of over £500 million by 2020–21 to enable CCGs to commission and fund extra capacity across England. This will ensure that by 2020 everyone has access to GP services, including sufficient pre-bookable and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to out-of-hours and urgent care services.

2.12 Service improvement: mental health

Delivery of the funding commitments the Government has made for mental health is crucial to the delivery of meaningful parity of esteem. As we return to this subject through the Spending Review period, we will be looking for clear, verifiable evidence that the additional funding for mental health is being delivered to the front line, as well as evidence of sustainable progress towards the culture change across the NHS, from

commissioners to providers, necessary to deliver genuine parity of esteem. (HC 139, paragraph 166)

104. We welcomed the publication of the independent Mental Health Taskforce's *Five Year Forward View for Mental Health*¹² which set out the vision for transforming mental health services over the next five years, and we are working to embed its recommendations in our policies. This includes increasing investment in mental health by £1 billion and developing a comprehensive set of mental health care pathways by 2020 to ensure that everyone who needs it has access to high quality mental health services.

105. NHS England published an implementation plan in July for delivering the NHS recommendations of the *Five Year Forward View for Mental Health*.

106. The Department will hold NHS England to account through the NHS Mandate for investing this funding to deliver the recommendations of the *Five Year Forward View for Mental Health* and Future in Mind vision for children and young people's mental health.

107. CCGs have been required through planning guidance issued by NHS England to increase their spending on mental health each year up to 2020 at least in line with the increase in their overall funding allocations. We have requested that NHS England monitors this commitment through the Improvement and Assessment Framework.

¹² Independent Mental Health Taskforce (February 2016) *The Five Year Forward View for Mental Health* www.england.nhs.uk/mentalhealth/taskforce/

ISBN 978-1-4741-3681-5



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