# The Government's Response to the House of Commons Health and Social Care Committee Report on Clearing the Backlog Caused by the Pandemic

Presented to Parliament

by the Secretary of State for Health and Social Care

by Command of Her Majesty

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# Summary of government response to the recommendations

1. The government welcomes this opportunity to respond to the House of Commons Health and Social Care Committee's report, '*Clearing the backlog caused by the pandemic',* chaired by Rt Hon Jeremy Hunt MP. Responses to each of the recommendation in the Committee's report can be found from page 8 onwards.

2. Recovery of health and social care services from the Covid-19 pandemic is a major priority for the department and for the government.

3. The Department of Health and Social Care and NHS England and Improvement (NHSE/I) set out their ambitious plans for the recovery of elective services in the Delivery plan for tackling the Covid-19 backlog of elective care, which was published in February 2022. Having made a major investment in the pandemic, including developing a world-leading vaccination service, the government has continued to invest in securing the recovery of health services, ensuring that the NHS remains free at the point of use. The challenges brought by the pandemic have been unprecedented, with our health and care staff battling tirelessly to care for patients in the most challenging of circumstances, and the government has shown its constant commitment to giving the NHS what it needed.

4. Throughout the pandemic, the NHS has worked tirelessly to keep vital services going. At the start of the pandemic there was a need for a temporary postponement of all non-urgent elective operations from 15 April 2020. This was needed to prevent the overwhelming of NHS services and free up 30,000 beds. Using lessons learned during the first wave, the NHS was well prepared for the second wave of the pandemic and was able to keep elective services operational, whilst also looking after thousands of people sick with Covid-19.

5. Since this postponement, incredible efforts have been made to recover backlogs, deliver high activity levels, and get patients the healthcare they need as quickly as possible.

6. However, recovery in itself is not enough. We do not intend to go back to business as usual before 2020. As such, we are embarking on transforming health and social care services through the Health and Care Bill and focusing on three key pillars. Firstly, we must better prevent healthcare needs developing in the first place and promote good health for all. Secondly, we must empower people to be in control of their own care and ensure that it is delivered in family, primary and community settings where possible. Finally, we will ensure services are delivered as effectively and efficiently as possible when treatment is needed, delivering world class care.

7. We welcome the Committee's report and the body of evidence that it has collected as part of this inquiry. We recognise many of the issues raised and in some cases our responses to the Committee's recommendations highlight activity already underway to tackle these concerns.

8. The government believes that as a part of the sea change in the way the NHS operates, the recruitment, training and well-being of NHS staff is of key importance. On 22 November 2021, the Secretary of State announced that Health Education England (HEE) will be merged with NHSE/I, subject to parliamentary passage of the Health and Care Bill containing the enabling powers. This change will help ensure that service, workforce, and finance planning are integrated in one place at a national and local level. It will simplify the national system for leading the NHS, ensuring a common purpose and strategic direction. It will also enable us to drive the changes we need in education and training both further and faster – to enable employers to recruit the health professionals they need to provide the right care to patients in future. We have also asked the NHS to put together a long-term 10-year-plus workforce strategy.

9. The introduction of Integrated Care Boards (ICBs) through the Health and Care Bill will allow for a more joined-up way of working across systems. ICBs will exercise their functions to promote innovation in the delivery of health services, which will be complemented by the duty on ICBs to ensure health services are delivered in an integrated way where this would improve the quality of services and reduce inequalities of access or outcome. In combination, these duties will ensure ICBs work in a way that promotes innovation and best practice in a joined-up way across their system area. The proposed legislation seeks to provide ICBs scope to fulfil these duties in the manner most suitable for their local areas, rather than being overly prescriptive.

# Responses to individual recommendations made by the Health and Social Care Committee

## Scale and impact of the backlog

***Our key new recommendation is that, by April 2022, the Department of Health and Social Care works with NHS England to produce a broader national health and care recovery plan that goes beyond the elective backlog to emergency care, mental health, primary care, community care and social care. It should be sensitive to the needs of local populations, incorporate the plans already announced in the ten-year plan, and explain how they will be delivered by the new Integrated Care Boards (ICBs). That plan must also set out a clear vision for what 'success' in tackling the backlog will look like to patients. In setting those metrics for success, the plan must take account of the risk that a reliance on numerical targets alone will deprioritise key services and risk patient safety. Instead, it must embrace a range of indicators to demonstrate that hidden backlogs are also being tackled and compassionate cultures encouraged. (Paragraph 12)***

10. The delivery plan for tackling the Covid-19 backlog of elective care, which was published in February 2022, builds on initiatives that were already taking place and puts workforce at the heart of the government's plans to improve the NHS and recover services. This plan has set out clear objectives on what success will look like, with commitments to:

    - Eliminate waits of longer than a year by March 2025 and ensuring no one is waiting more than two years by July 2022.
    - Make sure that 95% of patients needing a diagnostic test receive it within six weeks by March 2025.
    - The continued prioritisation of cancer care, with the target of 75% of patients referred by GPs for suspected cancer given a definitive diagnosis within 28 days of referral by March 2024.
    - Making greater use of technology and transform models of care, in outpatients.

11. We of course recognise that elective care is only one element of the system which has been significantly affected. As we move from a crisis response, the department is committed to prioritising health and care recovery and addressing the backlogs caused by the pandemic.

12. Cancer care is a priority area, and the department has launched an 8-week call for evidence to mark the start of our 10-Year Cancer Plan, a new vision for how we will lead the world in cancer care. This call for evidence seeks the views of individuals, professionals, and organisations to understand whether and how we can do more to make progress against this vision, and to build on lessons learned from the Covid-19 pandemic.  Local systems have been

asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023, and our ambition, set out above, is that, by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

13. Over the past two years, there has also been unprecedented demand on mental health services. The government published its Mental Health Recovery Action Plan in March 2021. This was backed by an additional £500 million for 2021-22, beyond planned investment as part of the NHS Long Term Plan, to ensure we have the right support in place to respond to the impact of the pandemic on the mental health of the public. This includes a focus on addressing specific backlogs which have arisen as a direct result of the pandemic – including funding to support discharge from acute settings, support for 18- to 25-year-olds transitioning into adult service, and memory assessment services and recovery of the dementia diagnosis rate – as well as further funding to support workforce growth, action to support early intervention and prevention, and broader acceleration of existing NHS Long Term Plan commitments. In Spring 2022, the department will publish a discussion paper to support the development of a cross-government ten-year mental health strategy to drive improvements in mental health outcomes.

14. In December 2021, DHSC published its adult social care reform white paper '*People at the Heart of Care'*, which set out a 10-year vision for adult social care. This followed the reforms to how people in England will pay for their social care announced as part of the September 2021 '*Build Back Better: Our Plan for Health and Social Care*' announcement. The department is now fully committed to implementing these reforms.

15. The department's '*Living with Covid'* strategy sets out our approach to continuing to protect the most vulnerable from Covid-19, while scaling back the level of government intervention and returning to longstanding ways of managing the threat of acute respiratory infections. The Department of Health and Social Care, Public Health Wales, Public Health Agency Northern Ireland, NHS National Services Scotland, UK Health Security Agency, and NHS England have issued jointly in April 2022 their updated Infection Prevention and Control guidance to replace the existing suite of Covid-19 guidance.

16. More broadly, the NHS Long Term Plan, published in January 2019, is the NHS's flagship 10-year national strategy. It sets out a range of NHS commitments and ambitions which will ensure the NHS is fit for the 21st century, including through:
    - Boosting provision of out-of-hospital care
    - Redesigning and reducing pressure on emergency hospital services
    - Further rolling out digitally-enabled primary, community, and outpatient care
    - Providing more personalised care to people when they need it

- Supporting the focus on prevention, population health and local partnerships

17. The direction of travel set out in the NHS Long Term Plan (LTP) remains broadly the right one, and a number of commitments outlined in the Plan have already been successfully delivered. However, the pandemic has understandably impacted on progress towards implementing many elements – both through accelerating progress in some areas and delaying in others. Elective recovery funding has been issued to support these areas through more than £8 billion from 2022-23 to 2024-25, in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund already made available to systems last year.

18. There have also been other developments in the context – for example in the establishment of Integrated Care Boards. A new national discharge taskforce has been established with membership from local government, social care, the NHS, and national government, focusing on the local authority and NHS actions required to drive sustainable progress on delayed discharges. We plan to publish an update to the LTP, which will reset commitments made in the plan where necessary and set out next steps in delivering against those commitments.

***NHS England has already commissioned an evaluation of the role of digital tools in primary care. We recommend that it publishes that evaluation at the earliest opportunity and uses it as a basis to produce clear and consistent guidance on best practice in***

- ***a. Reducing bureaucracy and day-to-day IT administration tasks, including those associated with referrals, routine blood tests, and follow-up appointments.***
- ***b. The use of remote consultations in general practice. This should include guidance on how to approach conversations with patients about remote care, considering that while patients may not necessarily always be able to have a face-to-face appointment, they should have input into the decision and the rationale for any refusal should be transparent and consistent. (Paragraph 44)***

19. General practice appointment numbers have risen from their lowest level of 0.83 million average appointments per working day in April 2020 to 1.28 million average general practice appointments per working day in January 2022, excluding Covid-19 vaccination appointments. During the pandemic, the government made £520 million available to improve access and expand general practice. This is in addition to £1.5 billion announced in 2020 to create an additional 50 million general practice appointments by 2024 by increasing and diversifying the workforce.

20. *'Our plan for improving access for patients and supporting general practice,'* published by the government and NHSE/I on 14 October 2021, and backed up by a Winter Access Fund, included a long-term measure to drive the adoption of cloud-based telephony across all practices. We have also put in place interim arrangements, to help practices manage demand on their phone systems which enable all general practices to use Microsoft Teams telephone functionality for outbound calls, freeing up lines for incoming calls. This is at no additional cost to practices and runs until the end of April 2023.

21. The plan also committed to supporting the establishment of a digital locum bank model or equivalent in all parts of the country, to aid the process of recruiting and deploying GPs. Examples of how the Winter Access Fund has been used include additional hubs and helplines, expanding home visiting capacity, funding additional sessions from staff.

22. The government believes that practices should respond to the needs of their local population and work together with patients to establish the most fitting mode for their consultations based on clinical outcomes. During the pandemic, we know that access to general practice changed, and practice teams have worked hard and adapted to stay open safely, offering triage and a blend of remote and face to face consultations in order to see an many patients as possible while protecting staff and patients from infection risks. NHSE/I guidance is clear that patients' input into choices about appointment mode should be sought and practices should respect preferences for face-to-face care unless there are good clinical reasons to the contrary. Patients should experience the same high quality of care regardless of how they access their GP surgery.

23. To reduce bureaucracy, NHSE/I have a number of projects underway to make improvements, such as streamlining the administrative process required for patient registration with GPs and improving the interface with secondary care. They will continue to publish guidance to support improvement and encourage best practice.

24. The NHSE/I Access Improvement Programme is also working directly with practices to plan and deliver improvements to administrative and other processes. Drawing on the successful Time for Care programme, teams of experienced facilitators are supporting practices whose patients are experiencing the greatest access challenges, including long waiting times, poor patient experience or difficulties in embedding new ways of working relating to Covid-19, such as total triage. This programme was expanded in October 2021 to enable more practices to access support.

25. NHSE/I have several evaluations underway on how online access tools can support patients and practices. This includes research into the impacts of online access systems on practices during the pandemic and user experience research into patient and staff perspectives on digital tools. They will publish each section of research as soon as possible and expect to publish some outputs soon.

26. NHSE/I are also working collaboratively with external research groups to support the broader effort to understand the use of digital tools in primary care and the impacts on patients, staff, and service delivery. Guidance and training resources have been developed to support clinicians and other primary care staff with new ways of working, including remote consultations, and they will continue to develop these – working in particular with the Royal College of General Practitioners and Health Education England.

27. The introduction of the NHS APP and with increasing use of the more and more patients will be able to take control of how they interact with GPs through for instance, booking appointments and ordering repeat prescriptions via the app instead of calling the surgery. This will reduce administrative burden on GPs and admin staff, freeing up time for care. We have recently announced a target to have 75% of the adult population registered to use the NHS App by March 2024.

***We therefore recommend that NHS England completes and publishes evaluations of NHS 111 call first services as soon as is practicable, including learning from those evaluations and the implications for any future iterations of the service. (Paragraph 54)***

28. We agree that it is essential that steps are taken to continue to manage the demand into Emergency Departments (EDs), and that clinical validation of NHS 111 will help to ensure only patients that require ED are directed there. We will publish the evaluation of the initial actions taken as part of the NHS 111 First project to inform the future approach to regulating demand. Since these initial actions, we are working more closely with EDs, and have trialled further initiatives as part of the '*Further Faster'* project. NHSE/I will continue to work closely with EDs and optimise service referral throughout the urgent and emergency care system.

***We therefore recommend that NHS England publishes, before the end of this financial year, a long covid plan covering the period until 2023. The plan must be developed in consultation with a wide range of stakeholders, including patient groups. NHS England should integrate this into its wider health and care recovery plan, as long covid is likely to have implications for demand and workforce across a range of services. (Paragraph 61)***

29. The government welcomes the Committee's recognition that the NHS in England has been at the forefront of clinical practice for Long Covid, working at pace to establish Long Covid services for adults, children and young people which support their care and recovery.

30. NHS England will work with stakeholders, including patient groups, to develop and publish a new Long Covid Plan for 2022-23 which considers the points raised by the HSSC, and demonstrate how the plan relates to the overall NHS recovery plan.

***The national health and care recovery plan must set out a clear vision for what 'success' in tackling the backlog will look like, and what patients can expect their care to look like in their local area in the coming years. The plan must include minimum expectations for ICBs in managing waiting lists actively and communicating with patients awaiting planned care. The Department of Health and Social Care, NHS England and local ICBs must share responsibility for communicating the 'offer' to the wider public, considering the "social backlog" facing many members of the public. We request the Department of Health and Social Care to report back to us on how this will be delivered. (Paragraph 66)***

31. The Delivery plan for tackling the Covid-19 backlog of elective care sets out what success will look like, as set out in our response to the recommendation made in paragraph 12.

32. Whilst the focus of the plan is on tackling the backlogs that have built up, the plan also sets out how the NHS will take this opportunity to increase transparency, improve communication and better support patients throughout their patient pathway. As part of this, the NHS will ensure choice is available for patients at the point of referral, and this choice will be enhanced for long-waiting patients through a national hub model.

33. To increase transparency on wait time, the NHS has launched '*My Planned Care'*, a new platform which provides a hub of support information and personalised care to patients. Using this platform, patients and their carers can access tailored information and support in preparation for their surgery, as well supplying access information on waiting times for their provider, allowing them to better plan ahead. NHS providers are also able to upload supportive information onto the platform to help patients manage their conditions while they wait for treatment.

34. We have also set out that ICBs will be required to improve effectiveness, efficiency, and economy. With a focus on the needs of the local population that they serve. ICBs will also produce and publish an annual joint forward plan which will set out how the ICB will discharge its duties in regard to deprivation and heath inequalities. ICBs will work with Local Authorities to develop Integrated Care Strategies, allowing for a more joined up approach to social care.

35. This will strengthen the partnerships between the NHS and local authorities and with local partners. This collaboration, and partnership working will be important in addressing the wider determinants of health, that lie behind much of the basis of the 'social backlog' and disparities in health outcomes and will be important in levelling-up and improving health outcomes.

36. We remain committed to working closely with partners across the heath and care system as we address the backlogs caused by the pandemic. We agree with HSSC on the importance of engaging with people who are living with

health conditions so that their lived experience continues to inform what we do and what research we undertake.

37. This is particularly important for people living with Long Covid. We have invested over £50 million in research studies to improve our understanding of Long Covid and how to manage and treat it. The selection of those studies was informed by the experiences of people living with Long Covid.

38. DHSC holds regular roundtable events, chaired by DHSC Ministers, to bring together clinicians, patients and their representatives, academics, researchers, NHS England, and other interested organisations to discuss Long Covid. Through these roundtables, we have heard at first-hand what patients are experiencing, giving us a clearer insight into the range of support and information they need in order to recover.

***We again recommend that the Care Quality Commission includes consultation with patient groups and details of patient outcomes in its assessment of ICSs. (Paragraph 68)***

39. DHSC agrees with the committee on the importance of engaging patients in the proposed Care Quality Commission (CQC) assessments of Integrated Care Systems (ICSs) in the Health and Care Bill. The CQC is developing its methodology for the proposed assessments of ICSs and intends its methodology to be subject to co-production.

40. The CQC's proposed assessments will consider the outcomes for people using services across systems, and one of the CQC's categories of evidence will be people's experience, public and patient groups will form a key part of this. CQC will also carry out individual case tracking, following people through their pathway.

## Funding and policies to tackle the backlog

***As part of its national health and care recovery plan, we recommend that the Government sets out the contribution that public health services will make, and ensures that this contribution is backed with a level of funding that acknowledges their crucial role. (Paragraph 80)***

41. Funding for local government's health responsibilities is an essential element of our commitment to invest in preventing ill health, promoting healthier lives, and addressing health disparities, and an important complement to our plans to invest strongly in both the NHS and social care.

42. The 2021 Spending Review confirmed that the Public Health Grant for local authorities will increase in each of the next three years. In 2022-23 each local authority will receive a 2.81% increase, taking total funding to £3.417 billion. This will enable local authorities to continue to invest in prevention of ill health and essential frontline services, like child health visits, drug treatment and sexual health services.

43. The Public Health Grant to local authorities is part of a wider package of DHSC investment in improving the public's health, including additional targeted investment over the Spending Review period of £170 million to improve the Start for Life offer available to families, including breastfeeding support and infant and parent mental health; and £560 million to support improvements in the quality and capacity of drug and alcohol treatment. A significant proportion of this further funding will flow through local government, meaning that total investment in local authority public health services will be greater than the headline real terms protection for the Public Health Grant.

44. The role local authorities play in improving public health is far broader than the important services and interventions funded through the Public Health Grant. Other local government responsibilities, such as those for transport, housing, and economic development, can have an important impact on the health and wellbeing of local populations.

45. The new Office for Health Improvement and Disparities (OHID), launched on 1 October 2021, has put the prevention of ill health and the reduction of disparities in health outcomes at the heart of the Department of Health and Social Care, ensuring public health and prevention are prioritised. OHID will support all areas of the country to drive improvements in health, with particular focus on those places and communities where ill health is most prevalent.

46. In addition, we have established the Health Promotion Taskforce to drive forward a cross-government effort to improve the nation's health. The new Taskforce will drive and support the whole of government to go further in improving health and reducing disparities, because many of the factors most

critical to good physical and mental health are the responsibility of partners beyond the health service. The Taskforce will identify additional opportunities to take action to improve health and reduce health disparities.

***We repeat our recommendation that HEE must be required (whether in its own right or as part of NHS England) to publish objective, transparent and independently-audited annual reports on workforce projections that cover the next five, ten and twenty years, including an assessment of whether sufficient numbers of staff are being trained. These projections must cover social care as well as the NHS given the close links between the two systems. We urge NHS England to ensure that workforce planning is included in any future iterations of the elective recovery plan. (Paragraph 93)***

47. Education and training of the health workforce is the core function of Health Education England (HEE).

48. To support longer-term strategic planning, in July 2021 the Department commissioned HEE to work with partners to review long term strategic trends for the health workforce and regulated professionals in the social care workforce. This will review and renew the long-term strategic framework for the health workforce, to help ensure we have the right skills, values, and behaviours to deliver world-leading services and continued high standards of care. This work will look at the key drivers of workforce demand and supply over the longer term and set out how they may impact upon the required shape of the future workforce. This work is nearing its final stages and we anticipate publication of the Framework in Spring 2022.

49. Building on this work, the Department for Health and Social Care has recently commissioned NHSE/I to develop a workforce strategy, and the key conclusions of that work will be shared in due course.

***We recommend that the Government undertake an urgent review of short-term recruitment and retention issues within the health and care workforce, including productivity improvements, sharing of best practice through data, removal of professional demarcation, use of technology, additional training places and additional immigration measures. This should be published before the arrival of the funding due in early 2022 (Paragraph 94)***

50. In the last year, we have seen record numbers of staff, including doctors and nurses, working in the NHS. The monthly workforce statistics for December 2021 show that there are over 1.2 million Full-Time Equivalent (FTE) staff (which is over 1.3 million in headcount) working in NHS Trusts and CCGs.

51. Since December 2020, there are now almost 20,600 (3.3%) more professionally qualified clinical staff working in NHS trusts and CCGs, including over 4,300 (3.5%) more doctors and over 11,700 (3.9%) more nurses. In total there are over 41,700 (3.6%) more Hospital and Community Health Service staff compared to December 2020.

52. We are focused on providing support to NHS trusts through the NHSE/I Retention Programme, so they have access to the capacity and skills needed to drive retention by focusing on improving flexible working, workplace culture, health and wellbeing, and supporting staff at the start and end of their careers when they most need it. The NHS People Plan aims to retain staff by helping organisations to provide ongoing support to NHS staff, to improve their health and wellbeing.

53. We continue to introduce measures to expand the workforce.

54. The government has committed to deliver 50,000 more nurses by the end of this Parliament. This will be achieved through a combination of investing in and diversifying the training pipeline, recruiting, and retaining more nurses in the NHS. As of December 2021, there are 27,000 more nurses, putting us on track to meet the commitment.

55. To support both the 50k Programme and recruitment in general, since September 2020 government has offered non-repayable grants of at least £5,000 per academic year of a standard 3-year course to eligible students studying pre-registration programmes across nursing, midwifery, and allied health professions. Extra funding worth up to £3,000 per academic year is also available to eligible students with child dependents (£2,000 per academic year) or students studying specialist subjects (£1,000 per academic year).

56. Over 30,000 nurses and midwives accepted places to study nursing and midwifery at English universities in the 2021 recruitment cycle. This is the highest combined nursing and midwifery total since these statistics were first recorded and a 28% increase compared to the 2019 cycle. There are currently over 70,000 people training to be nurses, over 9,000 people training to be midwives and over 30,000 training to become Allied Health Professionals.

57. There are record numbers of medical students in training. The government has funded an additional 1,500 undergraduate medical school places each

year for domestic students in England. This 25% increase, completed in September 2020, also delivered five new medical schools in England. In addition, the government temporarily lifted the cap on medical school places for students who completed A-Levels in 2020 and in 2021 and who had an offer from a university in England to study medicine, subject to their grades.

58. The government has taken steps to make the process of recruiting overseas less costly and more attractive through implementation of the Health and Social Care Visa and an exemption from Immigration Health Surcharge (IHS) for health and social care staff who come to work in the UK.

59. HEE continues to drive innovation and new technologies in the education and training of health and care staff. The Topol Review (published in February 2019) made recommendations that to ensure that, within five years, education and training equips future employees to achieve their full potential as staff in the technology-enhanced NHS – including making the most of innovative technologies such as genomics, digital medicine, artificial intelligence, and robotics. HEE hosted a series of round tables in 2021 to discuss progress on the original Topol Review, and in due course will publish a report setting out the outcomes of those round tables and the work delivered so far.

60. Other HEE initiatives include its DART-ED programme (Digital, Artificial Intelligence and Robotics Technologies in Education), delivered in partnership with Academic Health Science Networks, which links clinical competencies required to work with artificial intelligence and robotics with clinical training. In addition, HEE's Digital Readiness programme is creating an uplift of digital skills, knowledge, understanding and awareness across the health and social care workforce. HEE's '*Knowledge for Healthcare'* strategy, published in January 2021, is seeking to enable all NHS staff and learners to benefit equally from high-quality knowledge services, and optimise the expertise of knowledge and library teams to inform decision making.

61. For social care, we are expanding the Health and Care Visa to include Care Workers and Home Carers for a minimum of 12 months. These roles will be added to the Shortage Occupation List (SOL), which providers lower visa fees and a reduced salary threshold of £20,480, in addition to senior care worker roles, registered managers and registered nurses which have been on the SOL since April 2021 (nurses since January 2021). This will make it quicker, cheaper, and easier for social care employers to recruit eligible workers from overseas, helping to fill thousands of vital vacancies. We will monitor the number of care workers recruited from overseas and review this policy at the end of the 12-month period.

62. To provide additional support to the sector for the winter, on 10 December 2021 we announced an additional £300m to support local authorities working with providers to further boost staffing and support existing care work through the winter.

63. This new funding is in addition to the existing £162.5 million Workforce Recruitment and Retention Fund (WRRF) announced on 21 October 2021.

64. As set out in detail in the adult social care White Paper, the government is implementing a range of interventions which aim to support the recruitment, retention, and development of the social care workforce.

65. The vast majority of care workers are employed by private sector providers who ultimately set their pay, independent of central government. Local Authorities work with care providers to determine a fair rate of pay based on local market conditions.

66. The government is providing a sustainable local government settlement, which is designed to ensure key pressures in the system are met, including National Living Wage and National Minimum Wage.

67. On 1 April 2022, the government increased the National Living Wage (NLW) for workers aged 23 years and over by 6.6% to £9.50. This means a full-time care worker on the National Living Wage will see their annual earnings rise by over £1,000.

68. The government has set a target for the National Living Wage to increase further, to reach two-thirds of median earnings by 2024 for workers aged over 21, taking economic conditions into account.

69. The white paper also outlines at least £500 million to support the adult social care workforce. This investment will enable a five-fold increase in public spending on the skills and training of our direct care workers and registered managers. It aims to ensure staff feel recognised, rewarded, equipped with the right skills and knowledge, and have their health and wellbeing supported.

***We call on NHS England to demonstrate its ongoing commitment to staff wellbeing by publishing a refreshed People Plan to cover the financial year 2022/23 as soon as is practicable. (Paragraph 96)***

70. We know that NHS staff have worked tirelessly to provide excellent care throughout the pandemic and that looking after the wellbeing of staff is crucial. The four themes of the People Plan – *Looking After Our People, Belonging in the NHS, New Ways of Working and Growing for the Future* – provide a common framework and clear direction for the system to develop its workforce plans and priorities.

71. The NHS People Plan is not a single document: it is an overarching programme of work, aiming to ensure staff feel supported at work, are happy with their working environment and want to remain in the NHS. The actions set out in the 2020 iteration of the People Plan remain priorities across the NHS.

72. Delivery of the People Plan will continue to be overseen by NHSE/I's People Plan Delivery Board (PPDB) which brings together national People Plan leads, DHSC representatives, Regional People Board Chairs, system, Trust and Primary Care Network representatives.

73. The plan prioritises the wellbeing of the NHS workforce, both as an end in itself and to support workforce retention. It set out a comprehensive range of actions including specialist mental health and wellbeing support co-ordinated through 40 hubs established over the past year. Every member of the NHS should have a health and wellbeing conversation with their line manager or a peer, and Wellbeing Guardians have been established to ensure board level scrutiny of staff health and wellbeing.

74. NHS England and Improvement's priorities for people and workforce have been published in its 2022/23 Priorities and Operational Planning Guidance, containing actions for systems and employers to continue investing in the workforce, implement new ways of working, and strengthen the compassionate and inclusive culture needed to deliver outstanding patient care.

***As part of its broader health and care recovery plan, the Government must produce an independently-verified analysis of how many, and what type, of extra beds the NHS needs in order to provide safe and effective everyday care for patients, whilst also responding to need directly created by the pandemic. This plan must be accompanied by sustainable, long-term plans to tackle delayed discharges. (Paragraph 99)***

75. The NHS constantly and tirelessly strives to deliver safe and effective care. It is important that the NHS is able to treat people in the right environment for their needs, but the number of beds required to achieve this will be a function of a range of other factors and reforms, including those put in place to deliver discharge and elective care. So, while the NHS does need to have an understanding of the demand for beds, this needs to be an ongoing process that the NHS keeps constantly under review not a one-off analysis.

76. The NHS has also demonstrated that it can flexibly expand general and critical care bed capacity to respond to spikes in demand driven by Covid-19. It has developed tried and tested plans to do so, including surging capacity within hospital trusts' existing footprints, across Integrated Care System footprints and clinical networks, patient transfers between regions, and through the delivery of Nightingale hospitals. These interventions help to ensure the resilience of the wider NHS and remain available to be deployed in response to Covid-19 demand in future.

77. A new national discharge taskforce has been established with membership from local government, social care, the NHS, and national government. Working to sponsors in both DHSC and NHS England, and closely with DLUHC, it is focusing on the local authority and NHS actions required to drive sustainable progress on delayed discharges. The taskforce will highlight possible areas for further interventions in relation to delayed discharges, utilising members' insights into national and local discharge practice.

***Ahead of the arrival of the new funding from the Spending Review in Spring 2022, we recommend that Government provides more details on the 100 new community diagnostic hubs, including where they will be placed, who will staff them and how they will contribute to service improvement within and beyond the covid-19 landscape. (Paragraph 103)***

78. The government has announced the roll-out of over 40 Community Diagnostic Centres (CDCs) by March 2022 to provide additional diagnostics capacity. These CDCs had already provided over 550,000 additional tests as of January 2022 and are expected to deliver around 1.5 million tests in their first full year of operation. 35 CDCs and 36 Early Adopter sites were already providing tests as of January 2022. At the Spending Review, the government announced a further £2.3bn investment for diagnostics, which will increase the number of CDCs to at least 160 by March 2025.

79. Local systems will suggest where CDCs should be located, with guidance from NHSE/I. Diagnostics funding will be assigned to regions based on a proportionate approach and then adjusted to take account of regional disparities and unmet need for diagnostics. Locations needed to meet the baseline requirements for CDCs, including separation from acute services, ability to host the baseline services, accessibility by different transport options, and requirements to have an impact on health inequalities. Local systems will be presenting three-year strategic plans for diagnostics service to NHSE/I, who will approve investment in CDCs and other additional capacity. Further detail on the location of CDCs will be available when this process is complete.

80. As part of the development of the CDC plans, detailed modelling of the workforce required to deliver these has been conducted. NHSE/I and Health Education England have formed a collaborative programme to support systems to ensure that the required workforce capacity is in place to deliver CDCs, and the wider diagnostic transformation agenda set out in the Richards review. This includes developing new roles, clearer pathways for progression, better utilising the existing workforce and improving workforce retention. Workforce expansion will also be driven by improving workforce productivity using digital diagnostic investments.

***We recommend that NHS England, together with ICBs and the new Office for Health Improvement and Disparities (OHID), work together to deliver regional and national coordination as the system tackles the backlog in elective care. If the independent sector is to prove an effective partner in tackling that backlog, the Government must ensure that plans take into account people living in those areas with less access to independent care. The goal must be equity of access to care on waiting lists regardless of geographic location. (Paragraph 106)***

81. In the 2021/22 NHS Operational Planning Guidance NHSE/I asked local health systems to report back on pre-existing disparities and how they were exacerbated during the pandemic. We set out five priority areas:
    - Restore NHS services inclusively
    - Mitigate against digital exclusion
    - Ensure datasets are complete and timely
    - Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
    - Strengthen leadership and accountability

82. NHSE/I's programme for elective recovery works with regional and system colleagues to co-ordinate a number of workstreams. Systems were required to use their data to plan the inclusive restoration of services, by breaking down the waiting lists by ethnicity and deprivation. NHSE/I developed a series of support tools and resources for systems to deliver on the Elective Recovery Fund gateway criteria (one of which was health inequalities); these include case studies to share learning and best practice.

83. The planning guidance sets out clear targets and trajectories for elective recovery, with every system required to develop an elective care recovery plan. The need to address health inequalities is embedded into this guidance. As part of this, NHSE/I provides tools and resources to help systems deliver against the elective recovery plan.

84. A renewed relationship with the Independent Sector (IS) is one of the workstreams included in the elective recovery plan, highlighting the important contribution of the IS to the management of waiting lists. NHSE/I recognise that there is inequity of independent provision throughout the country, and patients are being supported to travel to services if needed.

85. NHS regions are adopting insourcing approaches, patient transport, and personalised care where appropriate, working with NHSE/I teams and the Office for Health Improvement and Disparities.

***In light of the Government's commitment to reform social care, we again recommend that it publishes a ten-year plan for social care, setting out in detail how it will tackle the structural and financial problems the sector faces in the short-term, and operationalise its longer-term ambitions. The Government must also acknowledge the needs and wellbeing of staff working in the social care sector by publishing a People Plan for social care, aligned to the ambitions set out in the NHS People Plan. (Paragraph 113)***

86. The provisional Local Government Finance Settlement proposes making available an additional £3.5 billion to councils, an increase in local authority funding for 2022-23 of over 4% in real terms. This will ensure councils across the country have the resources they need to deliver key services.

87. We are reforming health and adult social care: on 7 September 2021 we committed to investing an additional £5.4 billion in social care over three years to begin a comprehensive reform programme. This funding has been allocated exclusively to the development and improvement of Social Care. On 1 December 2021 we published *People at the Heart of Care*, where we set out our 10-year vision for reforming adult social care and our priorities for investment.

88. The £5.4 billion investment includes £3.6 billion to reform the social care charging system and enable all local authorities to move towards paying providers a fair rate for care; and a further £1.7 billion to begin major improvements across the social care system in England.

89. Our 10-year reform vision puts people at the centre of adult social care and aims to make sure that people:
    - Have the choice, control and support they need to live independent lives,
    - Can access outstanding quality, as well as, tailored care and support,
    - Find adult social care fair and accessible.

90. The measures, which include a new £300 million investment in housing, £150 million of additional funding to improve technology and increase digitisation across social care, and a £500 million investment in the workforce, will bring tangible benefit to the lives of people who draw on care, their family and their carers.

91. In developing these plans for reform, we have worked with over 200 stakeholders, including local government, think-tanks, providers of care and their representatives, professional bodies, charities, unions, and people with lived experience of care and support.

92. The 1.5 million people who make up the paid social care workforce provide an invaluable service to the nation. They have risen to the challenge of the

Covid-19 pandemic, working tirelessly to support those in our society who need care. We are indebted to their service.

93. As stated in our answer to recommendation in paragraph 14, we have set out our workforce strategy within the '*People at the Heart of Care'* white paper.

94. Our workforce strategy includes three key aims for the next three years, backed up by an investment of at least £500 million. We want to build:
    - A well-trained and developed workforce
    - A healthy and supported workforce
    - A sustainable and recognised workforce

95. This £500 million is a major investment in the training and development of social care staff. We will work with sector leaders and partners to co-develop the training offer so that it can address skills gaps and meets the needs of the workforce and the people who use services.

96. Through our policies, we want staff to be empowered to deliver the highest quality of care. These policies include a new career pathways map, a new national knowledge and skills framework to support training and development, a new digital platform for social care staff, initiatives for social workers, nurses and other allied health professionals, and a package to support care staff health and wellbeing.

97. We have worked alongside the NHS and other organisations to provide a package of emotional, psychological and practical resources for the workforce. This includes a listening service, guidance, bereavement resources and a bespoke package of support for registered managers. We are also working with the sector to ensure that wellbeing resources and best practice advice are streamlined, easier to navigate and designed for the sector.

98. In addition, the Department commissioned HEE in July 2021 to refresh its Long-Term Strategic Framework ('*Framework 15'*). This project will review long term strategic trends for the health and regulated social care settings workforce and produce a robust long-term strategic framework for the health and regulated social care workforce for the next fifteen years, which for the first time will include regulated professionals in adult social care such as nurses and occupational therapists.

99. The number of jobs in adult social care is forecast to grow by almost one third by 2035. As the population grows, and the way care is delivered evolves and diversifies, the adult social care workforce will need to grow and develop with it. We will continue to work closely with local authorities and care providers to monitor workforce pressures, including on whether further action may be required. We are also taking action to support adult social care providers to recruit, for example through the National Recruitment Campaign across

broadcast, digital, and social media, highlighting the vital work care workers do, and by working with the Department for Work and Pensions to promote adult social care careers to jobseekers.

100. In addition, we have expanded the Health and Care Visa to include Care Workers and Home Carers for a 12-month period. These roles will also be added to the Shortage Occupation List (SOL) in addition to senior care workers, registered managers and registered nurses who are already on the SOL.

101. This workforce strategy set out in the white paper is just the beginning. We will need to work closely with adult social care leaders and staff, as well as people who draw on care and support, to implement it and take these policies forward now, and in the future.

***To encourage better integration and mutual understanding across health and social care, we again recommend that a duty is placed on ICSs so that where a decision by an ICS affects carers and the social care sector, the ICS must undertake a formal consultation with the groups and sectors affected. (Paragraph 114)***

102. ICSs are made of two components: Integrated Care Partnerships (ICP) and Integrated Care Boards (ICB).

103. The ICP is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. The ICP will provide a forum for NHS leaders and local authorities (LAs) to come together, as equal partners, with important stakeholders from across the system and community. Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for their populations – including carers - for which all partners will be accountable.

104. The Health and Care Bill also includes a proposed duty on ICBs regarding public involvement and consultation.

105. This duty requires ICBs to make arrangements to secure that individuals to whom the services are being or may be provided, and their carers and representatives, are involved in the planning of commissioning arrangements in areas that may impact the manner in which services are delivered, or the range of services available.

106. NHS England have published preparatory implementation guidance - subject to Parliamentary passage - for Integrated Care Systems. The guidance '*Building Strong Integrated Care Systems Everywhere'* is focused on working with people and communities. This guidance makes it clear that

ICSs should look to put the voices of people and communities at the centre of decision-making and governance at every level of the ICS.

107. The duties proposed in legislation alongside the guidance are appropriately extensive to ensure that relevant groups, including in the care sector, receive appropriate representation and involvement where decisions are being made that could affect them.

108. The integration white paper, published on 9 February 2022, is the next step in our journey of joining up health care and social care for citizens to make a reality of integration in local areas. This is based on the learning of local organisations in recent years. The integration white paper builds on reforms in the Health and Care Bill to accelerate progress in collaborative planning, pooled or aligned funding and a person-centred approach to service delivery. Further joining up health and care will help improve the quality and experience of care for individual patients, service users and carers.

109. The white paper benefited enormously from the thoughts and insights of a wide range of stakeholders, including local government. We included in the white paper a number of questions relating to implementation to support further dialogue with stakeholders and to shape the implementation process.

110. In response to the feedback, we received as part of this process (closed 7 April), we are now putting in place arrangements for the further development of this agenda to build on what we have heard in response and will be engaging with a wide range of stakeholders from organisations to citizens, in the implementation phase.

111. The expertise and input of partners across the health and care systems will be essential to ensuring the policies in the white paper are a success. We will work with partners to determine how best to deliver the policies.

112. This white paper sets out our approach to designing a shared outcomes framework and single accountable person for shared outcomes. This will support local organisations to work closer together to jointly prioritise the things that matter most for people locally. We will work with partners and stakeholders to ensure all places will identify a single accountable person by Spring 2023.

113. This means organisations including local authorities and the adult social care sector, can better collaborate towards a shared purpose which involves person-centred care ensuring more of the population live healthier lives for longer.

114. The white paper also sets out our policy vision on the key enablers of integration (workforce, digital and data and financial pooling and alignment, oversight and leadership) to enable better joined-up care. We will work with

partners and key stakeholders to have to have a single digital care record which all citizens, caregivers and care teams can all safely access.

115. The white paper is clear that in order to make integration a reality, the local area must consider integration in a way that meets their local needs. Integration will happen at a local level – central government's role is in facilitating and supporting that, ensuring the right structures, accountability and leadership are in place.

***NHS England must produce its roadmap in response to the Wade-Gery report on Putting data, digital and tech at the heart of transforming the NHS at the earliest opportunity so that we and others are able to scrutinise it ahead of implementation. (Paragraph 119)***

116. The Wade-Gery Review made a series of recommendations that cover operating model, skills and capabilities, financial incentives and funding flows, and digital inequalities. We are working with the relevant teams across NHSE/I, NHSD, Cabinet Office and the Treasury to develop plans to implement these recommendations in the upcoming months. Some of our implementation timeframes have been dependent on the passage of the Health and Care Bill through Parliament.

117. The department is working with NHSE/I on the recommendations set out in the Goldacre Review. This review provides 185 wide-ranging, and well-evidenced recommendations. The review is informed by interviews, open sessions and deep dives with more than 100 stakeholders throughout academia and healthcare. The government's initial response to the review will be included in the upcoming Health and Social Care Data Strategy, which will set the direction for the use of data in a post-pandemic healthcare system.

118. Many of the recommendations made in this report are aligned with our existing programmes. This includes work to improve the analytical capability and career trajectories in the NHS, as well as to implement Secure Data Environments as the default way of access to NHS data for research and analysis. In addition, over the next three years, NHS England, DHSC and BEIS will invest up to £200 million to improve how health and care data is collected, stored and accessed. A significant part of this investment will be used to develop Trusted Research Environments, a type of Secure Data Environment. This builds upon the review's recommendations to have secure online platforms where data can be accessed whilst maintaining the highest levels of privacy, to protect sensitive information. These secure spaces will only be accessed by verified researchers, as recommended in the review.

***We have previously recommended that Care Quality Commission ratings include an assessment of the progress ICBs make on the integration of information technology between primary care, secondary care, and the social care sector. We repeat this recommendation here. Although the CQC is an independent body, we believe that including the delivery of integrated care and the effective use of technology within the domains it inspects would encourage further progress on integration. (Paragraph 126)***

119. The government fully supports the interoperability of health and care IT systems to ensure that health and care data can flow between different IT systems and organisational boundaries in the health and care system, for the benefit of individuals and their outcomes. This is of particular importance as we aim to establish more system approaches and greater integration across health and care services.

120. The Care Quality Commission (CQC) intend for its assessments to consider the progress ICSs make on promoting the integration of information technology, particularly between primary, community and secondary care and the social care sector. The CQC has experience in assessing integration of technology through its previous work, including its Provider Collaboration Reviews and Local System Reviews. The use of health and care data will continue to be subject to data protection law.

121. We will work closely with the CQC, NHSE, and others to ensure there is robust oversight in place to support local areas to deliver on the proposals in the integration white paper.

***We recommend the Government creates a platform to share examples of good practice and innovation at ICB level so that lessons can be learnt, and practices adapted in ways that reflect the health needs of local areas. Without this, the risk of regional inequalities in waiting lists and postcode lotteries will continue. (Paragraph 127)***

122. The government recognises the importance of ensuring best practice innovations are shared effectively through the health system, however, it is not necessary for the government to create a platform on behalf of Integrated Care Boards (ICBs).

123. As set out in the government's response on page 7 of this document, ICBs will adapt and change in accordance to best practice and the needs of local populations.

124. Further, the Accelerated Access Collaborative (AAC), the umbrella organisation overseeing the health innovation ecosystem, is working with NHS partners to help ensure research and innovation objectives are embedded within the proposed ICB structure. For example, as articulated in their job descriptions, there will be a clear requirement placed on ICB Chief Executives and Chairs to foster a culture of innovation.

125. NHSE/I is also undertaking work to ensure ICBs collaborate and share best practice and is creating forums in which they are able to share information.

126. The government also recognises that local areas have been affected by Covid-19 differently and are starting from different points. The approach the Department is taking intends to level-up every area, while supporting those that can go further and faster to do so.

127. Throughout the delivery of this plan the NHS will involve people and communities at all levels. We will ensure a 'fair recovery' is at the core of our approach, with a particular focus on equity of access, experience and outcomes for the most deprived 20% of the population and the five clinical areas of focus set out in '*Core20PLUS5*' where we know we can make the greatest difference (maternity, severe mental illness, chronic respiratory disease, cancer and hypertension case-finding).

128. We aim to ensure that the right prioritisation decisions are being made in a consistent way, according to clinical urgency and to reduce the longest waits and deliver the best outcomes for patients on the waiting list.

129. As planned services are restored it is essential that they are opened up to all. To support this, NHS systems will be required to analyse their waiting list data by relevant characteristics including age, deprivation and ethnicity and by specialty. This will enable them to develop a better understanding of local variations in access to and experience of treatment, and to develop detailed clinical and operational action plans to address any inequalities in treatment.

130. The development of a national Health Inequalities Improvement Dashboard will support systems to pinpoint disparities in waiting times based on ethnicity and deprivation, enabling the NHS to take concerted action.

***We again recommend that a duty be placed on ICBs for them to have regard to mental health and public health. (Paragraph 128)***

131. The government is committed to supporting everyone's mental health and wellbeing and to ensuring that the right support is in place. The government also recognises the importance of public health. The current references in the Bill to 'illness' and 'health' cover both mental and physical health.

132. In exercising their commissioning functions under section 3 and 3A of the National Health Service Act 2006, Integrated Care Boards must act consistently with the Secretary of State's duty to promote a comprehensive health service in England, to improve mental as well as physical health.

133. The Bill includes a duty on ICBs to arrange for the provision of services or facilities for the prevention of illness, the care of persons suffering from illness, and the aftercare of persons who have suffered from illness as they consider appropriate as part of the health service. This broad duty includes physical, mental, and public health.

134. The Bill includes a further duty on ICBs to obtain appropriate advice for enabling the effective discharge of its functions, in particular from persons with expertise in the protection and improvement of public health.

135. At Lords Report stage, the government introduced amendments to ensure each ICB considers the skills, knowledge and experience it requires of its members to discharge its functions, and where there are gaps, consider what steps it can take to mitigate them. This should provide confidence that ICBs will have membership with relevant experience to ensure mental health and public health are properly considered. NHS England will publish statutory and non-statutory guidance to ensure that NHS bodies, including Integrated Care Boards subject to passage of legislation, are clear about their responsibilities for both mental and physical health, echoing the Secretary of State's duty in section 1(1) of the NHS Act 2006.

136. Further to this, the government also introduced a number of amendments at Lords Report Stage specifically relating to mental health. This included an amendment to clarify that references to health in the NHS Act 2006 include mental health.

137. The government also introduced a further amendment to require the Secretary of State to annually publish and lay before Parliament, before the start of each financial year, a document setting out a government expectation on mental health spending for the year ahead by NHS England and Integrated Care Boards (ICBs). NHS England and ICBs will also be required to include information about such spending in their annual reports.

138. ICBs, like Clinical Commissioning Groups, will be expected to report on how they have discharged their commissioning functions and will be assessed by NHS England and NHS Improvement.

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