Government response to the House of Commons Health and Social Care Committee's seventh report of session 2022 to 2023 on 'Integrated care systems: autonomy and accountability'

June 2023

CP 860

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

June 2023

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Introduction

This is the government's formal response to the recommendations made by the Health and Social Care Committee (the committee or HSCC) in its report, Seventh report - Integrated care systems: autonomy and accountability, published on 30 March 2023.

The government welcomes the committee's report and we are grateful to everyone who contributed their time and expertise to the inquiry, and for the recommendations on ensuring that integrated care systems (ICSs) are delivering for their populations. It was encouraging to hear the witnesses and their recognition of the enormous importance and potential of ICSs.

This document also sets out our response to the recommendations made in the Hewitt Review, which was commissioned by the government in November 2022 and published shortly after the committee's report on 4 April 2023. The government is grateful to the Rt Honourable Patricia Hewitt for chairing the review and welcomes the extensive engagement that it facilitated. There are some linked recommendations in the Hewitt Review and the committee's report, with several overlapping themes including ICS oversight, national targets and role of the Care Quality Commission (CQC). We have considered the related recommendations together to ensure we provide a comprehensive response to the committee and clarity to systems. The recommendations in the Hewitt Review cover some additional distinct themes, the response to which is annexed to this command paper.

ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live in their area. ICSs have evolved from voluntary partnerships since they were first launched by NHS England as sustainability and transformation partnerships in 2016. Since then, they have evolved to bring together NHS organisations, local government, and others to plan, innovate and address long standing delivery challenges. The Health and Care Act 2022 changed the statutory framework by establishing integrated care boards (ICBs) and integrated care partnerships (ICPs, a statutory joint committee), to bring together the NHS, local authorities and other partners.

The challenges faced by the NHS, local authorities and other partners, and the implications of these for the future of health and care, are significant and shared. ICSs hold enormous promise and bringing together partners from across the health and care system through ICSs is a unique opportunity to make meaningful long-term improvements to populations' health and wellbeing. ICSs are vital to future delivery and improvement in health and care and the government is committed to doing all it

can to support their success. ICSs have been designed to do things differently. They have been established to encourage and enable a truly whole-system approach to delivering core NHS commitments (where NHS England will clearly play a strong supportive role) integrating health and social care services and improving population health, by reinforcing and extending partnership working between NHS organisations, local authorities, the VCSE sector (voluntary, community, and social enterprise sector), the independent sector and others.

The government is committed to fostering the success of systems and will be particularly interested in supporting ICSs make these wider connections work well. We will do this by setting clear priorities, putting in place the right support and enablers and addressing barriers to progress and joint working. While strategic, at-scale planning is carried out at the ICS level, much of the activity to integrate care, improve population health and tackle inequalities will be driven by commissioners and providers collaborating over smaller geographies within ICSs called places. Places are the engine for delivery and reform. There is wide agreement that collaboration and innovation at place will be vital to delivering more efficient and joined up services, and the success of ICSs as a whole. Place-based partnerships and health and wellbeing boards (HWBs) play a crucial role in understanding the needs of their local populations across all ages and we recognise that these needs vary greatly across places. The government will continue to champion the role of systems to work flexibly, innovate for their communities and share learning between systems. We have been continuing with plans to further develop the opportunities set out in the integration white paper - 'Joining up care for people, places and populations'. The government is making good progress in developing a shared outcomes toolkit that will support places to develop their own robust shared outcomes frameworks, with priorities and metrics that are directly linked to the needs of their local populations.

We are already seeing the benefits of ICSs. For example, ICBs have been operating as a point of co-ordination and management across the system – supporting trusts, facilitating mutual aid, ensuring alignment of community services and primary care so that acute pressures can be relieved – and working with partners in the care sector and local government to improve discharge.

The government is committed to supporting individuals to live healthier lives, and at the heart of this is improving access to and levelling up health and care across the country. ICSs were established to help improve outcomes in population health and to tackle inequalities; they now have a crucial opportunity to accelerate work on prevention and the wider determinants of health. In addition to focusing on long-term issues including prevention and health inequalities, ICSs will need to balance this with the public's rightful expectation that systems deliver improvements in access to health and care services. To ensure this, the government is building on the commitments in the NHS Long Term Plan through the Delivery plan for tackling the COVID-19 backlog of elective care, the Delivery plan for recovering urgent and emergency care services, the Delivery plan for recovering access to primary care, as well as the forthcoming major conditions strategy.

Autonomy and accountability should not be viewed as contradictory, good systems will be able to use their autonomy to organise themselves in a way that enables them to improve services and outcomes for their populations and give a good account of

that to local people, regulatory bodies and to government. The Health and Care Act 2022 provides for the CQC to review ICSs as a whole, including how well system partners are working together. CQC published its interim guidance in March which sets out the framework for its assessments of ICSs, focusing on the baselining period during which it will complete its first assessments of all 42 ICSs.

The government remains committed to the development of ICSs. Working through NHS England and other national bodies, we will engage with system leaders and stakeholders to share best practice, listen to feedback on how the current arrangement is working and if any changes are needed and continue to align efforts towards achieving better health and social care access and outcomes for their populations.

Theme 1: targets and priorities for ICSs

HSCC and linked Hewitt recommendations

1. **Targets for ICSs set by DHSC and NHS England should be based on outcomes. There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.**

2. **Linked Hewitt recommendations - ministers should consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.**

DHSC and NHS England acknowledge the importance of outcomes-based targets in driving improvements in health and social care services and agree that other measures and targets may be needed alongside outcomes to demonstrate progress or to address key issues of public concern. There are clearly areas of particular national importance where we will set both a future target and a trajectory towards it, but there will also be areas where it is appropriate for local systems to set their own targets or areas where there may be a future national target where it makes sense for local systems to determine their trajectory of delivery against it. DHSC has already committed to a UK-wide Levelling Up health mission to narrow the gap in healthy life expectancy (HLE) at birth between local areas where it is highest and lowest by 2030, and increase HLE by 5 years by 2035, as announced in the Levelling Up white paper. The public rightly expects improvements to access to health services as well as longer-term health outcomes, including getting a GP appointment, receiving routine treatments and procedures, and being able to rely on urgent and emergency services when needed.

We also recognise the benefit of the centre focusing on a small core set of priorities, which has been reflected in the reduction to 31 national NHS objectives within the 2023 to 2024 priorities and operational planning guidance, and will be reflected in the forthcoming mandate to NHS England.

3. **DHSC should explain the mechanisms that will ensure that progress is made against local priorities. It should set out how this compares to mechanisms used to measure progress against national priorities, alongside an assessment of whether this balance will support ICSs to meet their 4 main objectives.**

4. **Linked Hewitt recommendation - each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care.**

5. **Linked Hewitt recommendation - health overview and scrutiny committees (HOSCs) (and, where agreed, joint HOSCs) should have an explicit role as system overview and scrutiny committees. To enable this DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.**

An effective health and care system is able to respond to both national and local priorities for improving services and outcomes; and progress in delivering those priorities will need to be measured and accounted for. The framework created by the Health and Care Act 2022 provides for the Secretary of State to set national priorities for the NHS through the mandate to NHS England. NHS England uses its planning guidance to translate mandate requirements into operational requirements for the NHS. The recently published plans for primary care, elective backlogs and urgent and emergency care set out key current national priorities for NHS recovery.

ICSs bring together NHS bodies, local authorities and their partners to agree how the universal commitments to the public are best met in their areas, alongside any specific priorities for improving services and outcomes for their communities.

ICSs should be enabled to set a focused number of locally co-developed priorities and we have already taken meaningful steps towards this approach, for example, recent reforms to the Commissioning for Quality and Innovation (CQUIN) 2023 to 2024 guidance pivoted from wholly national targets to identifying a small number of clinical priority areas, allowing local areas to also prioritise locally co-developed priorities and targets.

Whole system planning is captured in the integrated care strategies developed by ICPs and the joint forward plans prepared by ICBs, and the plans of local authorities in the ICS area. These will be informed by joint strategic needs assessments and the joint local health and wellbeing strategies that describe the health needs across each ICS and the local priorities for addressing. These plans will support the delivery of the 4 purposes of ICSs as set out by NHS England:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

DHSC are also committed to publishing a shared outcomes toolkit to support the development of local outcomes.

Mechanisms to ensure progress of the national and local priorities and plans

The Department of Health and Social Care (DHSC), NHS England, CQC, health overview and scrutiny committees (HOSCs), HWBs, local Healthwatch and NHS bodies collectively have a role to play in governance and accountability across the health and care system to ensure national and local priorities are being progressed.

The Secretary of State's objectives for CQC's ICS assessments state that each assessment should refer to any relevant place-based, local, system-level or nationally-set strategies. As acknowledged by the Hewitt Review, ICSs vary considerably in size and architecture, with corresponding differences in what 'place' means. CQC will therefore consider how well each ICS is addressing strategic issues, and will continue to develop a sampling based approach to look at the effectiveness of place-based arrangements.

For the NHS, NHS England's oversight of ICBs and NHS providers is described in the NHS oversight framework 2022 to 2023. NHS England has a legal duty to annually assess the performance of each ICB in each financial year and publish a summary of its findings, taking into consideration how well they are carrying out their statutory duties. In conducting a performance assessment, NHS England must consult each relevant HWB as to its views on any steps that the board has taken to implement any joint local health and wellbeing strategy to which the board was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007. Also, An ICB must, in each financial year, prepare an annual report on how it has discharged its functions in the previous financial year.

HOSCs have legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. In July 2022 DHSC published guidance that sets out the expectations of DHSC, the Local Government Association (LGA) and the Centre for Governance and Scrutiny on how ICBs, ICPs, and local authority HOSC arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities. In addition, we plan to refresh the guidance later this year to reflect the statutory changes made by the Health and Care Act 2022, and emphasise the HOSCs and joint HOSCs role in scrutinising systems; we will include examples of best practice and reflect existing statutory guidance for councils and combined authorities. This work will engage ICSs, NHS England, LGA, and the Centre for Governance and Scrutiny in its development.

DHSC will work closely with local government and ICSs to identify how to support HOSCs to carry out their roles in a way that supports outcome focused, balanced, inclusive, collaborative and evidence informed overview and scrutiny of ICSs. This support could include providing necessary resources, guidance, and expertise to HOSCs.

The Office for Local Government (Oflog) will also bring together meaningful data to provide a transparent and authoritative source of information about the performance of local government. As it develops over time, its aim is to enable central Government, local leaders and citizens to make meaningful comparisons between local authorities in relation to their adult social care and public health performance.

6. **Following engagement with ICSs and being conscious of the space required for local priorities, DHSC and NHS England should issue guidance with additional detail on what ICSs are expected to achieve within each of the 4 core purposes. As we have said previously, the focus here should be on outcomes and not dictating to ICSs how they achieve the goals.**

As set out above, the combination of the mandate to NHS England, NHS England's planning guidance and system planning provide a complementary and aligned set of processes to deliver on the 4 core purposes of ICSs. This will allow for the right balance between clarity of national requirements and local innovation and flexibility.

ICSs will combine the national targets and requirements for the NHS that flow through the mandate and the planning guidance with local priorities rooted in the integrated care strategy generated by the ICP, incorporating local joint health and wellbeing strategies. The use of shared outcomes to provide purpose and to draw together partners to collaborate across organisational boundaries will also enhance delivery of local and national objectives. ICBs' joint forward plans will set out how each ICB will deliver both the national and local commitment and address ICSs' 4 core purposes.

DHSC has published guidance for ICPs on the preparation of integrated care strategies. NHS England issued guidance on preparing joint forward plans in December 2022, to support ICBs and their partner NHS trusts and foundation trusts to develop their first plans with system partners.

Theme 2: autonomy, leadership, and support for ICSs

HSCC and linked Hewitt recommendations

7. **The government and NHS England should set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders.**

8. **Linked Hewitt recommendation - NHS England should work closely with the LGA, NHS Confederation (Confed) and NHS Providers to further develop the leadership support offer.**

DHSC is working closely with NHSE and other partners to explore how current and future system leaders are best equipped with the right skills and behaviours to successfully lead their organisations in a fully integrated way. We accept the value of having a national leadership programme across health, care, and wider sectors.

The programme will be aligned with to the response planned to the independent review on health and care leadership led by General Sir Gordon Messenger, Leadership for a collaborative and inclusive future, published in June 2022. A senior advisory group across health and care has been brought together to advise and help to plan a 3 year roadmap of leadership and management support and development in response to this and other reviews.

Associated Hewitt recommendations

9. **In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement.**

The principle of this recommendation closely aligns with the approach taken by NHS England in the existing NHS oversight framework. NHS England has statutory accountability for oversight of both ICBs and NHS providers. In general, NHS England will discharge their duties in collaboration with ICBs, asking ICBs to oversee and seek to resolve local issues before escalation. In some exceptional circumstances, such as where enforcement action is required, NHS England will

intervene directly with providers. Should such intervention be required this will happen with the full awareness of the relevant ICB.

10. A national peer review offer for systems should be developed, building on learning from the LGA approach.

A national peer review offer should be developed by partners within the system, moving towards a more bottom-up, autonomous model of improvement and agreeing that this should build on learning from the approach developed by LGA.

There would need to be further consideration given to how peer review works as part of NHSE's wider improvement offer which includes shared learning for systems.

11. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions.

NHS England has published a new operating framework setting out how it will operate in the new structure created by the Health and Care Act 2022, following the establishment of ICSs and the merger of NHS England, NHS Improvement, Health Education England and NHS Digital to create a new organisation that is at least 30% and up to 40% smaller.

The framework was developed following engagement with system leaders and stakeholders. It describes the relationship between NHS England, ICBs, NHS providers and their wider partners and the principles guiding how they will work together. This includes working in a collaborative and inclusive way, with NHS England's national and regional teams continuing to co-design strategy, priorities and support offers with system leaders. NHS England continues to work closely with ICBs to design the arrangements for delegating further commissioning functions from regional teams to ICBs, following the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services.

12. The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.

Implementation is being supported by a very senior advisory group made up of staff from health, social care, local government, the third sector, patient representatives, networks, system leaders and think tanks. System leaders with significant experience from across health and social care and other sectors have been involved in design of all new initiatives. Learning around successful implementation of organisational change and new ways of working has also been sought from within health and other industries including retail, the military, logistics and catering, and incorporated into the team.

13. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA.

The ways of working described in NHS England's new operating framework reflect the change to system-based approaches to improvement and stronger partnership working.

In the framework NHS England describes its aim to co-create and secure co-ownership of strategy, priorities and plans both within the NHS and with wider partners, building on the close partnership working that already exists, as demonstrated through the establishment of ICSs and in developing the most recent planning guidance.

Theme 3: ICS governance, accountability, and oversight

HSCC recommendations

14. The Secretary of State should set out further detail about how he intends to empower MPs to hold their local ICSs to account and what performance measures he envisages being available to support this.

It continues to be the case that local leaders are best placed to make decisions about their local populations with fewer top-down national targets, missives and directives. That is why ICSs have greater devolved responsibilities than their predecessors. ICSs are accountable to the individuals and communities they serve. In addition, there are formal accountability arrangements for different partners of ICS that are defined in legislation and other supporting guidance, with local authorities held to account through local democratic processes and NHS organisations accountable to NHS England, which is in turn accountable to government and to Parliament.

As mentioned in response to recommendations 3, 4, and 5, Oflog will enable us to look across the totality of adult social care and public health services delivery by local government to gain a holistic view of local government performance in these areas. This will help to improve performance, leading to better real-world outcomes for local people and the areas they live in. NHS England segments ICBs and NHS providers according to the level of support they require on a scale of 1 to 4 under the NHS oversight framework and this data is publicly available. CQC assessments of ICS will provide independent assurance to the public and Parliament. DHSC and NHSE are committed to increased transparency of performance metrics and in November 2022, we started publishing practice-level appointment data for the first time, showing the length of time between when appointments are booked and when they take place. NHSE are also now publishing data on the number of people who had to wait over 12 hours from arrival at A&E, as set out in the delivery plan for recovery urgent and emergency care services. In this plan, we included a commitment to introduce a new discharge metric based on time from discharge-ready date to date of discharge and committed to start publishing data ahead of this winter; we also committed to develop and publish better data on the reasons for delayed discharges**.** DHSC are also working with the Department for Levelling Up, Housing and Communities (DLUHC), local government and Oflog to ensure that discharge metrics are included in the wider set of metrics that Oflog will use to assess local authority performance.

15. a) DHSC should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise, by 1 October 2023.

15. b) Once the data is gathered, DHSC should review it with a view to understanding whether the policy of keeping mandated representation to a minimum is producing the intended results and whether any specialties are especially under-represented. They should report the outcome of this work, and whether any further mandating is required, to the House.

ICBs are required to publish their constitution, which includes a list of ICB board members in accordance with the Health and Care Act 2022. ICBs have made board member information, including members' expertise and knowledge, publicly available on their websites. Keeping records of ICB membership centrally with DHSC will be duplicating efforts as all the information is publicly available. Where the ICB proposes a change to its board membership this will be discussed with the NHS England regional team as part of the constitutional amendment approval process.

The Health and Care Act 2022 sets out membership requirements of the ICBs that include representatives from NHS trusts, primary care and local authorities. However, the local areas can go beyond the legislative minimum requirements in order to address their local needs. Most ICBs have used this discretion and appointed additional members such as members for public health, VCSE representatives and others based on their local area needs.

DHSC will continue to work closely with NHS England and ICBs to ensure that the current arrangements are working.

16. NHS England should provide more clarity about what ICSs should expect in terms of the monitoring of partnership working and how this will be assessed in ICB annual assessments.

As part of the NHS England ICB annual assessment process, there is an expectation that ICB partnership arrangements will be discussed as part of ongoing support and oversight relationships with consideration of how these are working. This is informed by feedback from stakeholders including health and wellbeing boards.

NHS England does not have a remit to assess the partnership working across the wider ICS. Effectiveness of partnership working across the wider ICS will be assessed by CQC through its new role undertaking ICS assessments.

17. DHSC, working with ICSs, should clearly set out what action could be taken, be that by the CQC, NHS England or others, to resolve issues of poor partnership working, in particular with adult social care.

The Health and Care Act 2022 requires that all partners of ICS including the ICB, local authorities, NHS providers, social care providers, charities and other

organisations work together to provide more joined up care for people and improve the outcomes for their populations. Where relationships between partners are challenging, the legislation is designed to ensure they resolve those issues together at ICS level.

This is further reinforced by the duties to co-operate placed upon NHS and local authority partners by the NHS Act 2006. If there are persistent issues between partners, national bodies, including DHSC and NHS England, will work together to provide further support.

CQC will play an important role in assessing systems as a whole. The development activity for these assessments is underway and CQC plans to pilot its approach later this year, before beginning formal ICS assessments by the end of quarter 4 of the 2023 to 2024 financial year. CQC assessment reports will clearly set out required improvement and best practice. Following the report, system partners (ICBs, local authorities, providers, provider collaboratives and place partnerships) are expected to come together through a local system improvement summit to review assessment findings and publish action plans, which CQC will monitor.

While local government remains accountable to local electorates, the Health and Care Act 2022 also includes provisions for CQC to assess local authorities' delivery of their adult social care duties, as set out under Part 1 of the Care Act 2014. Through these assessments, CQC will identify areas that require improvement, areas of strength, and report on this to help drive sector-led improvement. New powers introduced in the Health and Care Act 2022 will enable the Secretary of State to intervene to secure improvements when a local authority is failing to discharge its duties under the Care Act 2014.

NHS England holds the regulatory powers to take necessary formal enforcement action if an ICB or NHS provider has failed or is at risk of failing to perform their duties or meet required standards and this includes duty to cooperate as placed by NHS Act 2006. ICBs are accountable to NHS England via their oversight framework.

Associated Hewitt recommendations

18. An appropriate group of ICS leaders (including local government, VCFSE and other partners as well as those from the NHS) should work together with DHSC, DLUHC and NHS England to create new 'high accountability and responsibility partnerships'.

DHSC supports the intent behind the recommendation and will undertake further work as ICSs mature to understand how it could be implemented in practice.

The provisions in the Health and Care Act 2022 are enabling, permissive and flexible, allowing the NHS and wider health and care system to respond to the needs of their populations. We want to empower local health and care leaders to pursue new and innovative ways of delivering for the people and communities in each part

of the country, and we support measures designed to promote further collaboration in systems and places.

It's important to recognise that ICBs and ICPs are still in their infancy, having been placed on a statutory footing less than a year ago, and are still finalising their first joint forward plans and integrated care strategies. We want to help ICSs to grow and develop in the self-supporting way that is envisaged in the review. But we need to consider further the most appropriate way of achieving this aim and how we can enable systems that are more advanced to go further and faster, giving them the flexibility and space to do this, whilst ensuring our approach is embedded across system partners.

Ensuring that we maximise the ability to improve and make decisions for the most advanced systems is an important challenge as systems improve and mature. More work needs to be undertaken to consider how partnerships of the kind described in the Hewitt Review might work in practice.

19. **NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.**

The new NHS England operating framework sets out a commitment to working collaboratively with systems to support effective system working. NHS England will work with ICB leaders to consider how to best support ICBs to mature, building on the co-design approach that has been used to support the development of ICSs so far.

20. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

DHSC is working closely with NHS England on the development of a new very senior manager (VSM) pay framework which will ensure that senior manager pay is set at the right level.

The new framework aims to improve consistency and transparency of VSM pay setting processes and will be made publicly available. Local NHS trusts and ICBs will therefore be able to review the framework directly when deciding on individual pay proposals. This will enable trusts and ICBs to ensure that pay cases are compliant with the framework, thereby simplifying the approvals process for cases requiring DHSC oversight.

Internal processes for official clearances have also been streamlined in order to improve approval times. We will continue to work with NHS England on this.

Theme 4: assessments and reviews of ICSs

HSCC and linked Hewitt recommendations

21. **DHSC should urgently provide the CQC with its decision on ratings and any priorities it would like the CQC to focus on. It should also communicate to ICSs what methods will be used to address any areas of concern that assessments might raise. ICSs should be given fair notice about this, and the CQC may need time to incorporate this into their approach, so it is imperative that this clarity is provided before the bulk of the CQC's assessment work begins.**

22. **Linked Hewitt recommendation - as part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors (set out on page 58).**

We support the vision set out in the Hewitt Review (paragraphs 3.117 and 3.118) and will consider the best approach regarding ICS ratings. This would build on existing plans and development work led by CQC and include ratings on the quality of services within the ICS across the key domains of care and ICS leadership; and we agree that the highest ratings would not be given to a system where the financial position is not being well-managed. DHSC and CQC will work with NHSE and other partners to develop these measures and CQC will start to test the ratings as suggested by the Hewitt Review (paragraphs 3.117 and 3.118) in 2024 to 2025. DHSC and CQC will also consider the factors listed on page 58 of the Hewitt Review.

The Secretary of State has now set objectives and priorities for both CQC's assessment of local authorities' exercise of their Care Act functions and of ICSs.

23. DHSC and NHS England should review existing regulatory assessments for ICSs with a view to ensuring there is as little duplication as possible. We recommend this work is done alongside the Department for Levelling Up, Housing and Communities given their role in local authority assurance.

24. Linked Hewitt recommendation - NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.

ICBs are accountable to NHS England, which will undertake annual performance reviews to assess how well each ICB has discharged its statutory duties. CQC's assessments of ICSs will look at the whole system.

CQC is continuing to work with NHS England in developing its approach to ICS assessment, to ensure alignment with NHS England's annual assessments of ICBs, including sharing evidence and information. CQC will test working arrangements with NHS England during its pilot assessments.

DHSC has worked closely with DLUHC, CQC, the LGA and ADASS to design a local authority assessment approach that minimises burdens on local authorities.

CQC will assess providers, local authorities and ICSs under a single assessment framework, providing a consistent and accessible means of ensuring safe and high-quality care at all levels. It will seek to avoid duplication: for example, a local authority should not have to provide the same information as part of a local authority assessment and again as part of an ICS assessment.

Theme 5: prevention and promoting health

HSCC recommendations

25. NHS England should provide an update on whether they intend to refresh their 2019 Long Term Plan and, if so, when. Any update to NHS England's Long Term Plan must put prevention and long term transformation at its heart, empowering ICSs to pursue these priorities and giving them the confidence that they have the necessary backing from the government and NHS England. This should also apply to the government's pending major condition's strategy.

The overall aims of NHS England's Long Term Plan remain the right ones and these strategic aims are reflected in planning guidance, service specific plans and work with systems. DHSC and NHS England continue to work together to monitor commitments in the plan on an ongoing basis.

The government is building on the commitments in the NHS Long Term Plan through the Delivery plan for tackling the COVID-19 backlog of elective care, the Delivery plan for recovering urgent and emergency care services, 'Delivery plan for recovering access to primary care' , as well as the soon to be published Long Term Workforce Plan and the major conditions strategy.

It is crucial that ICBs take a life course approach to reducing health inequalities. In order to tackle health disparities and enable more people to live healthy lives, we need to work together to give every child the best start in life, from pregnancy through to late adolescence. System plans should include a clear articulation of the needs of pregnant women, babies, children and young people within their population, and how those needs will be met through collaboration across the system.

On 24 January 2023, the government announced a new major conditions strategy with an interim report planned for publication in the summer. The strategy will set out a strong and coherent policy agenda that sets out a shift to integrated, whole-person care. Interventions set out in the strategy will aim to alleviate pressure on the health system, as well as support the government's objective to increase healthy life expectancy and reduce ill-health related labour market inactivity.

The strategy will outline that we need to shift the health system's model towards preserving good health, and the early detection and treatment of diseases. We have a proud record of opening new treatment possibilities in the NHS. Diseases that were once a death sentence have become conditions that can be managed over the long term. By harnessing innovation and technology we are increasingly capable of

detecting diseases at an early stage, in some cases before symptoms emerge. Intervening at this point will reduce demand downstream on health and care services.

The major conditions strategy will apply a geographical lens to each condition to address regional disparities in health outcomes, supporting the levelling up mission to narrow the gap by 2030.

Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together. The Strategy will set out the supporting and enabling interventions DHSC and NHS England can make to ensure that ICSs and the organisations within them maximise the opportunities to tackle health inequalities. In addition, as outlined in response to recommendation 26 (below) the government will continue to work to empower local leaders to improve outcomes for their populations.

26. DHSC should publish, as soon as possible, the proposed shared outcomes framework and more information about how and when ICSs should expect it to be implemented.

We welcome the committee affirming the importance of local outcomes and will maintain this focus in the development of a shared outcomes toolkit that will support places to develop their own robust shared outcomes, with priorities and metrics that are directly linked to the needs of their local populations.

Working with stakeholders across government departments, national organisations, systems, and places we have heard that many place-based partnerships have made progress in developing their own local shared outcomes and that adding additional national metrics could detract from the positive work done to date.

However, it is right to consider how local priorities align with national outcome measures. The NHS priorities and planning guidance and NHS mandate will continue to set the priorities for the NHS, and we recognise there may be potential benefits in reducing the number of priorities contained in these documents in future iterations. Adult social care and public health will continue to have their priorities set via the Adult Social Care Outcome Framework and the Public Health Outcomes Framework, and we will keep the need for additional national shared outcomes under review, to ensure our ambition for places is achieved.

We will work closely with other government departments to make sure that central ambitions for local outcomes are joined-up, especially where departmental responsibilities intersect.

27. To guarantee a continual focus on the prevention agenda, all integrated care boards should ensure they include a public health representative, such as a public health director or public health lead. In 12 months, DHSC should conduct a review to understand the extent to which this is happening. If necessary, further steps should be taken to mandate the inclusion of a public health representative so the focus on prevention is not lost.

We agree that there should be a continual focus on the prevention agenda. ICBs are expected to ensure that directors of public health and their teams have defined positions at an ICS and place level, ensuring that ICB decision-making is made with public health input to take account of joint local health and wellbeing strategies in which the directors of public health have a key role in the design and/or sponsorship. While public health is and should remain a crucial role of local government, and may have been included through the recruitment of partner members on ICB boards, systems have the autonomy to appoint members based on their area's priorities.

Local authorities have a statutory duty to provide a public health advice service to ICBs to inform effective commissioning of healthcare and related matters (as required by regulations under section 6C of the NHS Act 2006). ICBs have a parallel duty to seek advice from appropriate persons on prevention and public health (under new section 14Z38 of the NHS Act 2006). Guidance for ICBs on delivering a quality public health function has been issued by NHS England, in partnership with the Faculty of Public Health, the Association of Directors of Public Health and the LGA, which strongly emphasises the need to work in close partnership with directors of public health and their teams. The Health and Care Act 2022 sets out minimum membership requirement of the ICB boards that include members from NHS trusts, primary care and local authorities. However, the local areas can, by local agreement, go beyond the legislative minimum requirements to address their local needs. It is important to grant ICSs the freedom to create the architecture and governance for their ICP and ICB that enables them to best serve their population.

Associated Hewitt recommendations

28. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required:

a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from arrange of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention

b) following an agreed framework ICSs establish and publish their baseline of investment in prevention

The government's immediate priorities for the NHS are clear and have been set out in our recovery plans for elective care, urgent and emergency care and primary care.

However, the government agrees that in line with the ambitions of the NHS Long Term Plan, over time the focus for the NHS should increasingly shift towards implementing evidence-based interventions to help improve prevention and support healthier life expectancy.

However, we do not agree with imposing a national expectation of an essentially arbitrary shift in spending.

To support investment in prevention, NHS England and DHSC will work closely with integrated care systems, local government partners and NICE to develop practical information and evidence to support local investment decisions. This will include considering the methodologies for developing an appropriate definition for preventative healthcare spending and exploring options for local baselining. Once this process has concluded we will make an assessment on publishing this information.

29. **That the government leads and convenes a national mission for health improvement. Support for the Health and Social Care Committee's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework.**

We have already committed to a UK-wide Levelling Up health mission to narrow the gap in healthy life expectancy (HLE) at birth between local areas where it is highest and lowest by 2030, and increase HLE by 5 years by 2035, as announced in the Levelling Up white paper. We have continued to deliver a core set of policy activities to support people to live healthier lives, help the NHS and social care to provide the best treatment and care for patients, and tackling health disparities through national and system interventions. Given that policies affecting many of the underlying drivers of health are the responsibility of departments other than DHSC, we have established the Health Mission Working Group to provide a forum for working with other departments to explore opportunities for cross-government action to drive progress on the health mission and support common interests.

Additionally, as set out previously, in the coming months we will publish a toolkit that will support all places to develop local shared outcomes frameworks, sharing best practice and examples to promote learning between systems.

30. **The government should establish a health, wellbeing and care assembly.**

There are already a range of forums available to ICSs to facilitate learning and sharing of best practice, for example through the ICS network, place-level support offers facilitated by the LGA, the NHS Confederation and NHS England. In supporting a focus on prevention, population health and health disparities, there is also a specific Public Health and Integrated Care Systems Forum convened and co-chaired by the NHS Confederation, LGA, and the Association of Directors of Public Health, meeting 6 times a year.

31. A national integrated care partnership forum should be established.

More work needs to be undertaken consider the most effective way of meeting this recommendation. There are existing forums for ICS leaders, government departments and stakeholders to come together, including those referred to above. We need to consider, with partner organisations, the most appropriate and efficient way of facilitating ICPs to convene at a national level without duplicating or replicating existing mechanisms. We will set out more details on this in the coming months.

Theme 6: finance and funding

HSCC and linked Hewitt recommendations

32. We welcome the minister's (Helen Whately) comments about giving ICSs information about the funding that will be available to them further in advance. DHSC must set out how it intends to do this, and any decision to give that information must be made in plenty of time to support ICS preparations for winter 2023 to 24.

33. Linked Hewitt recommendation - building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, I recommend:

a) ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements

b) giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this

c) national guidance should be further developed providing a default position for payment mechanisms for inter system allocations

a) The allocation of funding to ICBs to support them in commissioning services for their local population is one of the key duties of NHS England. NHS allocations, which are published during the NHS planning process, are distributed using an independent 'fair shares' formula. NHS England published allocations for 2023 to 24 to 2024 to 25 on 27 January 2023.

In advance of the publication of the 2023 to 2024 local government finance settlement (LGFS), DLUHC published a policy statement in December setting out forward notice of the measures to be included in the 2023 to 2024 provisional LGFS and those expected to be maintained into 2024 to 2025. The government's intention was for this to support councils' budget setting processes by giving them additional, multi-year certainty over their funding levels. For social care, this included setting out the adult social care precept referendum principle for 2024 to 2025 and reiterating the increase in grant funding as set out at the Autumn Statement.

However, funding may be required outside this standard process where certain priorities require in-year funding that is accompanied with reporting requirements. For example, between December 2022 and March 2023, DHSC provided £500 million of discharge funding to reduce the number of people delayed in hospital waiting social care.

We have listened to the social care sector and understand how important long-term certainty and visibility of funding is. That is why, in addition to the multi-year funding announced at the Autumn Statement, we published the details of the £600 million 2023 to 2024 Discharge Fund on 4 April 2023, to give local systems the maximum time to prepare ahead of winter 2023 to 2024. We have also confirmed that we will provide £1 billion of additional funding to reduce delayed discharges in 2024 to 2025. Similar funding may be ringfenced for a particular purpose to ensure adequate funding for a specific priority. Ringfencing in these cases provides the necessary means to control aggregated spending within control totals. DHSC recognises that should additional reporting requirements accompany future funding of this type, they should be proportionate.

Additionally, for 2023 to 2024 NHS England have significantly reduced both the number of separate allocations of service development funding (SDF) for specific change programmes, and the level of reporting required against those allocations. This includes reducing requirements for ICBs to report individually to different national programmes in order to receive their SDF allocations. This approach gives ICBs scope to make more decisions about how to deploy their funding locally. We intend to maintain and develop this 'bundling' approach into 2024 to 2025.

Building on this progress, significant improvement will continue to be made to reduce the prevalence of in-year funding, particularly where it entails substantial and potentially onerous reporting requirements on systems. We recognise the importance of providing systems with certainty, often providing funding on a recurrent or multi-year basis, such as the commitments regarding the building of new hospitals. The introduction of ICSs has provided systems with greater freedom and autonomy to determine how best to deploy their resources to meet local needs and, with this in mind, in-year funding should be limited to situations where it is absolutely necessary.

b) DHSC agrees in principle that systems should be provided with sufficient flexibility to determine allocations for services and appropriate payment mechanisms, particularly to meet the needs of their local population. However, we believe that there are circumstances that warrant payment system incentives to encourage a particular activity; elective care, promoting value for money, and patient choice are all supported by common payment mechanisms.

We feel that significant opportunities to take account of local variation currently exist in the Payment Scheme, even where payment system incentives are used. For instance, under the current NHS Payment Scheme (NHSPS), providers and commissioners must agree a fixed payment covering delivery of all services outside the scope of the Elective Recovery Fund (ERF), as well as operate a payment-by-activity mechanism with defined prices for all activity within scope of the ERF. Systems have flexibility for the level at which they agree the fixed element. Further, where a system wants to deviate from the fixed or variable payment arrangements, they can apply to NHS England to have these variations approved. There is, therefore, already a degree of flexibility in how payments are agreed. As such, alterations to the payment scheme for this reason are not required.

NHS England runs regular engagement sessions with the sector and as part of this, seeks to understand what improvements can be made to the NHSPS. This engagement would cover what flexibilities could be offered to help better flow funding inside a system, including any barriers, perceived or real, that the payment scheme may have created to better joined-up working. These recommendations feed into the development of future NHSPS' proposals, which are then tested through the formal consultation process.

In the context of ensuring flexibility, we agree that ringfencing and hypothecation should be limited, but again note that ringfencing is necessary in some circumstances to secure adequate funding for a particular priority, for instance the Mental Health Investment Standard.

c) The NHS Payment Scheme (NHSPS), and associated technical finance guidance, does establish default payment approaches for inter-system funding flows. All activity within scope of the ERF is currently on a set national rule, which must be followed unless a variation has been agreed. For the fixed payment (which covers all activity not in scope of the ERF), NHS England issued guidance alongside planning to set default growth rates for inter-system contracts. Therefore, NHS England believes that there is already a high degree of specificity/defaults for inter system payment arrangements.

DHSC further recognises and appreciates the importance of strong analysis when determining local resource allocations, as discussed in paragraph 5.18 of the Hewitt Review, we agree that a robust, analysis-driven understanding of value for money should play a central role in decision making.

34. DHSC should therefore review the funding and commissioning arrangements for Healthwatch, with a view to ensuring they are fit for purpose within the context of new ICSs, and support Healthwatch to have a clear voice. The outcome of this review should be reported to the House.

The government is committed to a health and social care system that listens to and acts upon the feedback of its users and we work closely with Healthwatch England to understand the important insights that their work can offer. We are in regular contact with Healthwatch England about the challenges the Healthwatch network faces and how they can improve their impact. We will continue to explore options for improvement and in doing so, the value of a formal review of Healthwatch is something that the government will keep under consideration.

Associated Hewitt recommendations

35. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the running cost allowance (RCA) for 2025 to 2026 financial year should be reconsidered before Budget 2024.

NHS England has set out its policy intent with respect to the delegation of services to ICBs and the transfer of associated budgets. In 2023 to 2024 NHS England completed the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services to all ICBs. This is accompanied by a transfer of funding, as well as a transfer of staff and functions from NHS England to ICBs. In 2024 to 2025, the intention is to begin formal delegation of specialised commissioning services and NHS England will continue to explore the delegation of further services and functions into the future where it is agreed that ICB-level commissioning is the optimal commissioning model.

As part of the 'creating a New NHS England' programme (following the merger of NHS England, Health Education England and NHS Digital), NHS England is also making significant reductions in the size of regional and national teams over 2023 to 2024 and 2024 to 2025.

The 10% cut in ICB RCA planned in 2025 to 2026 forms part of the 30% real-terms reduction per ICB by 2025 to 2026, which has been agreed with government and which forms part of NHS financial plans. NHSE's requested reforms within the Health and Care Act 2022 aimed to ensure that resource could be most effectively focused on the front line.

36. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop a consistent method of financial reporting.

DHSC accepts that effort should be made to establish standardised reporting across ICS organisations and local authorities to support public spending on key policy areas. However, there are practical challenges associated with defining, tracking and reporting spending on broad areas, such as spending on 'reducing health inequalities'. This will need to be explored further.

We will therefore establish a working group, including NHS England, system partners and local authorities, partnered with CIPFA, to provide recommendations to the Secretary of State on how to improve the ability of NHS England and local authorities to track and report on collective spending on key areas of expenditure. DHSC expects that part of this project will include how systems define spending on a particular area, understanding what data already exists and how it can be improved.

37. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

The government is committed to supporting local areas to work in an integrated way to plan care across their communities and agrees that having clarity over financial allocations is an important enabler of integrated working. We will work together across government to align the publication of allocations for social care, local government, public health and the NHS as much as possible, and to give as much notice as is feasible of allocations for future years. For example, the government has already published indicative allocations for the Public Health Grant for 2024 to 2025 to support systems to plan and is committed to publishing the confirmed 2024 to 2025 allocations before the end of this calendar year.

38. Government should accelerate the work to widen the scope of section 75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of section 75 arrangements.

DHSC is committed to facilitating greater integration of health and social care services. We want to encourage areas to use partnership arrangements and pooled budgets more widely to support further integrated models of service delivery. Pooled budgets are principally delivered through 2 sets of provisions in the NHS Act 2006. Firstly, the joint working and pooled fund arrangements under sections 65Z5 and 65Z6; and secondly, the provisions relating to arrangements between NHS bodies and local authorities under section 75, the route through which the Better Care Fund (BCF) is delivered. The BCF is one of government's key levers for integration; 94% of local areas agreed that joint working had improved as a result of the BCF in 2021 to 2022.

To support further integration of health and care services, we committed in the Integration white paper, 'Joining up care for people, places and populations', to review the section 75 legislation covering pooled budgets to simplify and update the underlying regulations where necessary.

This review is underway and includes exploring widening the scope of health-related services that could be included in these arrangements and giving consideration to expanding the range of organisations that can enter into these arrangements.

39. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

It is critical that ICSs are able to draw on a range of resources to support and incentivise improvement. As part of its role in supporting ICBs to deliver their plans, NHS England already makes a wide range of resources available to ICBs to enable systems to identify and realise productivity opportunities. These include (but are not limited to):

- benchmarking resources (for example, Model Health System, ICS cost benchmarking tool, NHS Spend Comparison Service
- guidance (for example, medicines value opportunities, guidance on temporary staffing, guidance on evidence-based interventions)
- toolkits, case studies and best practice (for example, GIRFT, Outpatient Recovery and Transformation programme, Digital Productivity programme)
- NHS Impact's (the new single, shared NHS improvement approach), has recently launched a web space which has been designed as a one stop shop for improvement resources, tools and activities
- a new Leadership for Improvement programme is being co-designed and established to ensure that NHS staff have access to entry level quality improvement training

NHS England will continue to work with systems to improve the range of existing resources, as well as develop new ones, to best support systems and organisations to deliver productivity and efficiency opportunities in different areas.

40. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify most effective payment models to incentivise and enable better outcomes and significantly improve productivity.

We recognise the importance of best practice in implementing innovative payment models across the country. As part of the NHS Payment Scheme development process, NHS England undertakes a significant programme of engagement with ICBs and other organisations in England, seeking to understand best practice and effective payment models. NHS England is also looking at international comparisons of different payment mechanisms and the resulting impacts they have.

41. There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

Taking into account that in 2021 the NHS capital regime was subject to full independent review and that we, together with NHS England, have continued to iterate every year in response to feedback from the NHS, we support this

recommendation in principle (for example, last financial year we raised NHS investment delegation level from £15 million to £25 million). We agree with the need for a review, particularly with respect to areas that were not already covered in detail by the 2021 review - specifically setting an overall strategic direction for NHS capital, considering how the current capital regime operates for primary care, clarifying the position on new private finance and improving the data held and management of the NHS estate. We will set out next steps in due course.

Annex: response to additional Hewitt Review recommendations

The committee will be aware that there were some additional recommendations in the Hewitt Review in relation to digital and data sharing and primary and social care workforce, which, although separate from the themes in committee's report, are pertinent to the system.

We are annexing the response sent to Rt Honourable Patricia Hewitt to these recommendations to the command paper to ensure system leaders receive a comprehensive response and can consider the government's response to both the reports in full.

39 Victoria Street
London
SW1H 0EU
Tel: 020 7210 4850

By email

13 June 2023

Dear Patricia,

Responding to the Hewitt Review: an independent review of integrated care systems (ICS).

The department welcomes your report into ICSs and thanks you and the co-chairs of the 5 work streams: Sam Allen, Rt Hon Paul Burstow, Felicity Cox, Dr Penny Dash, Adam Doyle, Sir Richard Leese, Dr Kathy McLean, Patricia Miller, Cllr Tim Oliver and Joe Rafferty for the work you put into developing it.

Both your report and the Health and Social Care Committee's report into ICSs were published around the same time and share linked recommendations and several overlapping themes including ICS oversight, national targets and role of CQC. The government is therefore providing a comprehensive and joined-up response to both the reports as this is most useful for the public, Parliament and the health and care system.

The department is laying a command paper in Parliament on 14 June 2023 to respond to the committee's report and this will respond to all the linked and associated recommendations across the 2 reports. There were some additional recommendations in your report in relation to digital and data sharing and primary and social care workforce, which, although separate from the themes in the committee's report, are pertinent to the health and care system. I have set out the government's response to these recommendations below. This letter will be added to the government's response to the committee's report so that the public and colleagues in the health and care system can see all of the responses in one place.

My department and I are grateful to you for chairing the review and in particular for the way in which you involved a wide range of colleagues from the health and care system in its development.

RT HON STEVE BARCLAY MP

Data and digital

42. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.

A plan for digital health and social care (June 2022) included milestones for setting standards on interoperability and system architecture that will enable all relevant health and care data to be accessible by those with a legitimate right to access it at the point of need, no matter where it is held.

Currently, NHS and publicly funded adult social care organisations in England must have regard to information standards. Changes made by the Health and Care Act 2022 - once commenced - will make information standards binding and extend them so that they also apply to certain private health and adult care providers. The changes will deliver these improvements by promoting interoperability between IT systems, making it easier for people delivering care to access accurate and complete information when they need it, and by supporting the use of data for purposes beyond direct health and care while protecting patient privacy.

In the interim, we have been working to support interoperability, through:

- launching the Standards Directory service for health and adult social care, which went into public beta in August 2022 - this is a digital service that ensures information standards are easily discoverable, supporting the needs of a community of standards adopters and creators
- publishing in January 2023, a clinical information standards roadmap, which is a list of proposed, developing or changing standards in health and care
- sharing examples of how open source approaches to code, community, governance and documentation can help teams develop, improve and promote their work through open source digital playbooks in February 2023
- developing mechanisms to track standards adoption, aligning levers and incentives for uptake and compliance by care providers and IT suppliers

DHSC and NHS England have invested £50 million in the Digitising Social Care programme (up to March 2023), with a further £100 million to be spent up to the end of March 2025. The programme is currently focussed on the implementation of Digital Social Care Records (DSCRs) across the adult social care sector. In Next steps to put People at the Heart of Care, we committed to ensuring care teams can access appropriate information easily and securely through interoperability standards. In January 2023 we published the standards and capability requirements that DSCR suppliers must meet to achieve assured supplier status. We have focussed on standardised existing terminology for social care and in defining standardised data fields for all DSCRs. By January 2024 for example, DSCR suppliers are required to ensure care providers have visibility of core patient information via 'GP Connect'. We are linking with work already underway to use standards to support information sharing and interoperability, such as that on the NHS Data Standards directory.

43. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the data saves lives strategy (2022)

Data saves lives contained a commitment to engaging with stakeholders and the public on understanding the potential for changes to The Health Service (Control of Patient Information) Regulations 2002 to facilitate timely and proportionate sharing of data. This is a complex issue, and we will engage further this year to determine the best approach. This may include revising the regulations, which would proceed subject to the Parliamentary timetable. Other actions may also achieve the same impact on the effective and secure sharing of data.

In relation to the use of health data for research, the government recently committed, in response to Lord O'Shaughnessy's review into commercial clinical trials in the UK, published in May 2023, to (1) streamline the process of approaching patients about research, and (2) establish the means by which the public should be consulted.

44. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.

NHS England recognise the importance of partnership working to achieving the ambitions of the Data Alliance Partnership, which aims to maximise the benefits from using and sharing data already held in health and care systems to minimise the burden of collecting more data from frontline service providers.

The Data Alliance Partnership Board, chaired by NHS England, has responsibility for the assurance and approval of information standards, data collections and data extractions (collectively known as information standards and data collections) across all health services and adult social care. NHS England will work with system representatives to review the membership of the board and understand how best to involve digital and data leaders from across systems.

45. Building on the existing work of NHS England, the NHS App should become an even stronger platform for innovation, with the code being made open source to approved developers as each new function is developed.

In A plan for digital health and social care (June 2022) we highlighted the importance of supporting industry innovators by making it simpler to collaborate with health and care system partners.

One of the ways in which NHS England seeks to achieve this is through taking an open source approach where appropriate. We operate an open architecture for the NHS App and have open sourced 2 of its core components to date; integration with the NHS login and the integration components ('integration in a box' - for example,

suppliers can download a self-contained version of the NHS App to install on their local network, to allow development teams to integrate their code and test their planned concept quickly and easily). All code that is open sourced is published on the NHS England website. As we continue to develop the NHS App we are committed to continuing this approach of open sourcing elements of the code that are most useful for others to have access to.

46. The government should set a longer-term ambition of establishing citizen health accounts.

Research shows that increasing numbers of patients want easy access to health information about them, including 80% of the 32 million NHS App users. There is also widespread international consensus about the benefits to patients and the effectiveness of the health system to provide digital on-demand access to personal health information.

The NHS is making exciting progress in allowing patients to access the health information in their GP record digitally via the NHS App. Since December 2022, GP practices have started to enable patients to access new health record entries online, as part of a phased rollout. To date the rollout of full prospective record access by default is now one in 5 practices, with 6.5 million patients already able to see their prospective records and 100 million views of patient information (including pathology information). To make it easier for patients to access their health information online without having to contact their practice, the GP contract has now been updated so new health information is available to all patients (unless they have individually decided to opt-out or any exceptions apply) by 31 October 2023 at the latest.

Work is ongoing to consider further changes to the NHS App and explore the legal and commercial implications of implementation.

47. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability. In particular:

a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking situation report (sitrep) and other reported data directly from the Federated Data Platform (FDP) and other automated sources, replacing both sitreps and additional data requests

b) data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis

c) data collection should increasingly include outcomes (including, crucially, patient reported experiences and outcomes) rather than mainly focusing on inputs and processes

d) data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

DHSC supports the spirit of this recommendation and is already making progress in several ways.

We are reducing the burden on services which provide information for these different uses, through better strategic co-operation between the key stakeholders, and through judicious use of the latest technology. The central organisations which oversee health and social care delivery are increasingly working together to remove any duplication in data collections. The Data Alliance Partnership brings together key organisations to maximise the benefits of sharing data already held in health and care systems and to minimise the burden of collecting more from frontline services. The philosophy is to collect once and use for multiple purposes.

It is important that NHS England, DHSC, ICSs, and CQC - and other key stakeholders responsible for the oversight of health and social care - should have equitable access to high-quality information, in its broadest sense, to ensure the accountability of services, and to support their continuous improvement.

The types of data, the level of detail, and those who need to see and analyse it, will depend on the different use cases (care for our patients; improving population health; planning and improving services including for regulatory purposes; researching new treatments, and finding new ways to deliver services), and the legal

basis on which the data was accessed. It is essential that people have confidence in how their data is used, and that access and analysis is subject to the highest standards of data protection, and in particular, that only those who need to see the data do so, and that the data is appropriately protected. NHS England has made 5 data promises, articulating their safeguards.

A core commitment within the data saves lives strategy, was to move to a system of 'data access as default' for the secondary uses of NHS health and social care data; facilitated by the implementation of secure data environments (SDEs) across the NHS in England. Guidance will continue to be published by DHSC and NHS England to support this transition, such as the SDE Policy guidelines and the recent consultation on the draft policy update. As part of delivering this commitment, some DHSC analysts are already able to access data within the NHS England National SDE, ensuring they use the same platform as other users (such as academic and industry researchers), for automated, accurate, secure and high-quality data access.

NHS England is also currently procuring the Federated Data Platform. This will connect existing data and IT systems, making it easier for staff to access and link the information in those systems, in one safe and secure environment. It will allow access to information across different systems which haven't previously been able to easily communicate with each other, to give a comprehensive picture of activity and outcomes, and to use the data to deliver improvements. It will reduce the reporting burden on frontline staff. The software will be 'federated' across the NHS. This means that every hospital and ICS will have their own version of the platform which can connect and collaborate with other data platforms as a 'federation' – making it easier for health and care organisations to work together, to compare data, benchmark, and analyse it at different geographic, demographic and organisational levels.

NHS England and DHSC have committed to a review of data collections. DHSC and NHS England are also keeping under review the directions made to NHS England (and previously, to NHS Digital) by the Secretary of State for Health and Social Care, for establishing information systems (Directions, Section 255 Requests and Data Provision Notices).

Primary and social care

48. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

As set out in the Delivery plan to recover access to primary care, published May 2023, we will engage on the future of primary care. Over the course of 2023 to 2024 government and NHS England will engage with the profession, patients, ICSs, and key stakeholders to build further on the Fuller stocktake report. We want to work with the profession and engage on the development of the future general practice contract.

49. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

It is important to acknowledge the structural differences between the NHS and the largely independent sector adult social care market, where core responsibilities for workforce planning and market shaping sit with local authorities. Local government has a key role to play in supporting recruitment and retention in their areas, utilising their oversight of local systems to identify workforce shortages and develop workforce plans. This should be in tandem with ICSs, providing joined-up workforce planning by working with local authorities and independent care providers to ensure effective system-wide coordination of recruitment and development.

The government's July 2022 (updated in November) integrated care strategy guidance recommended ICSs take forward joint workforce planning with local authorities as a next step toward integrated workforces. Through our Integration white paper, we have committed to continue to work with national and local partners to identify opportunities to remove barriers to collaborative planning.

While local government, along with ICSs, should continue to play their central role in social care workforce planning, the government remains committed to our vision for an adult social care workforce where people feel supported, recognised, and there are opportunities to develop and progress. In December 2021, People at the Heart of Car' was published, setting out a 10-year vision for reforming adult social care. The government remains fully committed to this vision, and the social care workforce remains at the heart of our plans.

On 4 April 2023, the government published the plan Next steps to put People at the Heart of Care which sets out how we will build on the progress so far to implement the vision for adult social care. In the plan we announced that we are investing up to £250 million over the next 2 years to:

- launch a new care workforce pathway for adult social care, which will support development and provide a career structure. The first part of the pathway, focussing on those in direct care roles, will be published in autumn 2023.

- funding for hundreds of thousands of training places to support development and progression. This funding will give care workers the opportunity to develop and improve skills to support them to deliver high-quality, personalised care. This training offer will include:
- investment in leadership, dementia, digital and learning disability and autism training
- funding for continued professional development for regulated professionals

50. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

Healthcare regulators have existing standards and guidance on the delegation of healthcare tasks. DHSC will bring together the relevant regulators to review this existing guidance and to consider options for reform.

51. Currently the agenda for change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, and general and specialised analytical and intelligence. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

The Agenda for Change (AfC) framework does currently allow for certain flexibilities, such as the use of Recruitment and Retention Premia (RRPs), which can either be applied nationally or locally, where market pressures would otherwise prevent the employer from being able to recruit and retain staff. These can be worth up to 30% of basic pay. Awarding an RRP may allow for competition with the private sector for these specific roles outlined. However, any RRP would first need to be suitability assessed and approved via the appropriate process.

NHS England recently carried out an extensive stakeholder engagement project and found that despite these flexibilities, there is an issue with attracting and retaining talent, which they attributed in part to inflexibility within AfC banding. The project found that budgetary issues are often an obstacle to the utilisation of local RRPs as these have to be locally funded, but also that even where they are applied, salaries are still not as competitive as industry and so are having limited impact. Despite these findings, we would still encourage trusts to use the available flexibilities where possible.

Further to maximising the use of existing flexibilities, DHSC has commissioned NHS England to develop a long-term workforce plan for the next 15 years. This plan will be published shortly and will help ensure that we have the right numbers of staff, with the right skill sets to transform and deliver high quality services fit for the future.

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