Government response to the House of Lords committee report on integrating primary and community care

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

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Introduction

This is the government's formal response to the recommendations made by the House of Lords committee in its report Patients at the centre: integrating primary and community care published on 15 December 2023.

The government welcomes the committee's report and its recommendations. We are grateful to everyone who contributed their time and expertise in providing evidence to the committee. It was encouraging to hear the witnesses and their recognition of the enormous importance of primary and community care as an important part of the wider health and care system.

In preparing this report, the committee explored the challenges facing primary and community care and the sustainability of the NHS, as well as how integrating services could address these challenges. The committee sought evidence from clinicians, community care services, local authorities, researchers and voluntary organisations from across the country.

Locally, integrated care partnerships (ICPs) play a key role in furthering integration and have now published their integrated care strategies, setting the strategic direction for each integrated care system. These strategies highlight a continued focus on integration, with many strategies prioritising or referencing efforts to improve integration. The government has reviewed its guidance for ICPs on integrated care strategies to update and provide additional clarity where necessary to support further integrated working practice.

In October last year, the government published the shared outcomes toolkit for integrated care systems to support the development of shared outcomes as a powerful means of bringing local organisations together to deliver on a common purpose.

The House of Lords committee collected testimony from national and local system leaders to ensure that individuals and communities have primary and community healthcare services readily available and seamlessly integrated. These testimonies were used to create 16 recommendations to improve integration of services.

The report underscores the critical importance of primary and community services for the successful integration of care for patients. It sets out a helpful framework for the challenges facing the integration of care, and many of its conclusions resonate with the government's own engagement with integrated care systems (ICSs) and the organisations within them.

Structure and organisation recommendations

Recommendation: maturity of ICSs

ICSs should be given time to mature and further wholescale re-organisation of the health service should be avoided. The Department of Health and Social Care (DHSC) should ensure that ICS structures are subject to a thorough and ongoing long-term evaluation before any further major reforms to the health service are implemented.

This evaluation should consider the extent to which ICS structures and processes have successfully facilitated improved integration within the different sectors of the NHS, and between the NHS and other stakeholders - and whether any further guidance or change in primary or secondary legislation might secure better outcomes from integration. It could be similar in scope to the Hewitt Review, but with the benefit of 3 years' worth of data and experience, rather than just one.

This recommendation reflects actions already underway to ensure that statutory ICS structures established in July 2022 by the Health and Care Act 2022 ('Health and Care Act') are given time to mature. DHSC, through the National Institute for Health and Care Research Policy Research Programme (NIHR PRP), has commissioned an independent research study to evaluate the implementation of the act. The research will be undertaken by academic experts from the London School of Hygiene and Tropical Medicine, the University of Manchester and the University of Kent.

The mixed methods, multi-year project will explore the impact of system changes to promote collaboration on patient outcomes as formalised by the Health and Care Act and identify appropriate metrics for assessing the impacts of collaborative activity. The study will specifically aim to understand the different ways that integrated care boards (ICBs) and ICPs, and system partners (at system, place and neighbourhood level) are coming together to design, commission and deliver services, and fulfil their duties, and the potential impacts. The study will take approximately 3 years to complete - all the study outputs will be published.

In addition to the long-term evaluation, DHSC will continue to monitor the progress of the ICSs by working closely with national organisations such as NHS England, the Local Government Association (LGA), the Care Quality Commission (CQC), the Department for Levelling Up, Housing and Communities (DLUHC) and the Office for Local Government (OfLoG). We will provide continued support to the system partners as they mature and improve.

Recommendation: membership of ICSs

Elected local government officials should be granted the right to chair ICBs. Representatives of VCSE organisations should be allowed to be members of ICBs. This would encourage integration by allowing elected officials responsible for social care, as well as voluntary sector service providers to direct the work of ICSs, as well as health service leaders. Directors of public health should be statutory members

of ICPs. These 3 targeted changes can be enabled by amending the Health and Care Act.

We support the intent of this recommendation to ensure strong local representation as part of ICBs and ICPs.

The voice of local government, VCSE organisations and independent sector providers is an important feature of ICSs, which aim to bring together local partners in understanding local needs and arranging services to meet these needs. Collaboration between these partners can therefore improve patient outcomes by encouraging integration, where this is in patients' best interest.

Within ICSs, ICBs are responsible for meeting the health needs of the population, managing the NHS budget and arranging the provision of health services. The NHS Act 2006 sets the criteria for ICB membership and must include a chair, a chief executive and at least 3 'partner' members (to bring 'knowledge and a perspective from their sectors'. This includes a local authority member, nominated by local authorities in the ICB area).

NHS England has set a criterion prohibiting all ICB chairs and non-executive members from holding a public office role or a role in a healthcare organisation within the ICB area. Elected local government officials, however, are able to chair the ICP - a committee of the ICB that sets the health and care strategy for the system.

ICBs can exceed the legislative minimum requirements for ICB membership to address local needs, which may include representation from a diverse range of stakeholders including but not limited to VCSE leaders. This should be seen as only one potential element of working in partnership with the VCSE and adult social care providers, on which NHS England and DHSC have issued advice to ICBs. Social care, VCSE leaders and independent sector providers should help shape the work of ICSs through contributing to ICS strategies developed by ICPs, joint health and wellbeing strategies by health and wellbeing boards (HWBs), and 5-year joint forward plans developed by ICBs and their partner trusts and foundation trusts.

A number of ICBs have used the legislative discretion and have appointed additional members to ICB boards including VCSE representatives - this is the case in Kent and Medway ICB and Greater Manchester ICB.

The Health and Care Act amends the Local Government and Public Involvement in Health Act 2007. This amendment requires the ICB and its partner local authorities to establish a joint committee for the ICB's area. This committee is the ICP. ICPs can establish their own processes and appoint additional members that reflect the needs of their local populations. In relation to ICP membership, the Health and Care Act was purposefully framed in a permissive way to allow local areas to develop models that work best for them.

Directors of public health are located in local authorities, and local authorities are already statutory members of the ICP. It is for the local authority, with the ICB and

other partner organisations, to determine who best represents the needs of the local populations, and this can include directors of public health. Existing guidance sets out the important roles of directors of public health and their teams including providing expertise and advice on how system partners can work together to improve health and care outcomes and experiences across the whole population.

Recommendation: accountable officer

The government should provide an update on its plans for a single accountable officer at place level. The government should also give more detail on how this role would be equipped to deliver on local health needs and how their work would be scrutinised.

Since the introduction of the Health and Care Act we have seen good progress with the development of arrangements at place level. The act was permissive in its approach to place level to enable areas to respond to the needs of their local communities. The integration white paper Joining up care for people, places and populations published in February 2022 set out policies for places to go further with their integration arrangements. This included a single person, accountable for the shared plan and outcomes for the place, as one way of establishing accountability arrangements at place.

In October 2023 DHSC published a toolkit to support places to develop their own local shared outcomes framework and in it we recognised the varying ways in which places had established their governance and accountability arrangements. Through our engagement we heard that mutual accountability to other partner organisations, and shared accountability were also important to deliver at place.

Effective governance and accountability arrangements are vital for place-based partnerships to deliver for their populations, and to support the success of ICSs as a whole. Because of this, places will be included in CQC assessments of ICSs, and shared outcomes frameworks may be assessed as part of this.

Recommendation relating to coterminosity

Coterminosity of ICS and local authority boundaries should be a long-term aim for the government and a consideration when implementing future local government or health service reform. Greater coterminosity would make any future integration of local health and social care budgets more straightforward.

During the passage of the Health and Care Act, NHS England led a review to explore how far it would be possible to align ICS boundaries with existing local authority boundaries. This was done in close consultation with DHSC and ministers with final decisions being published in July 2021.

The final position following this consultation included some changes to align boundaries but also some decisions to leave the boundaries in the same or similar form to the non-statutory ICSs that preceded statutory ICSs.

Local areas may still wish to keep under review how their boundaries are working. Therefore, this decision does not preclude the important work many systems undertake naturally to ensure they have boundaries that best suit local needs. Indeed we have heard from stakeholders in 2 ICS areas (Cheshire and Merseyside ICS and Humber and North Yorkshire ICS) that local boundaries should be reviewed and will work with NHS England to consider these areas.

NHS England has published the procedures that ICBs must follow if wishing to apply for a boundary change, which includes a requirement for support from all partner local authorities affected.

Recommendation: integration index

In addition to authorising the new CQC ratings for ICSs, the Secretary of State should instruct CQC to develop a specific ‘integration index’. This would evaluate and compare how well ICSs co-ordinate different services in their area. This should be in addition to the overall qualitative ratings and would give greater granularity than the planned 1 to 4 scale. The index should take account of activity levels, care pathways, population outcomes and assessments of structures.

CQC, NHS England and DHSC should use this data to better understand local challenges and opportunities, together with their influence on system outcomes. ICSs and place-based partnerships should use the index to explain how they intend to develop their performance in the context of national policy goals and priorities. Evidence about joint working should be reviewed in the context of the health outcomes achieved.

The index should also measure the frequency and quality of joint education and training. This is where NHS staff from different disciplines, social care staff and voluntary organisations come together to learn from each other and share experience at a local level. Joint training and a better mutual understanding of disciplines will lead to greater integration and should be incentivised by the index.

CQC’s forthcoming assessments of ICSs cover 3 statutory themes: leadership, integration, and quality and safety. Under integration, the assessments will look more specifically at how well they meet each of 3 quality statements:

- safe systems, pathways and transitions
- care provision, integration and continuity
- how staff, teams and services work together

The Secretary of State’s priorities for the assessments also ask for them to:

"Seek to understand how effectively the organisations within each ICS are forming strong partnerships and integrating their leadership arrangements. This is to plan and deliver joined-up care and services designed around people, not organisations."

They will therefore examine how well services are co-ordinated in each ICS.

In addition, the NHS Long Term Plan (published in 2019) commits the NHS to developing:

A new ICS accountability and performance framework which will include a new 'integration index' developed jointly with patients groups and the voluntary sector which will measure from patient's, carer's and the public's point of view, the extent to which the local health service and its partners are genuinely providing joined up, personalised and anticipatory care.

To address this, NHS England is working on an integrated care experience survey which will provide measures of people's experience of integrated care. National roll-out is expected in 2025 to 2026.

NHS England and CQC have committed to sharing the insights from (respectively) their ICB assessments and ICS assessments with each other to identify best practice and share this with systems to support continuous learning and self-improvement.

DHSC, CQC and NHS England share insights and intelligence to gain an understanding of the challenges ICSs face, as well as areas of success and best practice. Additionally, DHSC will use insights gained from oversight and assessment mechanisms to inform its policy making.

As set out in the NHS Long Term Workforce Plan, the introduction of ICPs provides a unique opportunity. NHS systems and local authorities will be able to work more effectively together to provide integrated care that meets the health and wellbeing needs of the population they serve. This will include integrated workforce planning to best develop and deploy staff - for example, through opportunities for joint teams, joint training and rotation between NHS and social care settings.

Recommendation: pilot studies review and engagement

The government should ensure that CQC pilot studies are widely disseminated and reviewed. Maximum engagement in CQC studies will lead to a better inspection regime for ICSs. This will help CQC judge the extent to which ICSs are acting in line with the spirit, as well as the wording of the Health and Care Act.

CQC is fully committed to ensuring that co-production and engagement is at the heart of developing the methodology and ways of working for its review of ICSs.

Over the past 2 years, CQC has worked in partnership with people who use health and social care services, their families, voluntary sector organisations, providers and their representative organisations, ICSs, local government, NHS England, DHSC and other strategic partners to design its approach to assessing systems. The feedback received has been invaluable in defining and developing the new approach. It has helped to avoid duplicating activity from CQC's pre-existing functions and those of its partners.

CQC will continue to work in partnership with these groups to ensure ICS assessments focus on what matters to people, and to local communities,

when they access, use and move between services. This includes engaging stakeholders on the learning from the 2 pilot assessments.

CQC will publish the pilot findings as narrative reports and communicate them widely. Evaluation has been embedded throughout the pilot assessments and CQC will also publish this for the public and other relevant stakeholders to access. The findings from CQC's ICS pilot assessments and the learning from the evaluation will help inform both the introduction of the initial methodology and a longer-term assessment approach. CQC will continue to engage with stakeholders on how this is taken forward.

Contract and funding recommendations

Recommendation: reforms in primary and community care contracts

DHSC and NHS England should comprehensively reform and align primary and community care contracts to incentivise integrated working. Any new national contract should permit a high-level of flexibility for the ICBs carrying out primary care commissioning. The result should be a mixture of partnership and salaried GP practices, with 'point of delivery' (POD) and GP services receiving funding based on long-term health outcomes and levels of deprivation, as well as activity or capitation. This reform should also ensure that money is available within their mainstream funding for the training, planning and collaboration required for effective multi-disciplinary working.

One of the reasons the Health and Care Act created ICBs and ICPs was to address differences across contractual and commissioning arrangements that can be a blocker to integration. ICBs inherited commissioning of general practice services from their predecessor bodies, clinical commissioning groups (CCGs), and as of April 2023, all ICBs also hold delegated responsibility for pharmaceutical services, general ophthalmic services and dentistry. By locating commissioning for all primary care services with ICBs, this enables the integration of primary care and system-commissioned community services by ICBs. Over the coming years, we expect to see ICBs aligning and joining up pathways, and testing innovative approaches to integrated commissioning, using their new powers. Given the flexibility of their structures, ICBs can also create forums which allow all primary care and community care functions to be considered as one.

The introduction of ICSs has provided systems with greater freedom and autonomy to determine how best to deploy their resources to meet local needs. DHSC sets NHS England's budget, with funding increasing to a record £162.5 billion in 2024 to 2025. NHS England is responsible for allocating healthcare resources to ICBs to meet the healthcare needs of their populations. Allocations are determined using an independently recommended 'weighted capitation' formula to produce a target allocation or 'fair share', including for primary care, which takes into account population size. ICBs then decide how that funding is spent within the local ICS.

GP partnerships, individually and through primary care networks, deliver high quality care to patients all over the country. We recognise some GPs are less interested in

going into partnership, and the partnership model is not the only model currently delivering general practice. GP practices can and do choose to organise themselves in different ways, many of which cite evidence of good outcomes in terms of staff engagement and patient experience. While partnerships holding a GP contract will continue to be in the majority, we agree with the committee that it is important that sustainable alternative models are available, particularly where the difficulties of recruitment and retention may mean that a partnership cannot thrive. There is a diminishing appetite by GPs to hold property liabilities and this will also need to be addressed through any new or alternative models.

The introduction of the network contract directed enhanced services (NCDES) since 2019 has also supported at-scale working in general to support improved resilience across practices and achieving greater integration of general practice with other community-based services, the wider health and care system and the voluntary sector. The additional roles reimbursement scheme (ARRS) provides funding for additional roles in primary care networks to help create bespoke multi-disciplinary teams (MDTs). Since 2019 we have recruited over 34,000 additional staff into general practice, meeting our commitment to recruit 26,000 additional staff a year ahead of the March 2024 target.

National primary care contracts are kept under review, as is the NHS standard contract, and relevant parts of the profession are consulted on any changes proposed ahead of their implementation. We will consider the committee's recommendations carefully as we look ahead to 2025 to 2026 and beyond. We also recently launched a consultation on the role of incentives schemes in general practice which will inform the future of the GP contract, including considering the use of financial incentives to address variation and improve patient outcomes.

Recommendation: ownership models of GP practices

To facilitate co-located, multi-disciplinary working for primary and community care, DHSC should investigate different ownership models for GP practices, their co-location with other community services and how it can support ICSs and local authorities in exploring these models. As a minimum, these models must ensure that new GP premises are designed and equipped for multi-disciplinary working.

We recognise the value of co-location and multi-disciplinary working in primary and community care in order to promote the integration of services.

However, we also agree that models of primary and community care will vary by geographical setting, the needs of local communities, and the availability of existing buildings. Furthermore, the successful integration of services does not always require co-location.

There are also many examples of GP partnerships working closely and successfully with community health services. The partnership model is also not the only model available. GP practices can and do choose to organise services in different ways, many of which cite evidence of good outcomes in terms of staff engagement and patient experience. This includes different premises ownership and leasing

structures, from public or private sector third parties, which can enable co-location where appropriate. However, risk and premises liabilities for GPs associated with estate means that investment models and delivery of new assets need to deliver alternative solutions from those currently employed.

ICS estates infrastructure strategies are being developed to plan for future estate requirements and investment, necessary to ensure value for money for the taxpayer when developing primary and community care estate. ICBs should take the existing and future general practice and primary care estate into account when considering their wider strategy and investment requirements.

NHS England also continues to explore the viability of new models of primary care estates including NHS-owned multi-disciplinary integrated care hubs. While any future investment is dependent on the outcome of future spending reviews, DHSC and NHS England will continue to explore and support different models, including the partnership model, as well as exploring potential solutions to the challenges faced with primary and community care premises.

Recommendation: Better Care Fund

The Better Care Fund (BCF) should be enhanced to cover a larger proportion of relevant NHS and local authority expenditures. BCF statutory responsibilities should be devolved to place-based commissioners. This would enable decisions on joint funding to be taken by those with a better knowledge of local needs. DHSC should ensure that the current consultation on the BCF and section 75 funding is widely disseminated and that the results are shared with stakeholders as soon as possible to ensure that they can consider potential new arrangements quickly. In addition, DHSC must provide an update on its long-term plan for the integration of health and social care budgets.

DHSC is committed to facilitating greater integration of health and social care services where this supports improvements in outcomes. We encourage local areas to use partnership arrangements and pooled budgets more widely to support integrated models of service delivery. Pooled budgets are delivered principally 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 BCF is delivered.

We have no plans to mandate that a larger proportion of relevant NHS and local authority expenditure is pooled into the BCF. The BCF includes total mandated funding of over £8 billion in 2023 to 2024. In addition to the grant funding and minimum contributions, over £11 billion of voluntary contributions have been committed from 2019 to 2020 to 2022 to 2023 inclusive. Local areas can spend the BCF on a wide variety of services at the interface of the health and social care system such as:

- intermediate care (such as reablement services)
- hospital discharge

- community services
- core adult social care services
- prevention

We encourage pooling of additional funding into the BCF where local partners feel it would be beneficial to support the integration of services. Many local areas commit additional money to the BCF as they seek to go further on joint commissioning and integration based on the success of partnership working in their local areas.

The HWB is the appropriate, statutory forum for ICBs and local authorities to make and agree joint plans and pool budgets for the purposes of integrated care. HWBs have the structures, status and reach to create a single, local plan for the integration of health and social care. In doing so, they can take account of local circumstances, including using place-based commissioning of services where appropriate.

To support further integration of health and care services we committed in '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. We launched a call for evidence in autumn 2023 and we are currently analysing the responses to inform next steps. The outcome of the review will be shared with stakeholders as soon as possible.

Recommendation: place-level committees

The government should bring forward changes to the Health and Care Act to require, rather than permit, ICBs to establish place-level committees. These will be responsible for commissioning relevant health and local authority services and committing resources in line with local ICSs. This will facilitate more local decision-making, ensuring that care strategies are tailored to the specific needs of the community while promoting better integration. ICSs and local government should scrutinise these place-based commissioners and hold them accountable for their performance.

While we recognise the importance of strong and effective arrangements at place level, we do not think statutory requirements beyond those in the current framework would help to deliver the innovation and progress we would like to see at place-level.

While the Health and Care Act established 2 statutory bodies, the ICB and the ICP at system level, it was permissive in the arrangements at place, to enable flexibility for local areas to make arrangements that work for their local populations. Since the introduction of the Health and Care Act we have seen good progress in places developing their place-based arrangements. NHS England recognises there are 174 place-based partnerships, and the majority of these partnerships are set up as formal committees of the ICB, or a place board.

HWBs also operate at place level. These are statutory committees of the local authority and have a statutory responsibility to bring together system partners to assess the needs of their populations, in the form of a Joint Strategic Needs

Assessment (JSNA), and plan for how they will meet those needs in the Joint Health and Wellbeing Strategy (JHWS). The ICB and ICP must have regard to the JSNA and JHWS when developing their own system level plans, ensuring that localised decision making is reflected throughout the ICS. DHSC published updated guidance on HWBs in November 2022.

Places are the engine for delivery and reform. There is wide agreement that collaboration and innovation at place is vital to delivering more efficient and joined-up services and enabling the success of ICSs as a whole.

The 'Joining up care for people, places and populations' set out ways in which places could go further to develop integrated working practices to facilitate more local decision making. We published the shared outcomes toolkit in October 2023 which supports local areas to develop shared outcomes frameworks based on the needs of their local populations using a population health management approach. We are also reviewing section 75 NHS Act 2006 to see if there are any changes we should make to the regulations to enable further use of these partnership arrangements to deliver localised, person-centred, integrated health and care services. We published a call for evidence on this in autumn 2023 and are analysing the responses.

Our focus is on how government along with NHS England and other partner organisations can continue to support the development and maturation of place-based working arrangements to deliver health and care services in the way that was envisaged in the Health and Care Act, and in this recommendation. We do not agree that changing legislation to require the development of place committees will support this aim and will detract from the good work seen to date to develop localised arrangements that work best for their area.

CQC assessment of ICSs will include place-level evidence. Place-based partnerships are also accountable to each other, and to the ICB and relevant local authority within the ICB footprint.

System and data sharing recommendations

Recommendation: collection of data

DHSC should publish high-level guidance to standardise the collection of data and portability requirements in commercial data-sharing software, especially for social determinants of health. This should mandate the ways in which clinicians and data systems 'code' for (for example, record) health information, ensuring that it is accurate, machine-readable and interoperable with data systems across healthcare and relevant local government systems.

In addition, regulating data portability and coding standards would mean that anonymised, aggregated patient data from primary and community care can be more effectively used for scientific research. This would mean that data from NHS and related services would be better integrated with the wider life sciences research sector.

Digital transformation of health and social care is a top priority for DHSC. The system's long-term sustainability depends on it. There has been a wealth of learning from work to digitally transform the health and social care system over the last 20 years.

Getting health and social care providers and their technology suppliers to adopt the same technical standards will ensure useable data can flow between IT systems in different organisations. It is the key to making systems interoperable.

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.

Relevant work is already underway. We have been developing and publishing the necessary standards, and in social care we have published a standards and capabilities roadmap for digital social care record solutions that assured digital social care records suppliers will need to comply with.

NHS England is currently working on how to make clear which standards are 'musts' for the sector and how these can be enforced.

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 will make information standards, including the aforementioned milestones, 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.

These changes will result in data being in a standard form, both readable by and consistently meaningful to any reader anywhere in the health and social care system.

Service providers' ability to meet mandatory standards is partly a function of their IT suppliers' conformity to the standards. We are therefore working with the Department for Science, Innovation and Technology to include in the forthcoming Data Protection and Digital Information Bill further changes to section 250 of the Health and Social Care Act 2012. These will include a power to apply technical standards to suppliers of IT systems and services equivalent to those applied to health and social care providers. They will provide a power to enforce these standards through compliance notices and financial penalties, along with a power to establish and operate an accreditation scheme.

Our vision implies a health and social care system underpinned by technical standards that enable all relevant health data to be accessible by those (including the life science research sector) with a legitimate right to access it at the point of need, no matter where the data is held.

The government is funding an ambitious programme of digitisation for adult social care that is delivered through ICSs, spending almost £50 million last year, and a further £100 million over the next 2 years. A key part of this is investment targeted at increasing the adoption of digital social care records (DSCRs). These enable greater information sharing between social care and NHS systems, supporting collaboration, and improving opportunities for joined-up care between local health systems and CQC-registered care providers.

DSCRs must provide care staff with secure access to core patient information in the GP record (through integration to GP Connect). This integration means that, through DSCRs, staff will have access to a person's last 3 interactions with their GP and up to date information about their allergies, immunisations and medications (including any adverse reactions) - directly improving the safety and quality of an individual's care.

In December 2023, DHSC published the final version of its data strategy for adult social care: Care data matters: a roadmap for better adult social care. This sets out DHSC's vision for improving the quality and availability of adult social care data. Improving our use of data and digital technologies will transform how adult social care data is collected, held and used, delivering better joined-up care with information shared easily between professionals and services.

In parallel, we are making improvements to the way NHS data is made available for research. The Data saves lives strategy committed to the implementation of secure data environments (SDEs) as the default way to access NHS data for research and other secondary uses, as part of the strategic move away from the model of data sharing.

The 'Data for Research and Development (R&D) Programme' is making England-wide investments in SDEs and has established the NHS research secure data environment (SDE) network, comprising of the NHS England SDE and 11 regional NHS-led SDE teams.

The SDE network will facilitate world class research to prevent, diagnose and treat our biggest healthcare challenges by providing safer and faster access to NHS data for research. It also aims to improve the consistency and quality of service for researchers by streamlining and harmonising data access processes to support the delivery of rapid innovations and ultimately improve health outcomes.

Recommendation: interoperable data systems

One (or multiple) highly interoperable data systems should be made available to all community services through commercial negotiations made at a national level. This is cheaper than replacing multiple computer systems with one. This will ensure that single patient records (SPRs) can work across geographical and service boundaries, while reducing the expense of more fragmented commercial negotiations at a place or ICS level.

NHS England has developed guidance to help simplify the digital and IT framework landscape, remove duplication and reduce costs.

This recommends which framework agreements should be used by NHS buyers when buying digital and IT goods and services. It remains essential that local services have the flexibility to determine the services which best meet their needs, but which meet the common standards - for example, of interoperability.

Framework agreements enable buyers to place orders without running a lengthy full tendering exercise and to draw from a pre-determined list of accredited vendors. It also means that buyers do not have to approach all vendors in the market, and should, as a result, make the buying process easier and more cost effective.

Last November, NHS England announced its intention to develop a commercial innovation pathway to accelerate the adoption of innovation, reviewing the frameworks used by NHS buyers to remove duplication. The aim is to make commercial and procurement processes more streamlined and efficient to support technology and digital innovation. The framework accreditation programme will simplify the procurement landscape and will accelerate the adoption of innovation through frameworks. NHS England will change the NHS standard contract, requiring trusts and foundation trusts to only use accredited frameworks, from April 2024.

The Connecting Care Records programme, and implementation of an interoperable shared care record, is our vehicle for delivering joined-up health and social care patient records which cross service boundaries. By March 2025, most clinical teams in an ICS will have appropriate access to an agreed clinical subset of a person's health and social care record that they can contribute to. Non-clinical staff in social care settings will also be able to access appropriate information and in real time.

One of the priorities for our programme is to ensure connectivity of an agreed 'priority' list of community healthcare settings by March 2025.

NHS England and the Professional Record Standards Body have developed a core information standard which applies to Connected Care Records, ensuring a common clinical vocabulary (SNOMED CT) to support safe, accurate and easy sharing of information, and the standardisation of records, improved access to information across multiple providers, and improved medicines safety. There is also a common information governance framework for Connected Care Records.

Recommendation: data and privacy law

DHSC should publish high-level guidance that clarifies how data and privacy laws apply to patient data, so that clinicians do not feel inhibited from useful data sharing by data protection compliance concerns. A single source of guidance would give confidence to clinicians and security for patients. This guidance should also set baseline standards for the ease and timeliness of access that patients have to their own medical data through interfaces like the NHS App.

This recommendation has been delivered. There is already a single source of guidance, an information governance portal that acts as the single source of guidance for the health and social care system. All guidance published on the portal is reviewed by the National Data Guardian (NDG) and the Information Commissioner's Office (ICO). This includes the recently published statement of the NDG, ICO and the Chief Medical Officer relating to the sharing of information for direct care of the individual patient.

The resources available include guidance on access to patient records through the NHS App.

Workforce and training recommendations

Recommendation: protected time for training

There should be protected and funded time for training for integration within primary, community and social care contracts in England. Experiential training delivered by and to multi-disciplinary teams should be quality assured. This could be facilitated by the devolution of Health Education England (HEE) budgets to local government and ICSs. Devolving this funding to ICS and local government level would be consistent with ensuring that it is better aligned with local priorities and the principle of subsidiarity inherent in the reforms of the Health and Care Act 2022. In addition, we recommend that DHSC investigates whether university medical training should include more experience of integrated working with community clinicians.

The recommendation calls for NHS England to delegate some funding for the education and training of NHS staff to ICS and local government. HEE's responsibilities for education and training now sit with NHS England, following the merger of the 2 organisations in 2023. Implementation of the recommendation would be a complex change and would require appropriate governance and accountability mechanisms to ensure that the funding was spent on the purpose that it was voted for. Moreover, NHS England already has the ability to align funding with local priorities.

NHS England funds clinical placements for pre-registration healthcare students in England and directly commissions postgraduate medical education and training places in England through the NHS education contract. NHS England also funds continuing professional development (CPD) for nurses, midwives and allied health professionals (AHPs). The expectations for the quality of the educational environment are set out in the multi-professional quality framework. The overarching objective of the framework is to promote inter-professional learning and to support and facilitate service transformation that meets current and future patient needs.

It would not be appropriate to devolve budgets to ICS and local government. This is particularly true for smaller medical specialties and small and vulnerable professions - such as podiatry - which require national planning oversight so not to de-stabilise supply.

NHS England is encouraging greater regional and local involvement in education and training planning, and assures integrated workforce, training and education planning at system, region and national level across place, pathway and programmes. As such, ICSs have autonomy to develop their plans, and the NHS England's national workforce, training and education function provides assurance and ensures consistency through the development and application of high quality planning tools and data analysis.

The recommendation also sets out that DHSC should investigate whether university medical training should include more experience of integrated working with community clinicians. The government does not set the requirements for curricular content or delivery of training of healthcare professionals. The standard of training for healthcare professionals is the responsibility of the healthcare independent statutory regulatory bodies (for example, the General Medical Council (GMC) or Nursing and Midwifery Council), who set the outcome standards expected at undergraduate level and approve courses. It is the responsibility of higher education institutions to write and teach the curricular content that enables their students to meet the outcome standards set by the regulators.

GMC provides guidance on undergraduate clinical placements, which sets the expectation that medical students experience a variety of placements - including urban and rural, tertiary and district general hospitals, and community and third sector. The guidance also states that medical schools should work with placement providers in general practice and hospitals, to helps students understand the patient journey from primary to secondary care, and also community and social care.

The NHS Long Term Workforce Plan recognised that clinicians will require generalist skills in order to expertly work across ICSs and meet the evolving complexity of population health needs while championing staff wellbeing and professional development. NHS England has therefore created the 'enhance' programme. This is a professional development offer for all healthcare professionals, with the aim of equipping them with the additional generalist skills required to deliver excellent person-centred care across the evolving complexities of the health and care system.

Since spring 2022, 7 regional trailblazers have been piloting enhance across England, supporting over 400 multi-professional learners to date. These individuals will be the change leaders that facilitate the cultural and organisational changes needed to provide integrated, population-focused services.

We anticipate that as ICSs become more involved in education and training planning, there will be an opportunity to develop more multi-profession, system-based rotational clinical placements. This would include extending the provision of placements across primary, community and social care, and in the independent and voluntary sectors, to give students valuable experience in the delivery of care outside hospitals and introduce them to wider career opportunities.

We will ensure that all foundation doctors can have at least one 4-month placement in general practice by 2030 to 2031. At present, opportunities for such placements are variable across deaneries. This will give doctors in foundation training an understanding of work in primary care. We will also increase training and supervision

capacity in primary care so GPs in training can spend the full 3 years of their training in primary care settings.

Recommendation: independent prescribing and referral rights

More community disciplines should be given independent prescribing and referral rights, going further than the recently announced plans from the government for pharmacists. DHSC should build on this work and investigate whether other community clinicians can be given similar rights. POD and community clinicians are trained to a high level and could be given (new or enhanced) prescribing and referral rights that reduce demand on GPs as either prescribers or referrers. For example, orthoptists could monitor and prescribe glaucoma treatments.

Prescribing is a responsibility exercised by regulated healthcare professionals who for many years have been taking on increasing responsibilities for prescribing, supplying and administering medicines. This supports patients to receive the medicines they require from the professional who is appropriately qualified to help them and means they do not need to see additional professionals simply to access these medicines. There are mechanisms other than prescribing that allow for the supply and administration of medicines including, for example, patient group directions (PGDs). The legislation governing who can prescribe, supply and administer medicines and how this legislation is used in the NHS is evolving constantly. The NHS is also taking steps towards direct referrals and self-referrals where GP intervention is not clinically necessary.

For example, since April 2023 community pharmacists have been able to supply oral contraception to women without the need for a prescription, using PGDs instead. From early 2024 community pharmacists will be able to supply prescription-only medicines for 7 common conditions under PGDs. In 2023, DHSC consulted on changing The Human Medicines Regulations 2012 to also allow pharmacy technicians to supply and administer under PGDs and the response to that consultation will be published in due course. Legislation already allows pharmacists to train to prescribe medicine, and pharmacist prescribing is common in GP practices and hospitals. In 2024, NHS England will pilot independent prescribing in community pharmacies across the country to understand how prescribing could work in community pharmacy. In terms of referrals, community pharmacies are already required to signpost patients to other healthcare providers and NHS England is currently piloting direct referrals by community pharmacies to secondary care for people with suspected cancer signs and symptoms.

Reforms to initial education and training for pharmacists mean that every pharmacist will qualify with independent prescribing responsibilities at the point of registration from 2026. This will shorten the time it takes for a pharmacist to independently prescribe from approximately 8 years to around 5.

We can therefore expect at least 3,000 newly qualified pharmacists to enter the workforce with the ability to independently prescribe in 2026, growing to almost 5,000 by 2037, based on Long Term Workforce Plan (LTWP) growth projections. NHS England is also offering independent prescribing training to a further 3,000

pharmacists in the established workforce. These initiatives will have a significant impact on access to independent prescribers in the community, as 52% of registered pharmacists work in community settings (based on General Pharmaceutical Council (GPhC) data as of 31 October 2023).

In 2023, DHSC consulted on changes to the Human Medicines Regulations 2012 which would enable dental therapists and dental hygienists to supply and administer some medicines without the need for a prescription from a dentist. These include local anaesthetics, fluoride varnish and certain antibiotics. This could enable these clinicians to deliver more care for patients using skills already within their scope of practice, while also improving the job satisfaction these professionals experience. The proposed change would support dental hygienists and dental therapists in providing the right care to patients without unnecessary delays and add capacity in dental care teams. DHSC will respond to the consultation in due course.

Optometrists can already directly refer patients from the community into secondary eye care services. ICBs are currently putting in place mechanisms to support this direct process. This requirement was set out in NHS England's 2023 to 2024 priorities and operational planning guidance, published in December 2022. NHS England's eye care transformation programme is also looking at how services should be configured for the future, which will consider the potential for expanded roles across the eye care workforce. Optometrists can already train to prescribe and currently over 1,000 of them are registered independent prescribers.

In addition to direct referrals from community primary eye care providers to secondary hospital eye services, ICBs are currently expanding self-referral for a range of services where GP involvement is not clinically necessary. The 2023 to 2024 priorities and operational planning guidance stated that by September 2023, systems are expected to put in place self-referral routes to 'falls' response services, musculoskeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services. This was reiterated in the delivery plan for recovering access to primary care, published in May 2023.

NHS England has supported ICBs to introduce self-referral routes through a range of national measures including web-based collaborative sharing and learning spaces where examples, case studies and answers to frequently asked questions are shared and ICBs can discuss implementation with other areas. NHS England is also delivering a series of national communities of practice webinars.

Looking further ahead, to build the nurse and AHP prescriber workforce, NHS England is investing in professional development and nationally-defined career frameworks. Through the LTWP clinical education reform programme, we are reforming AHP training and career progression routes in particular, with a view to overcoming the barriers to AHPs utilising their full scope of practice. One of the key ambitions of this work is to grow the number of independent prescribers in the AHP workforce.

Recommendation: training of social care workers

There should be greater training and professionalisation for social care workers so that they can perform basic nursing procedures that would enable earlier treatment and more holistic care within care homes and in their own homes. For example, more social care workers could receive enhanced training and qualifications in skills like supporting catheter care. This training should be held jointly with local primary and community care clinicians. This would contribute to an increase in their professional status and possibility of career progression.

There should also be the opportunity for job rotations, so healthcare workers experience different roles across primary, community and social care. This would make it easier for social care workers to work in multi-disciplinary teams alongside primary and community care clinicians. The NHS England Long Term Workforce Plan should be amended to include a strategy for increasing the size of the social care workforce, ensuring it has adequate opportunities for training and promotion and is staffed sustainably in the long term.

We are investing £250 million over the next 2 years to recognise the adult social care workforce as a profession and to improve people's perception of a career in care. On 10 January 2024 the government, in partnership with the national sector support partner Skills for Care, launched the 'care workforce pathway', the first nationally recognised career structure for the adult social care workforce. The pathway acknowledges the breadth and complexity of adult social care, the knowledge, skills, values and behaviours required for a career in care and provides a clearer differentiation between different roles and the level of expertise people should have and expect to develop. We are also providing funding for over 100,000 training places and qualifications for the non-regulated care workforce, including learning and development to enable people to undertake delegated healthcare interventions, such as catheter care, percutaneous endoscopic gastrostomy (PEG) feeding and simple wound dressing.

We know there are significant benefits to 'upskilling' social care staff to undertake more clinical interventions (a recommendation in the government-commissioned review by Baroness Cavendish published in 2021), both to help retain and reward care staff and improve the efficiency and capacity of the registered nursing workforce. Enabling care workers to carry out delegated clinical activities also supports personalised, timely care in the right environment at the right time, when the person needs it, rather than waiting for services to arrive. However, despite the clear benefits, any decision to delegate must consider the complexity, safety and potential risks and be made with the consent of the individual in receipt of care and with the agreement of everyone involved.

That is why we have been working with Skills for Care to co-develop guiding principles to support safe, effective, person-centred delegation of healthcare interventions, which were published in May 2023. We have since been working with 8 trial sites to evaluate the principles to identify further good practice and address any gaps and challenges to inform refreshed resources in spring 2024. Early findings from our sector fieldwork indicate that the principles have been welcomed and are being utilised by local systems.

We are continuing to identify further opportunities to promote and embed the principles, including showcasing exemplar projects and workforce models. In addition, for the next phase of the care workforce pathway, we are developing an enhanced and/or complex care worker role category, which will provide opportunities for more care workers to upskill to undertake more clinical roles and enable social care to play a more preventative role, particularly supporting people living with multiple co-morbidities in the community.

The NHS Long Term Workforce plan acknowledges that people's career paths may span both health and social care, and that staff working in social care play an integral role in the overall delivery of health and care services. The plan also highlights the interdependency between health and care services and the need for capacity to increase in both. The modelling used to inform planned expansions across education and training will increase the entire pipeline for regulated health professionals for health and adult social care.

It is important to acknowledge that for the rest of the adult social care workforce there are structural differences between the NHS and the largely independent sector adult social care market. Core responsibilities for workforce planning and market shaping sit with local authorities and care workers are employed by private sector providers who set their terms and conditions.

However, DHSC agrees that ICSs have a key role to play in ensuring joined-up workforce planning. They should be working with local authorities and independent care providers to ensure effective system-wide co-ordination of recruitment and development. This should continue to be supported through section 75 and greater pooling of health and care budgets. DHSC is currently reviewing section 75 arrangements to see if there are any changes that need to be made to the legislation to support further use. We ran a call for evidence during autumn 2023 and are currently analysing the responses. We will disseminate the findings of this review as soon as possible.

We want to enable all student nurses to have the chance to undertake a placement in an adult social care setting as part of their training and are keen to widen this aspiration to other clinical qualifying programmes. Deb Sturdy, Chief Nurse for Adult Social Care, has been leading work with Skills for Care to produce resources to enable social care providers to engage with nurse education and the requirements for placement supervision.

As we develop the pathway to wider parts of the adult social care workforce, we will consider how we can support better integration of health and care to create a more flexible, agile workforce which supports people to remain in the place they call home.

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