National Care Forum Response to Questions in the Integration White Paper 7.4.22

Introduction

At the beginning of February, DHSC published its white paper on the integration of health and social care: Joining Up Care for People, Places and Populations. The paper acts as an accompaniment to the Adult Social Care White Paper and the Health and Care Bill.

This submission is the National Care Forum's response to the Integration White Paper and the questions posed by DHSC throughout it. Our response has been informed by the input of our members following engagement around the wider integration agenda. We are also in the process of creating a set of resources to support providers to engage with ICSs and the wider integration agenda. The first couple of these can be found here: https://www.nationalcareforum.org.uk/integrated-care-systems/. More will be added as we work with providers, NHSE and DHSC.

What is the National Care Forum?

The National Care Forum brings together 160 of the UK's leading social care organisations, representing large numbers of care providers, offering thousands of services across the country, which are not-for-profit and always at the heart of community provision. Collectively, these organisations deliver more than £2.3 billion of social care support to more than 220,000 people in over 8,200 settings. The NCF membership body collectively employs more than 117,000 colleagues.

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Overall Observations from the White Paper

The overarching goal of this white paper is to better integrate health and social care so the system works better for people. We welcome this aim and many of the policies announced but much of the detail is still missing. We are also concerned that the potential of adult social care providers as key strategic partners in integration has been completely overlooked. Instead, the white paper conflates Local Authorities with adult social care. There is also no recognition of the contribution of wider VCSE alliances or other local partners. As such, there is a danger we won't see the full realisation of care that is truly joined up for ordinary people.

The paper is focused on structures, frameworks and organisations, with some additional policy proposals and aspirations. The Integrated Care Systems (ICS), which now go live in July 2022, have become lynchpin of this white paper and the wider reform agenda, with the 'Place' level being the focus of integration. There seems to be a lot for them to do very quickly.

When it comes to leadership and accountability, governance arrangements aren't exactly clear. The place-based partnership board model suggested in chapter 3 looks rather like a CCG with LA involvement – and it is not clear how this interacts with an Integrated Care Board (ICB) at the top of the system. It is also not clear how a 'single accountable person' at place level who has powers delegated from the ICB and LA will be able to navigate such a potentially tricky, highly political role. Our members have also pointed out that many ICSs will involve more than one LA, and many of these have more than one tier. The white paper doesn't address the complications this will cause.

We must also ensure that integration does not become a substitute for adequate funding for social care and health, or worse, an excuse to cut public spending in these two areas.

The section looking at pooling NHS and LA budgets is very limited and doesn't suggest anything concrete or mandatory.

There are welcome statements about the need to join-up health and social care workforce training and development, but there is still no dedicated information or firm requirement for a joint workforce plan for social care & health. It also focuses too much on 'Place' when this is a nationwide issue, and will certainly be a system wide issue.

Finally, there is a big focus on data and digital which is welcome but the timescales are very ambitious with relatively little resource to implement. The government aims to have a shared care records in place for everyone by 2024 but only 40% of social care providers have fully digitised records and there is no detailed plan to bridge that gap.

Below we have addressed the questions posed for each chapter of the white paper. We have taken the questions for each chapter as a whole when writing a response.

Shared Outcomes

The questions listed in the white paper for this chapter are:

1. **What role can outcomes play in forging common purpose between partners within a place or system – and can you point to examples of this?**
2. **How can we get the balance right between local and national in setting outcomes and priorities?**
3. **How can we most effectively balance the need for information about progress (often addressed through process indicators) with a focus on achieving outcomes (which are usually measured and demonstrated over a longer timeframe)?**
4. **How should outcomes be best articulated to encourage closer working between the NHS and local government?**
5. **How can partners most effectively balance shared goals or outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?**

Our reflections

As this chapter stresses, shared goals will help different organisations in a local system collaborate in pursuit of the same outcomes for people's health and wellbeing. However, this chapter does not have much detail and stays at a high, aspirational level. It outlines plans to develop a shared outcomes framework with a focused set of national priorities from which different 'Places' can develop their local priorities. We look forward to working with DHSC as they work on the national framework.

There are a number of key aspects to get right from a social care perspective if we are to reach national and local outcomes frameworks which work for people.

First, we need to ensure that we are not setting shared outcomes as 'clinical outcomes' or 'process outcomes' at either national or local level – we need to be focusing on the wellbeing of people who use care and support services. We need a broad focus, involving multiple stakeholders – not just Local Authorities and NHS as the questions posed imply – drawn from the community. For instance, a target for a certain amount of people to be discharged from hospital within a certain amount of time is no good if the wellbeing of those being discharged is negatively impacted. It might work for the system from a clinical point of view, but it may not work for other aspects of a person's life. VCSE alliances, social care providers and housing associations, among others, will all be key in bringing slightly different perspectives to what people need from their health and care systems. What one partner in the system thinks is an efficient process may, in a system-view, be counterproductive to the wellbeing of people. The safeguard against this is a multi-disciplinary approach.

Second, the national priorities need to be co-produced with people who use care and support services, as well as representatives from some of the types of organisations listed above. We will be repeating the same mistakes if the national framework is set by NHS and LA commissioners without other input – ask the question, what are the metrics that matter to people and their wellbeing? It is important to get this right as the national framework will be shaping the local shared outcome arrangements. This will make articulating shared outcomes a lot easier because they will have buy-in from more than just NHS and LA commissioners. The national framework is also important as it will give an element of consistency to the shared outcomes that are developed at a local level – this will help social care providers, and similar organisations, who are spread across multiple ICS areas.

Third, shared outcomes, and attempts to align and nuance existing priorities, need to be linked to wider attempts to create a coherent data strategy for adult social care and a minimum dataset. This in turn needs to analyse what already exists across the system to reduce duplication in terms of data collection. We need to ensure we are able to capture data relating to entire care journeys and population wellbeing to get a better sense of whether shared outcomes are working. As alluded to above, what may look like a positive metric in one organisation (say a certain % of people discharged within a certain number of days) can look like a system failure if, for instance, care packages or housing arrangements fall through due to complexity of need or pressures in the social are sector. A system-view would solve this. One study of which we are a part – The Dacha Study - is looking specifically at what a Minimum Data Set would look like for care homes and is a useful start.

Fourth, there is a danger that governance arrangements of ICSs – focused on LA and NHS representatives on the Integrated Care Board and a selection of wider partners on the Integrated Care Partnership – will naturally drift towards outcomes which focus on the functioning of systems and processes. One way to fix this is to ensure that local governance arrangements surround shared outcomes proactively involve people who use care and support as well as representatives from a

wider selection of organisations than just the local commissioners. This will also give confidence to the regulator that there is a transparent process in place to set and review shared outcomes in a local system.

Fifth, individual organisations will obviously continue to have their own aims and goals and these too need to be measured and analysed from a system-perspective. We must ensure that policies an individual organisation pursues does not have a detrimental impact on another part of the local system for the wellbeing of people.

Sixth, increased collaboration and integration must not be used as a replacement for adequate funding for individual services. If shared outcomes are to work, every part of the system needs to be resourced properly and transparently – VCSEs and social care providers must be resourced effectively to deliver the shared outcomes and the overall cost to the system must be clear & transparent in terms of what it takes across the system to deliver better wellbeing outcomes.

Seventh, when we set shared outcomes, we need to ensure these don't define the processes or rigid goals which prevent organisations pragmatically acting in order to achieve the spirit of the shared outcome for the best for peoples' wellbeing.

Eighth, it will be important that once national outcomes are agreed, the desire of government to tinker and amend frequently must be resisted. Systems will need time to deliver against the outcomes framework and frequent changes to that will be unhelpful.

Finally, we want to give an example of one of our members who has engaged with their local partners in pursuit of a shared outcome to improve the outcomes of people with severe and enduring mental ill health. Look Ahead has been working with NHS partners and housing associations during the pandemic to help people who receive treatment in inpatient mental health wards to return to the community more quickly. One of the projects is a partnership with Camden & Islington NHS Foundation Trust (C&I).

Look Ahead's Integrated Hospital Discharge and Community Support Service, based at the Highgate Mental Health Centre, was initially piloted as part of the Trust's COVID-19 recovery and resilience programme. The service was initiated to support those who were ready to leave inpatient wards but who face other, non-medical, barriers to returning to the community. From the outset C&I and Look Ahead were clear about the need to develop the project as a collaborative pilot which could be adapted during the delivery phase as they tested approaches, learned from what worked and developed a clearer understanding of peoples' needs.

As of the end of January 2022, the team had an active case load of 29 patients with 30 patients having been discharged with Look Ahead support in that month. Of the over 400 patients who have been discharged up to 31 January 2022, just 28 patients have subsequently been readmitted to date, none of whom had experienced a subsequent tenancy breakdown with the overall rate of those being discharged to settled accommodation increasing by 70%.

The involvement of Look Ahead in this pursuit of a shared outcome brought a different perspective to the barriers to integrating a person back into the community that NHS colleagues simply were not placed to see. Typically issues centred around housing related issues, welfare or help engaging with community – rather than clinical need.

You can read the full case study here, along with a video.

Look Ahead's work, vision and values aligned with the NHS's desire to ensure more people with severe and enduring mental ill health were able to leave inpatient settings (a national goal). Part of setting successful shared outcomes, will be finding those common values and sense of duty and purpose that motivates much of the public, VCSE and social care sectors. Align the shared outcomes around those and make administrative processes serve the outcome desired, not the other way round.

Financial Frameworks and Incentives

The questions listed in the white paper for this section are:

1. **How can we improve sharing of best practice regarding pooled or aligned budgets?**
2. **What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?**
3. **What examples are there of effective pooling or alignment of resources to integrate care or work to improve outcomes? What were the critical success factors?**
4. **What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?**

Our reflections

This part of the white paper outlines the difficulty that financial frameworks sometimes present in allowing for integrated working at place level between health and social care services due to difficult and lengthy processes which, at the end of the day, negatively impact the wellbeing of people. The white paper rules out mandating the pooling of budgets. Rather, it states it will review section 75 of the NHS Act 2006 to simplify it, as well as encourage more 'aligning' of budgets at local level. It strikes us that this makes it all the more important that we have an effective framework for shared outcomes.

We are not experts in section 75, but our observations would be that the Better Care Fund approach does seem to offer a relatively effective mechanism for sharing budgets between health and LAs. Linked to the budget issues is, of course, a clear outcomes framework and high quality commissioning to deliver those outcomes. If it would be helpful, we can ask our members for examples of where they feel aligned/ pooled budgets alongside respectful commissioning have helped them to develop better quality outcomes for the people they support.

Accountability

The questions listed in the white paper for this section are:

1. **How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?**
2. **What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?**

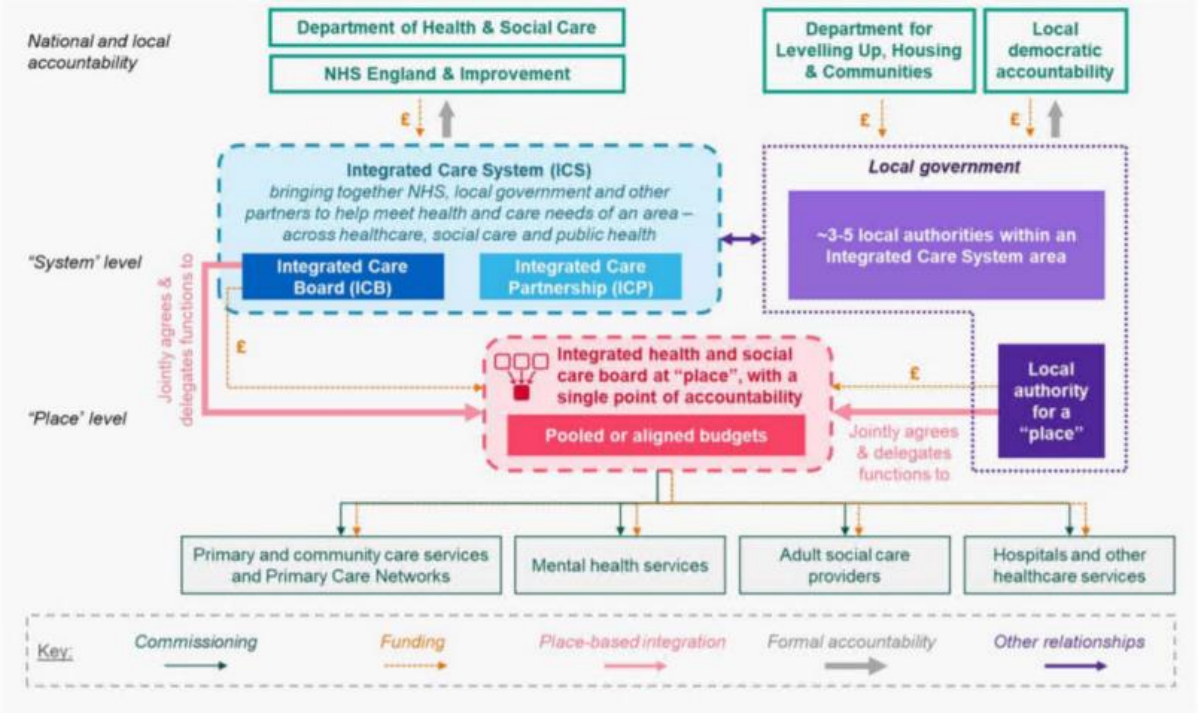
Our reflections

One of the problems with the Health and Care Bill and Integrated Care Systems, is that it isn't always entirely clear who is accountable for certain decisions. Unfortunately, this white paper doesn't really resolve that key problem despite setting out to do so.

The government expects all local areas to create place-based arrangements to bring together NHS and local authority leadership. This will include responsibility for effective commissioning and delivery of health and care services. Local health and care leaders are expected to set and agree the shared outcomes and will be held accountable for delivery of these outcomes.

The white paper proposes a model to do this using a 'Place-based board'. In this arrangement, a 'place board' brings together partner organisations to pool resources, make decisions and plan jointly – with a single person accountable for the delivery of shared outcomes and plans, working with local partners. In this system the council and ICB would delegate their functions and budgets to the board.

By 2023, all 'Places' within an ICS are expected to have adopted a model of accountability, like this one, with a clearly identifiable person responsible for delivering outcomes, working to ensure agreement between partners and providing clarity over decision making. The attempt by the government to turn this into a diagram shows that this is very far from being a clear or trouble-free line of accountability:



These governance arrangements aren't exactly clear. The place-based partnership board model suggested in chapter 3 looks rather like a CCG with LA involvement – and it is not clear how this interacts with an Integrated Care Board (ICB) at the top of the system. It is also not clear how a 'single accountable person' at place level who has powers delegated from the ICB and LA will be able to navigate such a potentially tricky, highly political role. Our members have also pointed out that many ICSs will involve more than one LA, and many which have more than one tier. We also would raise the potential political tensions resulting from councillors being nominated to the ICB. The

single accountable person will be dealing with politics in every single direction of that diagram. How will we manage the political dimension?

The most fundamental problem with the flows of accountability set out, is the continued assumption that LAs adequately represent social care and other types of organisations in a particular area. This is a very commissioner-led and dominated system of governance, accountability and decision-making. If we want to improve this model, we need to think about better representation of non-LA and non-NHS organisations at every level of the system. It also isn't clear where Health and Wellbeing Boards fit despite being in the Health and Care Bill.

Workforce

The questions listed in the white paper for this section are:

1. **What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?**
2. **How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?**
3. **Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?**
4. **What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?**
5. **What types of role do you feel would most benefit from being more interchangeable across health and social care? What models do you feel already work well?**

Our reflections:

This chapter has some welcome statements on the need to join-up health and social care workforce training and development, but there are a few gaping holes in relation to staff pay, terms and conditions, and the lack of a commitment to produce a coherent workforce plan for social care that is joined up with one for the NHS. This white paper, and the Adult Social Care white paper which it borrows heavily from for this section, do not constitute such a plan.

The commitments to encouraging more learning experiences of NHS staff in social care, the desire for more joined-up training and development and the recognition that the NHS and social care are competing for the same staff, are welcome. Nevertheless, there is no detail on how the workforce crisis will be resolved, nor the scale of resources to do this. Integration alone won't fix this problem. Focusing on 'place' level also will not solve what is a national issue which requires a national response. The reluctance of the government to include any specific joint workforce measure in the Health & Care Bill seems inexplicable – a missed opportunity to galvanise shared workforce planning at ICS level.

The biggest challenge social care and health now face is the workforce crisis. This crisis has been growing, quietly, for a number of years and this has been systematically illustrated by the annual workforce reports from Skills for Care. Now the COVID-19 pandemic and cost of living crisis have turbo-charged it. In October 2021, Skills for Care's annual state of the adult social care sector and workforce report stated that there were 105,000 vacancies in social care while the number of job

posts available had decreased over the previous 12 months. In February 2022 vacancies had increased to 9.8%. For care workers this is 12% (6.9% in March 2021) and registered nurses 18% (9.7% in March 2021). While demand is going up for social care, capacity in the system is shrinking.

For months now, the National Care Forum has been warning of a staffing crisis in social care as reported by our members, who are not-for-profit providers of care and support. In July 2021, we raised the alarm, following a survey of our members, where nearly 60% said they have seen the rate of staff exit increase since April 2021.

In August 2021, a survey of our membership found that nearly three-quarters of respondents had seen an increase in staff leaving and 46% said their employees were leaving the sector entirely.

In October 2021, our survey of registered managers found an average vacancy rate of 17% amongst respondents. 67% reported limiting or stopping admissions of new people into care homes or turning down new requests for home care. 33% limited or stopped admissions from hospitals.

In January 2022, a survey of our membership showed that situation deteriorated further:

- Overall, the providers responding reported an 18% vacancy rate with a 14% absence on top of this as a result of the Omicron variant.
- 66% of home care providers are having to refuse new requests
- 21% of home care providers are handing back existing care packages
- 43% of care home providers are closing to new admissions

This crisis has not been created by Omicron or the cost of living crisis, rather both have exacerbated pressures caused by chronic underfunding and a lack of workforce planning that were years in the making.

We are a long way from meeting long-term demographic changes if this workforce crisis continues any longer. Skills for Care estimates that by 2035, we will need a 29% increase in the number of adult social care jobs. Social Care will also need to be equipped to meet the needs of increasingly diverse communities and models of care.

The measures announced in the various white papers are welcome but do not provide the sector with anywhere near the level of urgency required. Integration will simply not work, if there are no staff to make it work and pressures will be added to other parts of the system such as Discharge to Assess or acute services.

Better pay is absolutely essential to solving the recruitment & retention problems in social care. Care providers need support now to deliver a funded pay increase for staff and a longer-term systemic approach to pay and reward structures. Those that argue that it is independent providers who deliver social care and therefore the state has no role in this are not fully sighted on the realities of the situation.

Social care is an integral part of the overall health and care system. Given that **between 60% and 70% of all care is commissioned and paid for by the state, via local authority and health commissioners, it is absolutely clear that the ability of social care providers as employers to increase the amount they pay their staff is hugely dependent on the income they generate from the services they provide. If the price that the state pays remains significantly below the true cost**

of providing those care & support services, this inevitably constrains the ability of social care providers to offer better pay to their staff.

The Skills for Care report tells us that recruitment has become more challenging as providers compete with the better pay in hospitality, retail and cleaning. While starting pay has gone up marginally, pay differentials have gone down. Pay in social care is still amongst the lowest in the economy due to underfunding.

A Workforce Plan is required

We are also calling on the government to develop a fully funded People Plan for Social Care, joined up with the NHS People Plan that provides clear career progression, better recognition and valuing of staff, investment in staff training and support, and introduces professionalisation and registration where this is appropriate. This needs to be based upon projections about the required need for social care in coming decades. We need to have such a plan in place to allow us to develop shared training, shared workforce placements, multi-disciplinary working and careers that span both sectors and which can go back and forth. The health and care workforce will be all the better for it if they learn from one another. This must not be restricted to simply registered professions such as nurses, it must include opportunities for frontline care workers to develop professionally. Respect will be central to this – too often people who work in social care are treated condescendingly by their NHS colleagues – parity of esteem will be key. Simply expanding the scope of HEE's Framework 15 is not enough. We need to future proof our workforce and ensure we are equipping it with the skills and career development it will need to meet the needs of people in ten, twenty or thirty years' time and longer.

Focusing on registered nurses to illustrate some of the barriers that need to be overcome - Social care nurses have an essential role in enabling the delivery of high-quality nursing care across social care services. They have distinct role, a relationship-based approach to support wellbeing, provide person-centred nursing practice, lead and enable others, operate within a complex regulatory and organisational landscape, and work at the frontline of health and social care boundaries.

The current and future training of all health professionals need to address the many misconceptions around what it is to be a nurse in Adult Social Care. These are highlighted in the Skills for Care "Ten Myths about being a Registered Nurse on Adult Social Care".

It is clear from the all the long-standing challenges to truly joined up integrated working that health and social care lack understanding of how each other works. The way that our future health and care professionals are trained offers a real opportunity to address those misconceptions and inaccurate perceptions.

The NCF is calling for specific measures to improve the placement opportunities in social care settings for all future nurses and doctors and relevant AHPs as a required part of their training. Work with HEE, the NMC, the GMC, the NHS deaneries and the higher education institutes must focus on how to improve the opportunities for social care to offer a much wider range of placements that are properly funded and supported with the appropriate supervision and clinical preceptorships. The current system of placements favours large well-resourced NHS Trusts and attitudes, perceptions and relationships will never change unless the placements system changes. Those of our members who have been able to engage successfully with the placements of health trainees have found it hugely valuable for them as care organisations and been able to inspire those students about social care, some of whom have chosen to pursue a career in social care - see here for an example:

https://www.caretalk.co.uk/11916-2/ and here: https://www.nationalcareforum.org.uk/draft/university-of-roehampton-student-nurses-begin-royal-star-garter-placements/

We would like to see opportunities for care workers and other social care roles in the opposite direction to gain experience and training from NHS colleagues.

Digital and Data

The questions listed in the white paper for this section are:

1. **What are the key challenges and opportunities in taking forward the policies set out in this paper, and what examples of advanced or good practice are there that could help?**
2. **How do we best ensure that all individuals and groups can take advantage of improvements in technology and how do we support this?**

This chapter builds on what was announced in the Adult Social Care White Paper and as such is full of welcome policies and ambitions:

- **Each ICS must have a functional and single health and adult social care record for each citizen by 2024**, with work underway to enable full access for the person, their approved caregivers and care team to view and contribute to.
- **To achieve 80% adoption of digital social care records among CQC-registered social care providers by March 2024**. Government will ensure that within six months of providers having an operational digital social care record in place, they are able to connect to their local Shared Care Record, enabling staff to appropriately access and contribute to the record
- **A suite of standards for adult social care to** enable providers across the NHS and adult social care sector to share information, starting with the consolidation of existing terminology standards by **December 2022**. A roadmap for this will be published in **April 2022.**
- **Data to support an understanding of population health, including unmet need and disparities, should be fully shared across NHS and local authority organisations**, to allow 'place boards' or equivalents, and ICSs to plan, commission and deliver shared outcomes, including public health and prevention services.
- **Each ICS will implement a population health platform with care coordination functionality** that uses joined up data to support planning, proactive population health management and precision public health by **2025.**
- **By March 2024, over 20% of care homes** will have acoustic monitoring solutions or equivalent care tech in place.
- **ICS Digital investment plans should be finalised by June 2022** which include the steps being taken locally to support digital inclusion.
- **An 'ICS first' approach**. This means encouraging organisations within an ICS to use the same digital systems, making it easier for them to interact and share information and providing care teams working across the same individual's pathway with accurate and timely data.
- **The inclusion and transparency of workforce, operational capacity, and financial data** across an ICS can also support better use of scarce resources, and improve productivity

One aim seemed odd to us - we didn't know what this meant considering we're already in 2022.

- By 2022, one million people will be supported by digitally enabled care pathways at home

The key challenge to the above set of policies is the short timescales and relatively little funding in relation to the scale of the ambition. There is a lot to do in a very short period of time – particularly when we consider that only 40% of social care providers have fully digitised records and there is no detailed plan to bridge that gap. With the establishment of the new ICSs and a recognition of the importance of digital and data, there is an opportunity to get this right but only if it is resourced properly.

First, we need much more detail about how each of the above policy ambitions is to be met, and we need to see the final version of the Health and Care Data Strategy as soon as possible.

Second, a key obstacle that our members are currently finding to the adoption of new digital technologies is access to funding and expert support – there is deafening silence from ICSs and the NHS Transformation Directorate about how providers access funding and support. The Unified Tech Fund was not well known among care providers and many streams of funding were only open to the ICSs or health colleagues, not social care providers. The digitising social care programme in particular was only open to the ICSs to apply for and as such providers were dependent upon their ICSs bidding (some didn't bid) and how they wanted to use the money. The digitising social care programme has operated as 9 pilots. This programme needs to be scaled up across all ICS areas, with details shared with providers so they are able to engage and adopt the systems that work best for their organisations and the people they work with.

Third, we must avoid a situation where ICS commissioners dictate what digital systems and technologies have to be adopted by care providers. In particular, while it may work better for the NHS system to have all care providers on the same electronic care planning system, this may not be the best solution for the people a provider works with. Instead, we must ensure that all systems adopted are interoperable and that data can flow, whatever the system.

Fourth, many care providers have services in more than one ICS area. This presents a key problem in terms of funding and resourcing if all the funding is coming via ICSs. If some ICSs use their digital funding for slightly different priorities, it is going to be difficult for care providers to adopt digital technologies across all their services in a consistent way. This must be kept in mind when directing funding through ICSs – there needs to be some form of grant conditions that ensures a consistency of approach.

Fifth, there is an opportunity to develop a minimum data set for social care that enables better insight into population wellbeing but opens the door to greater academic research in adult social care. A minimum data set will also allow individuals to move around the health and care system more easily. This must not be another health focused data set. It must be more expansive than that. NCF is involved in a piece of academic research to create a minimum data set for care homes in the DACHA Study and the insights from this will be useful for policymakers developing a sector wide data set.

Finally, financial resources aren't enough to enable successful adoption of digital technologies. We also need the support to implement change, digital transformation and new ways of working – as

well as the logistics of moving to new solutions. There will also be a requirement for staff to have the ability to analyse and interpret data. This is something our Hubble Project, funded by NHS Digital, sought to tackle. The Hubble Project helps care providers to understand the benefits of technology, how to build a business case for investment, and how to successfully introduce, use and evaluate technology. The Project tells the story of three care services' tech journeys in their own words. Based on a series of virtual visits to these 'innovation hubs' in 2020, we made available a range of resources from the project including films, detailed information packs, tech specifications, templates and checklists on the Digital Social Care website. Our end of project review identified the following which still apply now:

1. There is desire in the sector for peer-learning and networking opportunities around the adoption of digital technology. Don't just rely on commissioners or ICSs, set up networks of providers where they can learn from one another.
2. There is a real opportunity to enhance and extend the work of Digital Social Care, or something similar, to provide a single place for social care providers to go to get expert advice and support about the adoption and procurement/commissioning of new technology – particularly for SMEs
3. There are short-term barriers to the adoption of tech including financial uncertainty caused by Brexit and COVID-19. We would now add the current workforce crisis and cost of living crisis to this list.
4. While this White Paper is seeking to solve the following, we do need to acknowledge the challenge presented by the long-term barriers to the adoption of tech including the financial pressures in the social care sector, an absence of technology and software development standards to allow for integration and interoperability, and a lack of confidence around information and data governance, privacy and cyber security.
5. There are gaps in the technology market for social care providers as providers have struggled to buy technology that is truly interoperable or that integrates with existing technology they have purchased or with that of health. One example is the prevalence of eMAR systems which will only work with certain pharmacy interfaces.
6. Commissioners need to consider technological innovation when setting fee rates or specifying care packages. Innovation should not be seen as an extra but an essential part of care.

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