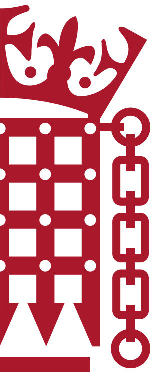

HOUSE OF LORDS

Integration of Primary and Community Care Committee

Report of Session 2023–24

Patients at the centre: integrating primary and community care

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Select Committee on the Integration of Primary and Community Care

The Select Committee on the Integration of Primary and Community Care was appointed by the House of Lords to consider the integration between primary and community care within the wider health and care system.

Membership

The Members of the Integration of Primary and Community Care Committee were:

Lord Altrincham
Baroness Armstrong of Hill Top
Baroness Barker
Baroness Finlay of Llandaff
Lord Kakkar
Baroness Osamor
Baroness Pitkeathley (Chair)
Baroness Redfern
Baroness Shephard of Northwold
Baroness Tyler of Enfield
Lord Watts
Baroness Wyld

Declaration of interests

See Appendix 1.

A full list of Members' interests can be found in the Register of Lords' Interests:
https://members.parliament.uk/members/lords/interests/register-of-lords-interests

Publications

All publications of the Committee are available at:
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Q in footnotes refers to a question in oral evidence.

SUMMARY

The quality and accessibility of healthcare services profoundly impact the lives of a country's citizens. A well-integrated system of primary and community care is a critical part of these services. This report examines how we can ensure that primary and community healthcare services are readily available and seamlessly integrated, to provide holistic care for individuals and communities.

It is well known that the NHS faces major challenges, particularly within primary care. Originally devised to treat individual conditions, the NHS now serves a population which is living longer and includes many people with multiple health issues, requiring complex and continuous care. The NHS has failed to improve its organisational structure, funding mechanisms, infrastructure, and workforce to meet this challenge. As a result, it is ill-equipped to meet current healthcare demands, and its long-term sustainability is threatened.

The Committee heard how these challenges have severely impacted patients' access and experience of health care. For instance, the British Red Cross explained why badly coordinated care leads to patients facing an avoidable health crisis and needing to present at A&E. Their experience encapsulates the problems faced by patients across the health service:

> "When people talk to us … they tell us that they have almost reached that point of despair where they feel as though they are not able to access the services they need elsewhere. They are often turning to A&E because they feel as though, in their own words, they have nowhere else to turn … There is an issue there of people and the system not understanding the whole story and not seeing the holistic needs that sometimes make up the reasons why people fall into crisis."[1]

Patients are constantly being inconvenienced, endangered, or miss improved long-term health because they are not receiving joined-up care, in the right place, at the right time.

Integration can help improve patient experience and offers a viable solution to many of the challenges facing the health service. Integration can be broadly defined as the way that different organisations can work together to deliver well-coordinated healthcare, which is designed to meet patient health needs. Integration can help improve poor public health outcomes by making healthcare more preventative. This in turn can help to reduce high demand for reactive health services. Better integrated care is often more time and resource efficient, which can also help address funding shortages. Patient pathways (the course of care that patients receive as they move through the health system) are often fragmented, but integration helps ensure that patients are treated by the right clinician at the right time. Better integrated care can also give more autonomy and responsibility to individual clinicians, increasing workforce morale and encourage retention.

Poorly coordinated care significantly undermines the quality of patient experiences with NHS treatment and can have profound consequences for their long-term health. This Committee has heard of patients suffering vision loss or facing critical delays in treatment due to the mishandling or loss of healthcare records between services. Patients in care homes frequently endure inconvenient

1 Q 174 (Tom Cottam)

and often unnecessary trips to see their GP or for hospital appointments due to the unavailability of online consultations with clinicians, or the lack of consistent access to a community nurse.

Patients are being deprived of the benefits of readily accessible, preventive, and highly effective community care services due to space constraints within the primary care estate, or because of a shortage of healthcare professionals. Additionally, the delivery of complex care is fragmented across various services, which do not coordinate to plan overall patient care and recovery. This must change to ensure that patients experience a health service, rather than a sickness service.

Four key obstacles—structures and organisation, contracts, data-sharing, and workforce hinder the implementation of integration policies in the health service. This report addresses each obstacle and puts forward recommendations to mitigate their effects.

Structures and organisation

Effective health service integration relies on professional relationships between services as much as formal structures or policies. While the Health and Care Act 2022 encourages local autonomy and subsidiarity, designing a universal policy to encourage constructive inter-service relationships has proven difficult. The collaborative ethos behind the new Integrated Care Systems (ICSs) is evident. However, imbalances between the power and representation of Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs), local authorities and voluntary, community and social enterprise organisations (VCSEs) within ICSs limits integration. The Committee proposes that ICSs should be given time to mature. Rather than implement further wholescale reorganisation to the health service, the membership of their governing bodies should be widened, and accountability should be enhanced through better inspection.

Contracts and funding

The NHS allocates an excessive amount of funding to reactive hospital care, at the expense of preventative primary and community care. Service contracts lack incentives for multi-disciplinary care, particularly in pharmacy, optometry, and dentistry, leading towards reactive rather than holistic care. Contract reform is needed to ensure that multi-disciplinary work is incentivised. Co-location, or housing multiple healthcare services under one roof, encourages better communication among professionals, easier access for patients and therefore better-integrated, patient-centred care. However, the existing GP contract and partnership model hinders co-location and therefore changes to these need to be investigated. Fragmented funding across different healthcare disciplines also impedes multi-disciplinary integration. A significant divide exists between social care, funded by local authorities, and primary and community care funded by ICSs. There have been efforts to bridge the funding disparities between the NHS and local authorities, notably the Better Care Fund (BCF), but existing payment systems and contracts have curtailed the effectiveness of these efforts. Joint funding models need to be enhanced to overcome this.

Data-sharing

Witnesses emphasised the importance of robust data collection, sharing, and analysis for successful healthcare integration. Single Patient Records (SPR),

which consolidate patient data and make it accessible across various health services, have not been universally adopted. Full implementation faces hurdles, including data interoperability issues (the ease with which different computer systems can communicate) and widespread IT inadequacies affecting data exchanges. Clinicians contend with significant technical barriers in data sharing, with outdated and incompatible systems. Fragmentation of data systems complicates patient pathways, with risks of data loss or repeated patient questioning between services. While technological solutions are available, data sharing is also hindered by cultural and perceived legal obstacles. Clinicians are often hesitant to share data at the risk of contravening GDPR and other data protections laws. Although legislation requires ICSs to share data, cultural attitudes lag behind this and so guidance on data sharing need to be clarified.

Workforce and training

A shortage of staff makes integration more difficult, as staff are required to spend more time meeting everyday demand, rather than proactively implementing new integration strategies. Specialised staff are not trained sufficiently in the work of other clinical disciplines and there are perceived hierarchies of professions and services. There is a need for integration to be included in initial clinical training and for clinicians to be introduced to the work of other services through job rotations. Social care is an important partner with primary and community care yet is not sufficiently integrated with them. Better training for social care workers would enable them to work more effectively with primary and community care. Social care needs to be included in the NHS's Long Term Workforce Plan to ensure that enough well-trained social carers are available.

The Committee found that trusting and constructive working relationships, aligned contracts and funding, and seamless data sharing are essential for integration. By removing obstacles to these, services will be better integrated and some of the major challenges facing the health service can be addressed. We urge the Government to build on its work on the integration of primary and community care and to implement the recommendations in our report, so that our crucial health and care services can evolve to meet the increasingly complex healthcare needs of our people.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Structures and organisation

1. ICSs need stability and continuity to develop more fully. Structures should be given time to mature and evolve; and for constraints on their performance to be well understood. The 2022 Act's underlying principles of subsidiarity and collaboration should continue to inform any future reform to the structure of services. These principles commanded wide support from witnesses, irrespective of the diversity of opinion on the overall merits of the 2022 Act and wider health policy. (Paragraph 55)

2. *ICSs should be given time to mature and further wholescale reorganisation to the health service should be avoided. The 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 recent Hewitt Review, but with the benefit of three years-worth of data and experience, rather than just one.* (Paragraph 56)

3. Health, social care, and voluntary sector leaders should work together closely as equal partners, as they are likely to possess a deep understanding of their respective communities. This will encourage integrated policy making and service provision, as well as a more preventative approach to public health. There should be a single accountable officer at place level, specifically charged with working with local leaders of providers, the voluntary sector, and local elected officials. There is a need for local champions, keen to drive integrated working, to explore local barriers and find local solutions. Their job appraisal should be focused on their effect on reported outcomes from those delivering and those receiving front-line care. (Paragraph 65)

4. *Elected local government officials should be granted the right to chair Integrated Care Boards (ICBs). Representatives of VCSE organisations should be allowed to be members of Integrated Care Boards. 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 three targeted changes can be enabled by amending the Health and Care Act 2022.* (Paragraph 66)

5. *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.* (Paragraph 67)

6. *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.* (Paragraph 69)

7. ICSs were created to ensure that services are well co-ordinated and that decisions are taken at the lowest appropriate level. In addition to assessing safety and leadership, the CQC needs to develop a more granular measure of the level of integration. This would enable long-term tracking of ICS

maturation, which will help measure the success of the reforms put in place under the 2022 Act. (Paragraph 74)

8. *In addition to authorising the new CQC ratings for ICSs, the Secretary of State should instruct the 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 1–4 scale. The index should take account of activity levels, care pathways, population outcomes and assessments of structures. The CQC, NHSE, and DHSC should use these 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.* (Paragraph 75)

9. *The Government should ensure that the CQC pilot studies are widely disseminated and reviewed. Maximum engagement in the CQC studies will lead to a better inspection regime for ICSs. This will help the CQC judge the extent to which ICSs are acting in line with the spirit, as well as the wording of the 2022 Act.* (Paragraph 76)

Contracts and funding

10. Primary and community clinicians should work more collaboratively at place and the individual patient levels. Their work should put a greater emphasis on public health and preventative health care. Payment by outcome, weighted by the level of deprivation—as well as payment by activity or capitation—should help incentivise integrated and preventative work. This is urgently required, and the needs of more deprived areas should be explicitly recognised. (Paragraph 93)

11. *The DHSC and NHSE 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 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.* (Paragraph 94)

12. GP practices should be housed in buildings that facilitate integration by acting as a physical hub where primary and community clinicians, together with other services, are co-located, sharing space for multi-disciplinary practice, planning, and training. In some areas, it might be appropriate to decouple clinical work from financial responsibility for the premises, in order to facilitate the building improvements required for co-located multi-disciplinary working and attract newly qualified clinicians. This would make it easier for patients to access a variety of different services from just one health setting. Models of primary-community co-location will vary by geographical setting, the needs of local communities, and the availability

of existing buildings for shared use and suitable adaptation. For example, a multi-disciplinary team based around a rural single-handed GP practice might make use of community assets, like a village hall, provided there is requisite privacy. (Paragraph 100)

13. *To facilitate co-located, multi-disciplinary working for primary and community care, the 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.* (Paragraph 101)

14. Patients in the community should be treated by a multi-disciplinary team of social care workers, community nurses, their GP and other specialist community clinicians like podiatrists. These teams should ideally be co-located with GP practices, share records, and meet to plan patient care. At a local level, staff contracts should consider ways that staff accountability (to managers) and care delivery responsibilities can be separated. This would enable different staff to collaborate and work together around an individual patient's needs without needing to change or review their contracts of employment. (Paragraph 107)

15. *The Better Care Fund should be enhanced to cover a larger proportion of relevant NHS and local authority expenditures. Better Care Fund 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. The DHSC should ensure that the current consultation on the Better Care Fund 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, the DHSC must provide an update on its long-term plan for the integration of health and social care budgets.* (Paragraph 108)

16. Devolved, place-based commissioning and funding should be the default option. Local stakeholders have a close knowledge of local needs and understand how services can work together. They have closer relationships that come from geographical proximity and better understand the opportunities for (and challenges of) integrated working in their local areas. Therefore, commissioning should primarily happen at a place, rather than ICS level. (Paragraph 112)

17. *The Government should bring forward changes to the Health and Care Act 2022 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 Integrated Care Strategies. 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.* (Paragraph 113)

Systems and data

18. The DHSC must ensure that data-sharing infrastructure, regulation and working culture are ready to respond to the next decade of technological innovation and are proactive in addressing public and professional concerns about data privacy and security. (Paragraph 135)

19. Fully integrated care requires seamless, co-ordinated digital interoperability. This would be facilitated by a culture of secure and appropriate data-sharing which has the confidence of staff and the public. Primary and community clinicians should be only "one click away" from securely stored and comprehensive patient information in an SPR, with full read and write access for clinicians (both NHS and non-NHS) across local care systems. The limiting factors to implementing an SPR are related to data portability standards and the purchasing of interoperable systems. The DHSC and NHSE should focus on helping ICSs to resolve these problems. Perceived technological barriers are not an excuse for delayed implementation. (Paragraph 136)

20. *The 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 (i.e. record) health information, ensuring that it is accurate, machine-readable, and interoperable with data systems across health care 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.* (Paragraph 137)

21. *One (or multiple) highly interoperable data system/s 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 SPRs can work across geographical and service boundaries, while reducing the expense of more fragmented commercial negotiations at a place or ICS level.* (Paragraph 138)

22. Clinicians should have the confidence to share patient data usefully and safely. For the individual patient, the sharing of individual data must be a priority for effective treatment and patient safety. For anonymised and aggregated population health data, seamless data-sharing for service planning and public health interventions is essential. The DHSC must ensure that primary legislation, secondary legislation, and guidance allow clinicians to easily navigate the tension between data privacy and effective planning of individual and population-level health. (Paragraph 143)

23. Data privacy and security are of utmost importance. NHS England should ensure that not only is data held securely, shared appropriately, and consensually, but that there is also public confidence that this is the case. (Paragraph 144)

24. *The 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.* (Paragraph 145)

Workforce and training

25. While it is beyond the Committee's remit to recommend general reforms to the NHS workforce, the NHS should implement its Long Term Workforce Plan without delay to avoid shortages undermining integration within the

health service. Better integration should reduce long-term strain on the health service as it leads over time to more holistic and preventative care. In addition, multi-disciplinary work should be more collegiate, give greater responsibility to perceived lower-status clinical disciplines, and encourage a problem-solving approach to work. As well as enhancing integration, this would in turn lead to better job satisfaction and retention. (Paragraph 157)

26. *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 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 2022 Act. In addition, we recommend that the DHSC investigate whether university medical training should include more experience of integrated working with community clinicians.* (Paragraph 158)

27. National policy envisages that there should be a general shift towards patients seeking treatment at the earliest opportunity and lowest possible level within the care hierarchy, meaning that conditions are addressed preventatively and before they reach an acute level. To meet this goal, services must be more proactive in supplying (and the public more proactive in seeking) a more extensive range of opportunities for preventative and early interventions. In addition, NHS and related services must be able to fulfil such expectations about the availability of such provision so that the public can be confident that they will be seen quickly and receive appropriate treatment. (Paragraph 167)

28. *More community disciplines should be given independent prescribing and referral rights, going further than the recently announced plans from the government for pharmacists. The 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.* (Paragraph 168)

29. An integrated healthcare system would maximise the preventative involvement of the NHS and other out of hospital services, including local authority social services, to prevent older people and others, in domestic and residential settings from becoming ill and being admitted to the acute hospital sector. In addition, social care workers should be empowered to deliver more complex care, through co-created, place-based training, designed to meet local needs. Better qualified social care workers would have increased status and career satisfaction, and would be able to play a greater role in community multi-disciplinary teams, enhancing the links between social, primary, and community health care. (Paragraph 174)

30. The DHSC should work towards parity of esteem for social care workers but avoid any perverse outcomes where better qualified social carers end up moving to the NHS, due to its better terms and conditions. Parity of esteem should mean equal terms and conditions for the NHS and social care, which will help facilitate better professional relationships and integration. (Paragraph 175)

31. *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 health care 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. (Paragraph 176)

Patients at the centre: integrating primary and community care

CHAPTER 1: INTRODUCTION

What is this inquiry about?

1. Integration is a concept within health policy which describes the effective relationships between services needed to provide co-ordinated care. The Committee investigated how better integration between two areas of the health services—primary and community care—could help address some of the significant challenges which are undermining the long-term sustainability of the NHS and damaging the experience of those needing care and support. The Committee identified barriers to the integration of primary and community care and has made recommendations on how these could be overcome. It is only by overcoming these barriers that services can deliver the outcomes that patients expect and deserve.

What are the challenges facing the health service?

2. When the NHS was founded, it primarily addressed single health conditions, which often lacked effective disease modifying treatments or interventions. Now, people are living longer, often with multiple ailments that require complex and ongoing treatment. As models of care have changed, the NHS's organisational structure has not adequately evolved in response. This is threatening the long-term sustainability of health and related services. The main challenges which were identified by witnesses can be broadly categorised as follows:

   (a) Poor public health outcomes and insufficient preventative care;

   (b) High service demand, exacerbated by an aging population with multi-morbidities;

   (c) Funding shortages;

   (d) Fragmented patient pathways, often without local family support; and

   (e) Workforce shortages.

What is integration?

3. Broadly, integration describes the way that different organisations or services work together to deliver health care. However, there are multiple definitions of integration and integrated care.[2] One review identified 175 different definitions.[3] While "clarity of purpose" is often viewed as a crucial element

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2 Nick Goodwin 'Understanding Integrated Care', *International Journal of Integrated Care*, vol 16(4): 6, pp 1–4: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5354214/ [accessed 5th October 2023]

3 Nuffield Trust, 'What is integrated care?', (June 2011) https://www.nuffieldtrust.org.uk/research/what-is-integrated-care [accessed 6 October 2023]

for successful integration,[4] it was not until 2013 that the then Department of Health and its national partners officially adopted the following as a standard definition of integrated care: "My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes."[5]

4. This was the first nationally agreed "understanding of what good integrated care and support looks and feels like for individuals."[6] In its 2022 policy paper the Government went on to define its understanding of "successful integration":

> "Successful integration is the planning, commissioning, and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time."[7]

5. In her evidence to the Committee, Professor Kate Walters, Clinical Professor of Primary Care and Epidemiology at University College London (UCL), cited the World Health Organisation definition of integration as:

> "Seamless, co-ordinated care, but care orientated around the person themselves, and people working together collectively to organise care around that person and what they want and to create actions as a result."[8]

6. While there have been different definitions of integration over the lifetime of the NHS, the intention of integrated care is to place the patient at the centre of services with a co-ordinated healthcare system around them. Achieving this requires multi-disciplinary collaboration, comprehensive healthcare planning, efficient communication between healthcare providers and stakeholders, and a focus on both immediate and long-term health. The Committee heard that realising successful integration requires active engagement and cooperation among healthcare professionals, local authorities, voluntary organisations, and other stakeholders.

7. As well as there being multiple definitions of integration, the term can also refer to different types of relationship between services. The Nuffield Trust identify four types of integration:

> "Organisational integration focuses on co-ordinating structures and governance systems across organisations, such as organisational mergers, or developing contractual or cooperative arrangements.

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4 Bob Erens *et al*, 'Can health and social care integration make long-term progress? Findings from key informant surveys of the integration Pioneers in England', *Journal of Integrated Care* (October 2019): https://www.researchgate.net/publication/336803285_Can_health_and_social_care_integration_make_long-term_progress_Findings_from_key_informant_surveys_of_the_integration_Pioneers_in_England [accessed 6 October 2023]

5 National Collaboration for Integrated Care and Support, *Integrated Care and Support: Our Shared Commitment* (May 2013): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013–05-13.pdf [accessed 14 September 2023]

6 *Ibid.*

7 Department of Health and Social Care, *Health and social care integration: joining up care for people, places and populations* (February 2022): https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations [accessed 13 September 2023]

8 Q 3 (Prof Kate Walters)

Administrative or functional integration involves joining up non-clinical support and back-office functions, for example, accounting mechanisms or sharing data and information systems across organisations.

Service integration involves the co-ordination of different services, such as through multi-disciplinary teams, single referral structures, or single clinical assessment processes.

Clinical integration involves the co-ordination of care into a single or coherent process, either within or across professions. This could involve developing shared guidelines or protocols across boundaries of care."[9]

This report considers elements of all four of these types of integration. However, these definitions are not exhaustive, and there are other possible conceptual analyses of the term.

Patient pathways: what does well integrated care look like?

8. The term "patient pathway" or clinical pathway broadly refers to the sequential episodes of care that a patient experiences as they move through the healthcare system.[10] The term has connotations of care being well-planned and integrated, with the patient kept informed as they progress from sickness to health. In a well-integrated system, funding and contracts would incentivise simple, co-ordinated patient pathways that are straightforward for patients to navigate.

9. In a badly integrated system, patient pathways might be disjointed or non-existent. This could mean that patients must interact with many individual services to receive care, without those services co-ordinating or sharing information. Tom Cottam, Head of Health and Resilience at the British Red Cross, told the Committee that high intensity use of A&E was caused by patients having interactions with multiple services, but without those services working together to address the underlying problem.[11] A lack of integration between Voluntary, Community, and Social Enterprise (VCSE) organisations, primary care, and social care can mean that there is not a clear patient pathway out of hospital, due to a lack of continuing care. This contributes to delayed discharge from hospital.[12]

10. During the Committee's roundtable event, we heard of patients who had to repeat crucial health information multiple times to doctors, or had their records lost during the referral process. Other patients were treated for different conditions by different doctors simultaneously, with professionals unaware of the treatment being carried out by their colleagues. Badly integrated care like this makes it difficult to provide truly effective treatments that will make the patient healthier in the long-term.[13]

11. In a well-integrated system, patients would experience a seamless transition from one sector of care to another. For example, Nora Corkery, CEO of

9 Nuffield Trust, 'Integrated care explained' (December 2021): https://www.nuffieldtrust.org.uk/resource/integrated-care-explained [accessed 2 October 2023].

10 Guus Schrijvers, Arjan van Hoorn, and Nicolette Huiskes, 'The care pathway: concepts and theories: an introduction.', *International Journal of Integrated Care*, 12(Spec Ed Integrated Care Pathways),. (18 September 2012): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602959/ [accessed 2 October 2023]

11 Q 174 (Tom Cottam)

12 Q 176 (Tom Cottam)

13 See Appendix 6.

Devon Communities Together, told us about "virtual wards". This is where patients are given more acute care, but at home rather than in hospital, provided by a multi-disciplinary team. She described how a mixture of services provided "wraparound" care, to ensure that the patient was treated, informed about their care, had a safe home, visitors, and ongoing care.[14]

How can integration help solve challenges in the NHS?

12. The NHS's organisational structure has not adequately evolved to support models of care which have changed since the NHS's foundation. Although they have been repeatedly reorganised, the NHS and its related services continue to operate as a patchwork of disconnected entities.[15] In this section, we outline the main problems facing NHS related services and explain how integration can help resolve them.

13. Poor public health outcomes and insufficient preventative care: services can work together to focus on the causes of poor health.[16] The Committee heard how some areas in England are taking a multi-service approach to address health inequalities. This could take the form of very local projects, of which the Committee heard many examples. These include the Bromley-by-Bow Centre in inner-city London, led by Professor Sir Sam Everington, where general practice works closely with charities to provide holistic care to patients.[17] Professor John Campbell, Professor of General Practice and Primary Care at the University of Exeter, told us about rural integration projects which help keep high-intensity A&E users out of hospital.[18] Integration projects could also be system wide—for example, in Coventry, a "Marmot City", where services collaborate across the city with a focus on health prevention, rather than just aiming for curative outcomes.[19]

14. High service demand, exacerbated by an aging population with multi-morbidities: witnesses told us how preventative, holistic integration strategies contribute to better overall health and therefore reduce long-term demand.[20] Integrated care is better at managing patients with multi-morbidities, as it treats them holistically. Integrated care is therefore a useful intervention in a country with an aging population, and where new therapies are keeping people in better health for longer and are controlling diseases that would have previously been fatal.

15. Funding shortages: more efficient, co-ordinated, and preventative care is a by-product of integration, which can often be achieved by re-structuring teams, organisations, or processes, rather than increasing them. There is some evidence that this will save money. Providing better healthcare with the same resources, will help reduce the issue of funding shortages.[21]

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14 Q 75 (Nora Corkery)
15 The King's Fund, 'How does the NHS in England work and how is it changing?', (26 May 2022): https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work [accessed 2 November 2022]
16 Q 41 (Fiona Claridge)
17 Q 123 (Prof Sir Sam Everington)
18 Q 3 Prof John Campbell)
19 A "Marmot City" is a city working in depth to reduce the social gradient in health by following the six policy objectives recommended in the Marmot Review, often referred to as the "Marmot Principles". Coventry City Council, 'Coventry: a Marmot City': https://www.coventry.gov.uk/coventry-marmot-city-1/coventry-marmot-city [accessed 2 October 2023]
20 Q 123 (Ed Davie)
21 Q 130 (Prof Sir Sam Everington)

16. Fragmented patient pathways: individuals frequently experience fragmented care from services that lack effective co-ordination and are not sufficiently patient-centred. This can negatively impact their experience and lead to poorer health outcomes, duplication, and inefficiency.[22] Integrating care pathways solves these problems by ensuring that a patient's care is planned and co-ordinated.

17. Workforce issues: providing integrated care requires innovation, problem solving, trust, autonomy, and truly inter-disciplinary working. This empowers healthcare workers of all disciplines and ranks to innovate and take ownership of care, rather than to just provide it.[23] Integrated care should therefore be more satisfying and meaningful for workers, increase morale, and therefore workforce retention. In addition, other positive impacts of integration, like better management of demand and the possibility of longer-term engagement with the same patient will have the same effect.[24] Bespoke care will also mean patients are more invested in their health and recovery.[25]

18. However, not all integration strategies are guaranteed to have a positive or significant impact. Professor Kath Checkland, Professor of Health Policy and Primary Care alerted the Committee to the fact that current academic research on multi-disciplinary teams is nuanced on the impact it can achieve. Prof Checkland told the Committee that while "there is fairly good evidence that it improves patients' experience of services" there is "little evidence that it does one of the things people often want it to do—keep them out of hospital."[26] This is because it can uncover unmet or undiscovered health needs, which offset any reduced demand. Therefore, integration strategies should be carefully assessed to discern their overall impact and value for money.[27] As Lord Lansley, former Secretary of State for Health, told the Committee, integration "is not an end in itself, but a means to an end. The means is integration. The end is improving patient outcomes".[28] While it is too early to judge the extent to which the new ICS structures have enhanced integration between services, the Committee has heard compelling evidence that specific integration strategies or projects can benefit patients on an individual or local level. NHSE and the DHSC should therefore ensure that data on integration strategies is comprehensively collected, and that good practice is shared.

19. There is a need to identify models of care which can reduce demand and then use integration to help operationalise them effectively. One such model is Pimlico Health at The Marven where Community Health and Wellbeing Workers (CHWW) act as a link between the GP surgery, local authority services, and voluntary groups to co-ordinate care for residents.

20. A 2018 study has considered the feasibility and impact of implementing CHWW schemes across England. The study found that around 110,000 CHWWs (costing £2.2 billion per year) could cover all of England. If they referred 20% of unscreened or unimmunised individuals there could be an extra 750,000 cervical cancer screenings, 370,000 breast cancer screenings,

22 The King's Fund, 'Integrated care systems explained', (19 August 2022): https://www.kingsfund.org.uk/publications/integrated-care-systems-explained [accessed 3 November 2022]
23 Q 3 (Prof John Campbell) and Q 15 (Prof Sue Yeandle)
24 Q 23 (Jacob Lant) and Q 235 (Lord Hutton of Furness)
25 Q 123 (Prof Sir Sam Everington)
26 Q 156 (Prof Kath Checkland)
27 Q 5 (Prof Hazel Everitt)
28 Q 230 (Lord Lansley)

and 480,000 bowel cancer screenings "within respective review periods". This would constitute a radical shift towards a more preventative model of healthcare.[29]

21. The Committee does not claim that this specific model of integrated care should be universal: it has arisen to address the needs of a compact, walkable, inner-city housing estate which is close to major teaching hospitals. Instead, we ask why the high levels of integration which facilitated the project are not universal. What can we do to ensure that CHWW, or a different but equally impactful model, can flourish anywhere in England? Box 1 outlines how this model in Pimlico, which the Committee visited, works in practice.

Box 1: Integration in action: visit to Pimlico

Pimlico is the location of a highly innovative model of community healthcare. It was inspired by work in Brazil yet also harks back to a time where the family doctor and district nurse in England were ubiquitous. The model works thanks to the high level of integration and close working relationships across services.

Community health and wellbeing workers (CHWW) are recruited from amongst the residents of the deprived Churchill Gardens estate. They work full time, are part of the local primary care team and live amongst the residents they serve. They help direct residents to health and wellbeing services, educate them in health literacy, and help tackle loneliness and isolation.[30]

The scheme is facilitated by many successful integrative practices. For example, the CHWW are employed and trained by the local authority, making it easier for them to direct residents to local authority services. CHWW work very closely with the voluntary sector and can act as informal social prescribers, meaning they can refer residents to wellbeing programmes which improve their mental and physical health, like sports clubs or counselling. CHWW have good relationships with a variety of services and can formally and informally pass information between them.

Which services did this inquiry consider?

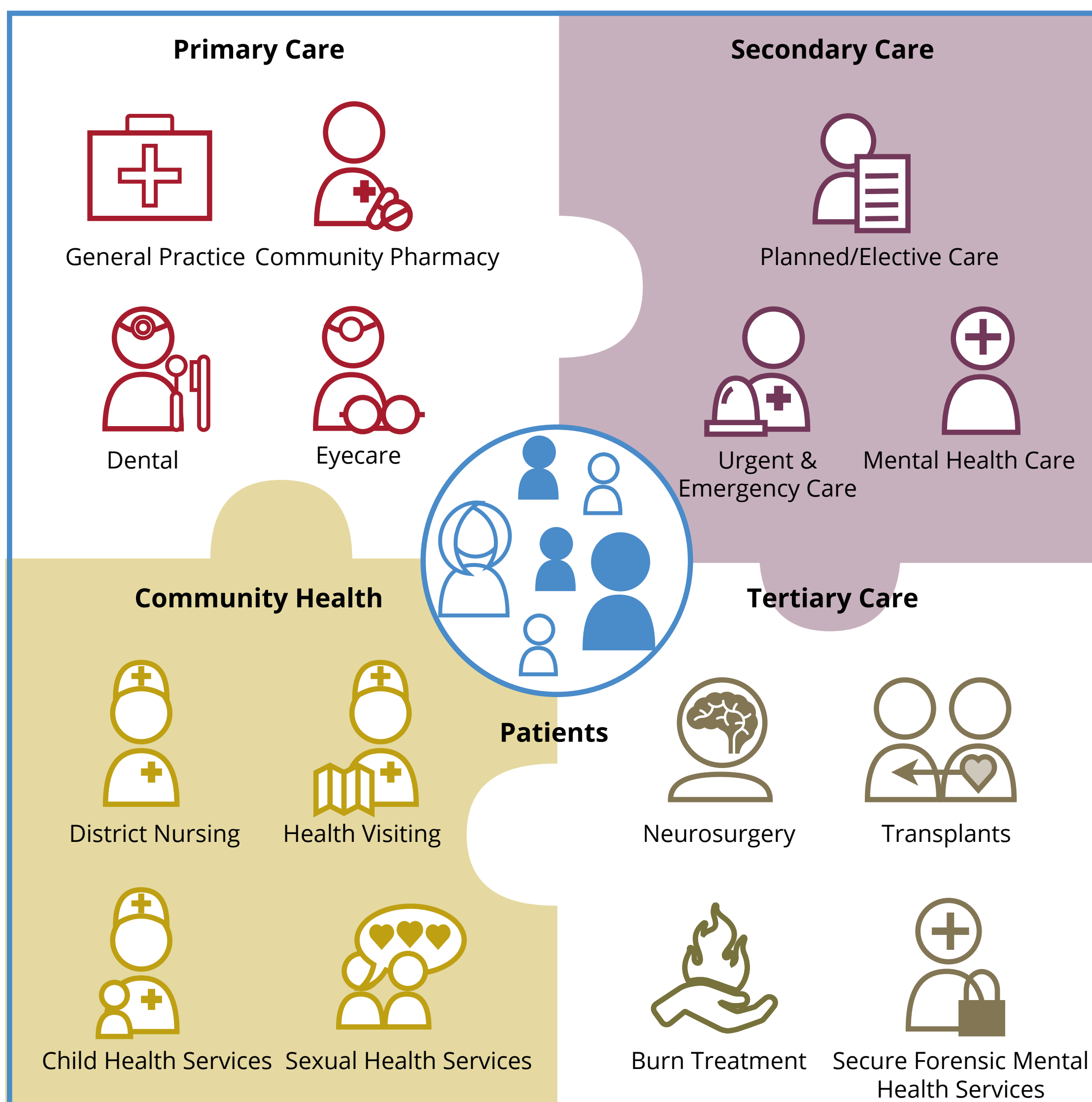
22. The Committee considered integration between primary and community care, as well as integration between both these sectors and other health and social care services, local government, and the voluntary sector. Primary care includes general practice, pharmacy, audiology, dental, and optometry services and are normally delivered in dedicated healthcare settings. In contrast, community health services are mainly delivered in people's homes, schools, clinics, and community centres (among others) and may include services such as school clinics, home-care services, mental health services, physiotherapy, podiatry, and nursing care, including efforts for health promotion.[31] This may also include services that are not provided by the NHS. Figure 1 outlines the key sectors of the health service, across primary, secondary, community health and tertiary care.

29 Benedict Hayhoe, *et al*, 'Integrating a nationally scaled workforce of community health workers in primary care: a modelling study', *The Royal Society of Medicines Journal*, vol 111, 2018, pp 453–461: https://journals.sagepub.com/doi/epub/10.1177/0141076818803443 [accessed 3 November 2023]

30 Community Health and Wellbeing Worker, *Translating the Brazilian model of Community Health and Wellbeing Workers into primary care in the UK* (January 2023): https://www.napc.co.uk/wp-content/uploads/2023/01/Community-health-worker.pdf [accessed 2 October 2023]

31 House of Lords Library, 'Primary and community care - Improving patient outcomes': https://lordslibrary.parliament.uk/primary-and-community-care-improving-patient-outcomes/ [accessed 15 September 2023]

Figure 1: Sectors of the health service



Source: Adapted from NHS Digital, 'The healthcare ecosystem': https://digital.nhs.uk/developer/guides-and-documentation/introduction-to-healthcare-technology/the-healthcare-ecosystem [accessed 1 November 2022]

23. Primary care serves as the cornerstone of the healthcare system. NHS England emphasises that primary care services act as the essential "first point of contact" and serve as the healthcare system's "front door".[32] Remarkably, primary care accounts for nearly 90% of healthcare delivery,[33] conducting approximately 300 million patient consultations annually, compared with approximately 23 million A&E visits.[34]

24. Community care services account for a fifth of NHS workers and have around 100 million patient contacts per year. Yet they are described by the King's Fund as "poorly understood compared to other parts of the NHS". This is "despite their vital contribution" to the work of the health service.[35]

32 NHS England, 'Primary Care Services': https://www.england.nhs.uk/get-involved/get-involved/how/primarycare/ [accessed 1 November 2022]

33 Health and Social Care Committee, *The future of general practice* (Fourth Report, Session 2022–23, HC 113)

34 NHS England, 'Primary Care': https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/primary-care/ [accessed 1 November 2022]

35 The King's Fund, 'Community health services explained', (14 January 2019): https://www.kingsfund.org.uk/publications/community-health-services-explained [accessed 2 October 2023]

Dr Crystal Oldman, Chief Executive at The Queen's Nursing Institute, explained that this happens because community care takes place "behind closed doors"—in people's homes, or in settings not typically associated with health, like schools.[36] This means it is less visible and its essential contribution to keeping people well is not appreciated. For example, the Committee heard from the Royal College of Podiatrists how their discipline plays an essential role in preventing diabetic limb amputations, reducing presentations at primary care with joint pain, and diagnosing stroke risk factors. They can even perform minor surgery in the community.[37] This takes the strain off other parts of the health service but is not as obviously curative as reactive hospital care.

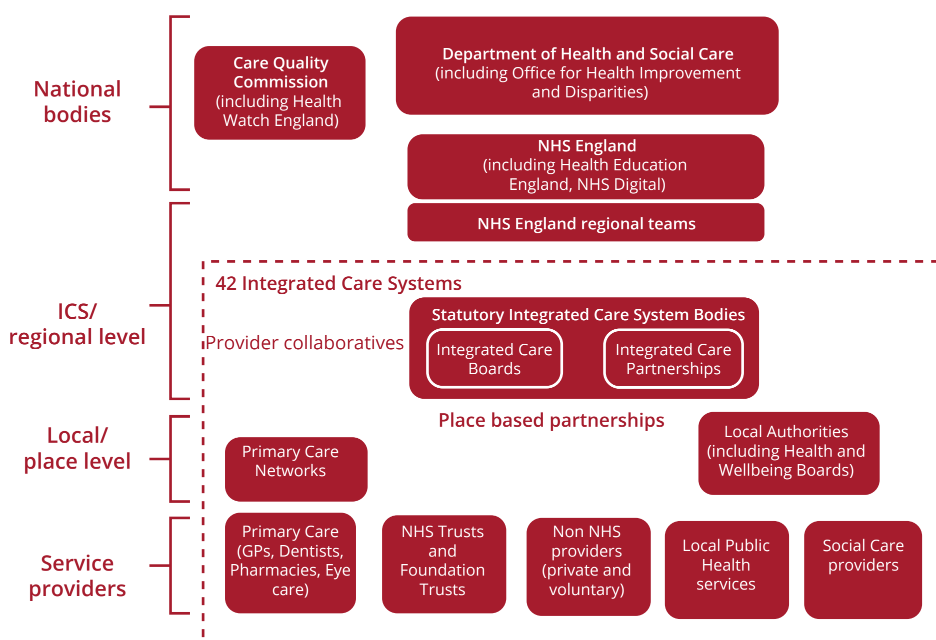
25. Both sectors have recently been affected by substantial reforms. The Health and Care Act 2022 has formalised Integrated Care Systems and Primary Care Networks, which seek to change the way that services interact at a local level. Yet despite the work they do and these recent reforms, both services are "often poorly understood by policymakers, national and local health service leaders and staff working in other parts of the system."[38] Box 2 offers a summary of the organisational framework of the NHS and some of the bodies that support it.

36 Q 24 (Dr Crystal Oldman)
37 Written evidence from the Royal College of Podiatrists (PCC0077)
38 The King's Fund, 'Community health services explained': https://www.kingsfund.org.uk/publications/community-health-services-explained [accessed 2 October 2023]

Box 2: How is the NHS run?

Health policy in England is the responsibility of the Department of Health and Social Care (DHSC) and NHS England (NHSE). Locally, Integrated Care Systems (ICSs) co-ordinate health services. Below, we outline these structures and their specific functions.

Figure 2: The structure of the NHS in England



Source: Adapted from House of Commons Library, The structure of the NHS in England (10 July 2023): https://researchbriefings.files.parliament.uk/documents/CBP-7206/CBP-7206.pdf

Department of Health and Social Care (DHSC): is responsible for funding and policymaking for the NHS and healthcare in the UK. The DHSC funds various health and care services, such as GP services, mental health care, ambulance services, mental health, community, and hospital services, which are commissioned by the NHS. Whilst the DHSC supports public health campaigns and some social care services, Adult Social Care (ASC) funding often comes through the Department for Levelling Up, Housing, and Communities (DLUHC). Local authorities can also get extra funding for ASC by adding a special charge to Council Tax known as the "ASC Precept" or provide access to ASC via means testing.[39] Additionally, a portion of the NHS budget is allocated via the Better Care Fund to support the integration of health and social care services.

NHS England: provides national leadership on service improvement, governance, standards of best practice, and data quality in healthcare.

Care Quality Commission (CQC): registers care providers and conducts inspections to assess and rate the quality of their services, to help protect users of those services.

39 Nuffield Trust, 'Who Organises and Funds Social Care?': https://www.nuffieldtrust.org.uk/news-item/who-organises-and-funds-social-care-1 [accessed 5 October 2023]

NHSE Regional Teams: oversee the quality, financial, and operational performance of NHS organisations within their respective regions. They collaborate with local ICSs to support their development.

Integrated Care Systems (ICSs): represent closer collaborations where organisations take on more responsibility for resource allocation and local population health. These evolved from Sustainability and Transformation Partnerships (STPs) which were introduced in 2016 to bring together NHS providers, commissioners, local authorities, and other partners to plan healthcare services according to the long-term needs of their communities. Following the passing of the Health and Care Act 2022, ICSs gained legal status with statutory powers and responsibilities. Statutory ICSs consist of two main components:

- Integrated Care Boards (ICBs): statutory bodies responsible for planning and funding most NHS services in the area.
- Integrated Care Partnerships (ICPs): statutory committees that bring together a wide range of partners. Stakeholders within the partnership include local government (within the ICS area), voluntary organisations, NHS entities, and others. The ICP is tasked with developing an integrated care strategy tailored to the health and wellbeing needs of the ICS's inhabitants.[40]

Primary Care Networks (PCNs): formally link general practices, so that they can collaborate with other local providers, including community services, social care, and voluntary organisations. Most GP practices in England are part of one of these networks. There are around 1,250 PCNs, each serving populations of 30,000 to 50,000 people.

Beyond the scope of the NHS are other bodies that play a crucial role in the delivery of care services. They include:

Local government services: although the NHS remains the primary provider of direct healthcare services, local government plays a pivotal role in delivering a wide range of complementary services, focused on social care. These services include:

- Social services departments which offer a variety of social care services ranging from children's services, housing, support to individuals with disabilities, and assistance for those with specific long-term health conditions.
- Support for the elderly in the form of homecare, day centres, and residential care homes.

Health promotion and public health campaigns that address issues such as healthy diets, smoking cessation, and vaccination.

40 NHS England 'Voluntary, community and social enterprises (VCSE)', https://www.england.nhs.uk/ourwork/part-rel/voluntary-community-and-social-enterprises-vcse/ [accessed 6 October 2023]

Voluntary, Community, and Social Enterprise (VCSE) sector: plays a key role in enhancing health outcomes and addressing health disparities through providing services such as social care and support, community engagement, promotion and health campaigns, and education and training. The VCSE Health and Wellbeing Programme was launched in April 2017 to enable the DHSC, NHS England, and UK Health Security Agency to collaborate with VCSE organisations to reshape health and care systems, champion equality, tackle health disparities, and support individuals, families, and communities in attaining and sustaining the wellbeing needs of the ICS's inhabitants.[41]

How was our inquiry undertaken?

26. This inquiry was initiated upon the recommendation of the House of Lords Liaison Committee and subsequently appointed by the House. A "Special Inquiry" committee was constituted to carry out the inquiry. These committees consider a single topical issue in detail over a calendar year. Consequently, the committee will have dissolved after the publication of this report. Post-publication scrutiny of this topic may be undertaken by the Liaison Committee.

27. The Committee had a membership of 12 peers and was chaired by Baroness Pitkeathley. The Committee appointed Professor Gerald Wistow as a special advisor to assist its work. Prof Wistow is a visiting professor at the Care Policy and Evaluation Centre at the London School of Economics and the author of Chapter 2 of this report..

28. The Committee published a call for evidence in March 2023, outlining specific questions for respondents to address.[42] Between March and July 2023, the Committee conducted a series of oral evidence sessions. Witnesses included academic experts, government officials, former ministers, and representatives from healthcare institutions, charities, and patient participation groups. Current DHSC officials and ministers gave evidence to the Committee. The Committee expressed its dissatisfaction with the DHSC at the delay in arranging these sessions.

29. The Committee examined 70 witnesses and received 76 pieces of written evidence. Seven witnesses brought international perspectives: they either told the Committee about models of care found abroad, practice medicine outside of the UK, or conduct international comparative health research. The Committee also undertook two visits and held a roundtable event with stakeholders. These are described below and in the appendices.

What needs to change?

30. Based on this evidence, the Committee found four overall barriers to better integration of primary and community care. These barriers relate to:

    (a) Structures and organisation;

    (b) Contracts and funding;

    (c) Systems and data; and

41 NHS England 'Voluntary, community and social enterprises (VCSE)', https://www.england.nhs.uk/ourwork/part-rel/voluntary-community-and-social-enterprises-vcse/ [accessed 6 October 2023]

42 See Appendix 3.

(d) Workforce and culture.

Each of these barriers is discussed in turn in Chapters 3 to 6. Recommendations are made to overcome the barriers, increase integration, and help the health service overcome the challenges it faces. Before this, in Chapter 2, we provide a brief history of health and care integration in England.

CHAPTER 2: INTEGRATION POLICY

31. In this chapter we briefly outline the history of integration in the NHS and related services, together with the wider policy context in which it has evolved. We noted in Chapter 1 that improved integration has been a longstanding goal of successive governments. Such aspirations arise from foundational decisions about the responsibilities and governance of the NHS and local government which have continued to influence policy making and implementation to the present day. The resulting integration challenges are of two distinct kinds: those which are *internal* to the NHS and those relating to relationships between the NHS and *external* organisations.

A brief history of integration policy

32. The NHS was launched in 1948 with a tripartite structure, based on hospitals, general practice, and local authority community health services, but with few co-ordinating mechanisms covering the NHS as a whole. An early review of the costs and operation of the NHS highlighted problems arising from its fragmented structures and their resulting inefficiencies.[43] A principal goal of the first reorganisation of the NHS (in 1974) was to unify health services locally in Area Health Authorities and to develop capabilities for comprehensive health service planning in each area. Local government was also reorganised in 1974 and the new NHS structures shared the boundaries of the top tier councils responsible for education and the newly unified personal social services.

33. As well as aligning geographical boundaries, the 1974 reorganisations altered NHS and local authority responsibilities for providing services. The revised responsibilities were (and continue to be) defined by the "skills of providers" rather than the needs of different categories of "primary user".[44] As a result the NHS became responsible for services where the main skill required was that of health professionals, while local authorities were responsible for services where the main skill was social care or support. As well as differentiating responsibilities in this way, however, the Government also recognised that collaboration between the NHS and local government would be needed in connection with their respective development plans, to ensure that the more complex care needs (such as for patients in social care) were met.[45]

34. A framework was designed to encourage and facilitate such collaboration. It contained several measures which are not unfamiliar today. They included: a statutory duty to collaborate; shared geographical boundaries; a statutory consultative forum for each area; joint planning teams; and financial incentives.[46] Since 1974, governments have regularly added to and subtracted from this framework, thereby effectively acknowledging, if only implicitly, the imperfections of preceding rounds of reforms.

35. Over this period, the policy terminology has also evolved from collaboration to joint planning, partnership, and integration. However, these are different labels for a broadly similar approach of assembling a collection of measures designed to bridge the gap between two separate and distinct organisations

43 The Health Foundation, 'The Committee of Enquiry into the Cost of the National Health Service' (January 1956): https://navigator.health.org.uk/theme/guillebaud-report [accessed 2 October 2023]
44 DHSS, *The Future Structure of the National Health Service* (London: HMSO, 1970), para 31
45 *The Future Structure of the National Health Service,* para 42
46 DHSS, *Report of the Working Party on Collaboration to the End of 1972* (London: HMSO, 1973)

operating within their own structural and cultural silos. Successive reforms have conspicuously failed to engage effectively with the executive functions of each service and their core mainstream management tasks such as service design, priority-setting, budgeting, workforce planning, or performance and outcomes assessment.[47]

36. There have also been recurrent criticisms that too much attention has been concentrated on planning machinery rather than patient outcomes.[48] External reviews of progress have consistently identified gaps between expectations underpinning integration resets and the reality of ongoing practice.[49] At the same time, localised and often project based successes have been identified and each iteration of reform has tended to interpret such evidence as indicative that barriers to change are capable of being overcome more widely.[50] There have also been proposals for more radical reform since the 1980s, though they have generally not been adopted.

37. These proposals include one made as early as 1985 to turn the statutory local consultative committees into the "engine room" for joint planning with their own staff and relatively modest degrees of accountability to the Secretary of State for the success of the resulting joint plans.[51] Soon afterwards, Sir Roy Griffiths called for local authority community care funding to be conditional on submitting approved local plans which demonstrated appropriate levels of NHS engagement.[52] Neither of these proposals was implemented, though a joint commissioning development programme grew out of the Community Care Act 1990. In addition, when health and local authorities argued that their progress was held back by various legal barriers, the Government legislated, through the Health Act 1999, for additional permissive powers in "lead" commissioning, pooled budgets, and integrated health and social care provider organisations.

38. A significantly broader approach was taken by a 2006 White Paper setting out a comprehensive strategy for "much more joint commissioning between Primary Care Trusts (PCTs) and local authorities" based on an outcomes

47 Gerald Wistow, 'Still a fine mess? Local government and the NHS 1962 to 2012 ', *Journal of Integrated Care*, vol 20, No2 (2012) pp 101–115: https://eprints.lse.ac.uk/43322/1/__Libfile_repository_Content_Wistow,%20G_Wistow_Still_fine_mess_Wistow_Still%20_Fine_%20Mess.pdf [accessed 6 November 2023]

48 Department of Health, *Caring for People: Community Care in the Next Decade and Beyond* Cm 849 (1989), para 69; Department of Health, *Our Health, Our Care, Our Say: A New Direction for Community Services* Cm 6737 (January 2006): https://assets.publishing.service.gov.uk/media/5a7c2baee5274a25a9140eab/6737.pdf [accessed 6 October 2023]; Audit Commission, *Means to an end: Joint financing across health and social care* (October 2009): https://lx.iriss.org.uk/sites/default/files/resources/Means%20to%20an%20end.pdf [accessed 6 October 2023]

49 Committee of Public Accounts, *Community Care Developments* (26th Report, Session 1987–88); Charles Webster, *The National Health Service: A Political History*, (Oxford University Press: 1998); Health Committee, *Social Care* (Fourteenth Report, Session 2010–12, HC 1583)

50 For example, Audit Commission, *Joining Up Health and Social Care: Improving Value for Money Across the Interface, Audit Commission* (December 2011): https://www.scie-socialcareonline.org.uk/joining-up-health-and-social-care-improving-value-for-money-across-the-interface/r/a11G00000017r9lIAA [accessed 6 October 2023]; Health Committee, *Social Care* (Fourteenth Report, Session 2010–12, HC 1583); NHS, *NHS Future Forum: Summary report–second phase* (January 2012) pp 11–14: https://assets.publishing.service.gov.uk/media/5a7b8b97ed915d131105ff25/dh_132085.pdf [accessed 6 October 2023]; National Audit Office, *Health and Social Care Integration* (February 2017): https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf [accessed 6 October 2023]

51 DHSS, *Progress in Partnership: Report of the Working Group on Joint Planning* (London: HMSO, 1985)

52 Bulletin of the Royal College of Psychiatrists: *Community Care: Agenda for Action. A report to the Secretary of State for Social Services* (August 1988) p 28: https://www.researchgate.net/publication/322591463_Community_Care_Agenda_for_Action_A_report_to_the_Secretary_of_State_for_Social_Services_By_Sir_Roy_Griffiths_London_HMSO_1988_Pp_28_390 [accessed 6 October 2023]

framework for health and wellbeing.[53] In turn, the outcomes framework was influenced by a deliberative consultation exercise and the person-centred values on which the later definition of integration introduced by the 2013 Pioneer Programme was built.[54] Funding for such outcomes was to be provided by "higher growth in prevention, primary and community care than in secondary care". The document also anticipated that "resources [would] shift from the latter to the former". The White Paper could be seen as containing many of the components for a broadly based and integrated change, but the proposed programme did not proceed to legislation.

39. More recent proposals have included a recommendation in 2011 from the government-appointed "Future Forum" that the Health and Wellbeing Boards proposed in that year's Health and Social Care Bill should have decision making powers over local commissioning plans. Once passed, the provisions of this Act became known as the "Lansley Reforms", after the then Secretary of State for Health, Andrew, later Lord, Lansley. The Committee took evidence from Lord Lansley. A different approach to the strengthening of local joint commissioning processes was proposed by the House of Commons Health Committee (2012) in its recommendation for the creation of "a single commissioning process, with a single accounting officer, for older people's health, care, and housing services in their area".[55] The then Government did not support either of these proposals. A similar initiative to the latter was subsequently implemented in Greater Manchester.

40. Successive administrations have also set two targets over the last decade which have yet to be realised. The first was the objective that, led by 25 Pioneer Sites, person-centred integrated care should become "the norm" over the five years 2013–2018. The Government has not formally reported on the status of this objective, but the Spending Review and Autumn Statement 2015 included a commitment to integrate health and social care services across England by 2020 and required local areas to submit plans by April 2017 demonstrating how they would achieve this. A 2017 National Audit Office Report (NAO) noted that the DHSC intended to replace this requirement with one "for local areas to set out how they expect to progress to integrated services by 2020 in their Better Care Fund 2017–2019 plans. They will also be required to include a statement in their sustainability and transformation plan to explain how it supports the integration 2020 objective".[56]

41. The DHSC developed a number of limited initiatives to support this objective, including an integration standard, an integration scorecard, and an example of how devolution deals "could give impetus" to integration. The Local Government Association (LGA) was also commissioned to provide a peer support programme for integration and an integration resource library. The NAO also noted that, in April 2016, the Government had commissioned a review of health and social care integration across England comparing it with international best practice. This review concluded that "limited progress had been made, and, on current trajectories, local areas would not deliver the target by 2020". When the NAO reviewed the Department's own

53 Department of Health, *Our health, our care, our say: a new direction for community services*, Cm 6737 (January 2006): https://assets.publishing.service.gov.uk/media/5a7c2baee5274a25a9140eab/6737.pdf [accessed 31 October 2023]

54 See para 47.

55 Health Committee, *Social Care* (Fourteenth Report, Session 2010–12, HC 1583)

56 National Audit Office, *Health and social care integration* (February 2017): https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf [accessed 2 October 2023]

arrangements for managing the implementation of the 2020 target, it found "limited oversight of ongoing work" and was critical of the absence of "work streams to bring together, monitor, and evaluate findings from the various integration initiatives or to assess emerging best practice on these barriers".[57]

42. In practice, the 2020 target was overtaken by the development of plans to establish Integrated Care Systems, the associated legislative process, and preparations for implementation from July 2022. The pandemic inevitably interrupted all those processes, and we report below evidence we took on the new arrangements which were seen to be bedding in.

43. Digital integration has also been an important policy objective for successive governments but has not always been successfully realised. An £11.4bn National Programme for IT was launched in 2002 to reform how the NHS in England used information, with the aim of improving service delivery. These costs included central expenditure on managing the Programme, delivering national systems, procuring systems for local NHS organisations, and the cost to those organisations of implementing these systems locally. The core aim was to create a fully integrated SPR to enable the transmission of data across all parts of the NHS for each patient. In 2011, the NAO highlighted implementation delays and concluded that the:

> "£2.7 billion spent on care records systems so far does not represent value for money. And, based on performance so far, the NAO has no grounds for confidence that the remaining planned spending of £4.3 billion on care records systems will be any different."[58]

44. That such a large sum of money was spent without apparent success demonstrates the perennial challenge of commissioning and delivering large data projects in the NHS. As a result of the NAO study, the Public Accounts Committee (PAC) of the House of Commons concluded in 2011 that the aim of ensuring "every NHS patient had an individual [SPR] … [had] proved beyond the capacity of the Department to deliver … "[59] Two years later, the PAC found that the full costs of the programme remained uncertain, that most of its expected benefits were still to be realised and "the Committee was sceptical that the Department could deliver its vision of a paperless NHS by 2018".[60] The limited nature of this vision is also noteworthy given its focus on digitising NHS records only, rather than the fuller range of health and care services many individuals receive. SPRs build on the work of digitalised NHS records and the delays in implementing the latter presented fundamental obstacles to securing the former. The DHSC continues to commit to introduce an SPR but has not yet delivered such a facility as of 2023. Digital integration remains as much of a key issue as organisational or structural integration.

45. In 2018, the Department for Health added "Social Care" to its title and became the DHSC. This emphasised a renewed focus on the Department

57 National Audit Office, *Health and social care integration* (February 2017): https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf [accessed 2 October 2023]

58 National Audit Office, *The National Programme for IT in the NHS: an update on the delivery of detailed care records systems* (May 2011): https://www.nao.org.uk/reports/the-national-programme-for-it-in-the-nhs-an-update-on-the-delivery-of-detailed-care-records-systems/ [accessed 6 October 2023]

59 Committee of Public Accounts, *The National Programme for IT in the NHS: an update on the delivery of detailed care records systems* (Forty-fifth Report, Session 2010–12, HC1070)

60 Committee of Public Accounts, *The dismantled National Programme for IT in the NHS* (Nineteenth Report, Session 2013–14 HC 294)

integrating social care into the rest of the health service's ongoing care.[61] We conclude this background chapter by considering the "integration White Paper" which was published in February 2022 alongside the passage of the same year's Health and Care Act.

Current government policy

46. The most recent government policy document on integration is the February 2022 White Paper *Health and social care integration: joining up care for people, places, and populations*. Its overall aim is to set out "measures to make integrated health and social care a universal reality for everyone across England regardless of their condition and of where they live."[62] As a joint document from both the Secretaries of State for Health and Social Care and for Levelling Up, Housing and Communities, it describes how better integration is expected to help the Government meet its "ambition to level up health outcomes over the long term". As a result, it says "it champions health and wellbeing as a real priority and places a much greater emphasis on prevention". At the same time, it makes clear that integration is an essential tool for improving access to quality, health, and care services so that people can experience person-centred care and support joined up around their needs in places they prefer.

47. As such, it recognises two critical aspects of the policy context for which it is intended:

    (a) The tension between meeting immediate needs and seeking to minimise demand in the long term; and

    (b) The need for integration to be viewed as a means for realising high priority goals rather than an end in itself

48. Both areas of policy are covered by the Committee's remit and the evidence it has received. However, at this point, it is important to recognise their implications. First, that by championing health and wellbeing, integration must encompass a wider range of stakeholders and perspectives. It will demand greater attention to leadership, including systems leadership as well as organisational leadership.[63] Secondly, the emphasis on integration as a means, and not an end, should help the White Paper's emphasis on outcomes. At the same time, it suggests the importance of recognising that the same means do not necessarily serve all ends. Given the range of policy objectives the White Paper aims to advance, the informed tailoring of integration mechanisms to differing long and short term ends also makes additional demands of leaders. The White Paper proposals include the development of a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review.[64]

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61 The Health Foundation, 'The Department of Health and Social Care' (January 2018): https://navigator.health.org.uk/theme/department-health-and-social-care [accessed 2 October 2023]

62 Department of Health and Social Care, *Health and social care integration: joining up care for people, places and populations* (9 February 2022): https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations [accessed 28 September 2023]

63 National Audit Office, *Introducing Integrated Care Systems: joining up local services to improve health outcomes* (14 October 2022): https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/. [accessed 6 October 2023]

64 *Ibid.*

49. The White Paper also identified the need for leadership development in the context of its view that strong leadership and accountability was required to make integrated working an effective tool for levelling up health outcomes and improving health and wellbeing more generally. Former Ministers in their evidence to the Committee made similar points.[65] Like the White Paper, they also expressed support for developing such capabilities at the place as well as ICS levels. In this context, the White Paper itself emphasised that "we would also expect a governance model to provide clarity of decision-making." It explained that this model should include:

> "a single person, accountable for shared outcomes in each place or local area, working with local partners (e.g. an individual with a dual role across health and care or an individual who leads a place-based governance arrangement). This person will be agreed by the relevant local authority or authorities and Integrated Care Board (ICB)."[66]

We report below evidence from current ministers on progress in developing and implementing this proposal.

Recent integration reviews

50. There have been several recent reviews into integration in health and related services:

(a) The National Audit Office's 2022 report: *Introducing Integrated Care Systems: joining up local services to improve health outcomes*.[67] This report considers the new ICS structures, particularly their value for money and the extent to which they are delivering the Government's priorities for health. The report concludes that:

> "The inherent tension between meeting national targets and addressing local needs, the challenging financial savings targets, the longstanding workforce issues and wider pressures on the system, particularly social care, mean that there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them."[68]

(b) *Next steps for integrating primary care: the Fuller Stocktake Review* (2022). The review was commissioned by the NHS and concluded that primary care should be supported by ICSs and the DHSC should play an enhanced role in providing more preventative healthcare through local teams.[69] The Committee took evidence from the report's author Claire Fuller, CEO of the Surrey Heartlands ICS.

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65 Q 230 (Lord Lansley) Q 233 (Lord Warner) and Q 233 (Lord Hutton)

66 Department of Health and Social Care, *Health and social care integration: joining up care for people, places and populations* (11 February 2022): https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations [accessed 6 October 2023]

67 National Audit Office, *Introducing Integrated Care Systems: joining up local services to improve health outcomes* (14 October 2022): https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/. [accessed 6 October 2023]

68 *Ibid.*

69 NHS England, *Next steps for integrating primary care: Fuller Stocktake report* (May 2022): https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf [accessed 6 October 2023] and NHS Confederation, 'Next steps for integrating primary care: what you need to know': https://www.nhsconfed.org/publications/next-steps-integrating-primary-care [accessed 6 October 2023]

(c) *The Hewitt Review: an independent review of integrated care systems* was commissioned by the DHSC and published in 2023. It is the first major review into the new ICS structures and focussed on how their oversight and governance could be enhanced. The *Review* found that "while structures matter, culture, leadership and behaviours matter far more", something this Committee also heard from witnesses.[70] Hewitt argues that ICSs can deliver health policy, but need more flexible funding, better data, and more guidance on accountability to do this.[71]

51. This report complements these earlier reviews, but covers new ground by focussing on community, as well as primary care. While this report also considers the new Integrated Care Systems, it takes a wider view and considers clinical and digital integration, as well as purely structural integration.

70 The Committee took evidence from the author of this review, the Rt Hon Patricia Hewitt.

71 The Hewitt Review, *An independent review of integrated care systems* (4 April 2023): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1148568/the-hewitt-review.pdf [accessed 6 October 2023]

CHAPTER 3: STRUCTURES AND ORGANISATION

52. Witnesses stated that successful integration relies on good working relationships between service representatives, in addition to more formal decision-making, policies or structures.[72] Helen Whately MP, Minister of State for Social Care, summarised the DHSC's view on this, saying that integration " … is all about relationships. Wherever you have great relationships, it really works".[73] Box 3 highlights an example of how this can work positively in practice, focusing on Coventry City Council.

Box 3: Committee visit to Coventry City Council

The Committee visited Coventry City Council, to meet health, local authority and VCSE leaders. The visit demonstrated that good professional relationships between service representatives is a prerequisite for essential integration. The various integrated care projects the Committee heard about were facilitated by intangible factors, like a shared vision for the city, a focus on health inequalities and close working relationships between both service heads and those involved in operations.

The warm and collegiate relationship between different professions and services encouraged collaboration, rather than competition. We heard from service leaders who had worked in different health-related professions in the city during their career. ICP participants knew each other well and saw each other as members of a team, rather than representatives of a particular service.

The examples demonstrated in Coventry may not be appropriate for every locality. However, the high level of co-ordination, alignment of aims and the close relationships between services are something to which all ICSs should aspire.

Source: Appendix 5

53. It is difficult to mandate a single set of mechanisms that will encourage working relationships for integration, especially when the spirit of the 2022 Act is to encourage autonomous decision-making at the most local level. This chapter will therefore make recommendations about how overall structures within the health service could be optimised so that they facilitate (or do not hinder) relationship forming between primary and community care and the wider health service.

Stability of structures

54. There was a consensus amongst witnesses that further reorganisation or structural reform of the NHS would be premature and disruptive.[74] Prof Campbell summarised this when he told the Committee that "we need stability in the structures. We have the potential for great progress … but we need stability over the next few years rather than change."[75] The Government would be unlikely to accept that the Health and Care Act 2022 (and the structures it formalised) should be replaced. Therefore, this chapter explains how structural barriers to integration can be reduced within the scope of

72 Q 13 (Prof Sue Yeandle) Q 19 (Prof Claire Goodman) Q 29 (Dr Crystal Oldman) and Q 38 (Ruthe Isden)

73 Q 254 (Helen Whately MP)

74 Q 1 (Prof John Campbell) Q 2 (Prof John Campbell) Q 2 (Prof John Campbell) Q 224 (Patricia Hewitt) and written evidence from NHS Confederation (PCC0032)

75 Q 1 (Prof John Campbell)

the Health and Care Act 2022, while recommending limited incremental reforms.

55. **ICSs need stability and continuity to develop more fully. Structures should be given time to mature and evolve; and for constraints on their performance to be well understood. The 2022 Act's underlying principles of subsidiarity and collaboration should continue to inform any future reform to the structure of services. These principles commanded wide support from witnesses, irrespective of the diversity of opinion on the overall merits of the 2022 Act and wider health policy.**[76]

56. ***ICSs should be given time to mature and further wholescale reorganisation to the health service should be avoided. The 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 recent Hewitt Review, but with the benefit of three years-worth of data and experience, rather than just one.***

ICS membership and boundaries

57. Links between local authorities and ICSs vary between systems. This can depend on factors like the maturity of the ICS, the extent to which ICS and local authority boundaries are coterminous, and differences in working relationships and cultures. Simon Williams, Director of Adult Social Care Improvement at the Local Government Association, told the Committee:

> "There are probably three key factors that drive the variability. The number one factor is history, because although ICSs are new, locally people were getting on in their previous guises for years, so they are all building on history in one way or another. Secondly, it depends on complexity, because there are greater levels of geographical complexity in some places than others. The third factor is relationships: what is the level of relationship that they are building on?"[77]

58. Nora Corkery, CEO of Devon Communities Together, added, "although great strides have been made in integration, there is a definite cultural clash between decision-makers in the National Health Service and those in local government."[78]

59. Minister Whately had confidence in the creation of ICSs as "the best effort that the system has made and the best structure that has been put in place to date to achieve it in practice … I am hearing that partly because the structure that we have legislated for was bottom-up; it came from the system". However, while integration within the NHS may be improved, this is less true of the external integration role of ICSs to stakeholders like local

76 Written evidence from the Association of Directors of Adult Social Services (ADASS) (PCC0069) and NHS Confederation (PCC0032)

77 Q 198 (Simon Williams)

78 Q 75 (Nora Corkery)

government. It was noteworthy that the Ministers made little reference to local government, while the role of social care in support of the NHS was referred to more frequently.[79]

60. There was a clear consensus amongst witnesses that the collaborative approach behind ICSs was positive.[80] However, Cllr Tim Oliver, leader of Surrey Country Council, explained that the imbalance in power between ICSs and ICPs had made this more difficult:

> "The challenge in part is how the ICSs were set up. They are predominantly focused on the work of the integrated care boards… The challenge has been getting the integrated care partnerships to have equal status and equal contribution, because it is the ICPs [that] bring along local government, the VCSE and social care generally."[81]

61. Claire Fuller, CEO of the Surrey Heartlands ICS and author of the Fuller Review said: "The local authority has always had the democratic accountability and has always been much better than the NHS at doing the patient engagement and listening to communities."[82] Yet, representatives of local authorities (such as the leader or health portfolio holder) can sit on ICBs but cannot chair them.[83] Local authority Directors of Public Health are sometimes not included on ICPs.[84] This means that they have, at best, consultative but not executive responsibilities for the health service. This is despite local councillors' democratic mandate, control of social care budgets, responsibility for public health and close relationships with VCSE organisations.

62. Overall, the power imbalance between NHS and local authority representation can significantly limit the level of integration between the NHS and local authorities, and the extent to which better integration is seen locally as a shared goal for equal partners. In terms of how this affects other organisations, Ruthe Isden, head of health influencing at Age UK, explained:

> " … where the relationship between the NHS leadership and the local authority leadership is not good, that tends to suck the oxygen out of those wider conversations. Those tend to be the areas where the VCSE organisations, carers and other communities are not really in the conversation, because the conversation is still stuck on unpacking some of the tensions in those statutory relationships."[85]

63. Similarly, the Committee heard that not all ICSs provide VCSEs (or an overall VCSE representative) with a seat on integrated care partnerships (ICPs).[86] The Health and Care Act 2022 does not make provision for representatives of VCSE organisations to have ex officio membership of integrated care boards (ICBs).[87] Their contribution is not adequately recognised, nor are they properly consulted or involved in wider decision making. This undermines the ability of VCSEs to influence the overall direction of ICSs. It also makes

79 Q 238 (Helen Whately MP)
80 Q 201 (Cllr Tim Oliver)
81 Q 198 (Cllr Tim Oliver)
82 Q 55 (Prof Claire Fuller)
83 Q 205 (Cllr Tim Oliver)
84 Q 139 (Julia Weldon)
85 Q 38 (Ruthe Isden)
86 Q 224 (Patricia Hewitt)
87 Q 13 (Prof Sue Yeandle) Q 137 (Julia Weldon) Q 198 (Cllr Tim Oliver) and Q 201 (Cllr Tim Oliver)

it more difficult for ICSs to co-ordinate the work of VCSEs (or recognise their contribution) through formal decisions and informal relationships made at ICBs and ICPs.

64. To rectify this patchwork of authority and accountability, the Government has considered introducing an expectation that systems appoint "a single person … accountable at place level, across health and social care, accountable for delivering shared outcomes and strong, effective leadership".[88] This was suggested in the Integration White Paper, published in 2022. "Place level" typically refers to geographical areas smaller than ICSs, such as towns or districts.

65. **Health, social care, and voluntary sector leaders should work together closely as equal partners, as they are likely to possess a deep understanding of their respective communities. This will encourage integrated policy making and service provision, as well as a more preventative approach to public health. There should be a single accountable officer at place level, specifically charged with working with local leaders of providers, the voluntary sector, and local elected officials. There is a need for local champions, keen to drive integrated working, to explore local barriers and find local solutions. Their job appraisal should be focused on their effect on reported outcomes from those delivering and those receiving front-line care.**

66. ***Elected local government officials should be granted the right to chair Integrated Care Boards (ICBs). Representatives of VCSE organisations should be allowed to be members of Integrated Care Boards. 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 three targeted changes can be enabled by amending the Health and Care Act 2022.***

67. ***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.***

68. While it is understandable that large ICSs cover many local authorities, it is undesirable to split local authorities between more than one ICS. A lack of coterminosity between ICS and local authority boundaries increases the complexity and costs of integration as well undermining linkages with local people and community organisations. In ICSs which are structured around a large hospital, the relative influence of acute services may be bolstered at the expense of primary and community care, as well as local government.[89] Ms Corkery told the Committee that:

> "The NHS tends to think about the catchment areas of the hospitals that it is working within, while local government thinks much more

88 Department of Health and Social Care, *Health and social care integration: joining up care for people, places and populations* (11 February: 2022): https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations/health-and-social-care-integration-joining-up-care-for-people-places-and-populations [accessed 2 October 2023]

89 Q 44 (Fiona Claridge) and QQ 52, 57 (Prof Claire Fuller

> about serving the population of a whole administrative area. There is a disconnect there."[90]

Coterminosity would help resolve this problem. Prof Checkland unfavourably compared ICSs with the footprint of earlier, smaller CCGs stating: "At ICS level, multiple local authorities are involved, as each ICS covers more than one local authority. The one-to-one relationship that we used to have between CCGs and local authorities, largely, has gone."[91]

69. ***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.***

Accountability

70. The Committee heard that some ICSs and PCNs are not as internally integrated as others. Prof Checkland said: "Our research found that PCNs are very variable across the country … the most well-established are those with a history of collaborating … others are finding it more difficult, such as if they have not worked together before or there is a history of poor relationships".[92] ICSs also vary in their level of integration, with one witness remarking that "If you've seen one integrated care system, you've seen one integrated care system".[93]

71. Accountability for the success of these new structures and for integration overall is complex. There is a Minister with responsibility for integration, but its incumbent—Helen Whately MP—told the Committee that although she had responsibility for ICSs, integration is encouraged by all health ministers through their various responsibilities.[94] Within ICSs, ICPs are primarily responsible to the DHSC and ICBs to NHSE.[95] Creating a system with "high autonomy and high accountability"[96] is challenging and the current arrangements are convoluted.

72. The Care Quality Commission is responsible for assessing ICSs and has recently published guidance on how it is going to do this.[97] The CQC will use an assessment framework composed of three themes, one of which is integration (the others are quality and safety, and leadership).[98] The Health and Care Act 2022 gave the CQC authority to inspect ICSs, but not to rate them. Therefore, the CQC inspection guidance and ratings must be approved by the Secretary of State.[99] This means ratings will not be awarded

90 Q 75 (Nora Corkery)
91 Q 161 (Prof Kath Checkland)
92 Q 157 (Prof Kath Checkland)
93 Q 224 (Patricia Hewitt)
94 Q 237 (Helen Whately MP)
95 Q 142 (Jason Yiannikkou)
96 Q 146 (Jason Yiannikkou)
97 Care Quality Commission, 'Our approach to assessing integrated' (March 2023): https://www.cqc.org.uk/news/our-approach-assessing-integrated-care-systems [accessed 28 September 2023]
98 Care Quality Commission, 'Assessment framework for integrated care systems' (20 September 2023): https://www.cqc.org.uk/local-systems/integrated-care-system/interim-guidance-assessing-integrated-care-systems/assessment-framework-for-integrated-care-systems [accessed 28 September 2023]
99 DAC Beachcroft, 'How will CQC assess ICSs?: what we know so far' (26 April 2023): https://www.dacbeachcroft.com/es/mx/articles/2023/april/how-will-cqc-assess-icss-what-we-know-so-far/ [accessed 28 September 2023]

until at least April 2024.[100] The CQC is currently undertaking "pilot assessments" to test and refine its inspection process.[101] These consist of "trial run" inspections of systems, with participants able to give feedback on the process.

73. Witnesses suggested that a specific "integration index" could help track how well ICSs are co-ordinated services.[102] This would enable areas of good practice to be identified, to encourage mutual aid between more and less matured systems. However, if this index factors in health outcomes, these must take deprivation into account, otherwise "if you assess the performance of integrated care system on the index and you identify some areas of poor performance, you may be identifying areas of deprivation rather than poor performance in using the resources available to those systems."[103]

74. **ICSs were created to ensure that services are well co-ordinated and that decisions are taken at the lowest appropriate level. In addition to assessing safety and leadership, the CQC needs to develop a more granular measure of the level of integration. This would enable long-term tracking of ICS maturation, which will help measure the success of the reforms put in place under the 2022 Act.**

75. ***In addition to authorising the new CQC ratings for ICSs, the Secretary of State should instruct the 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 1–4 scale. The index should take account of activity levels, care pathways, population outcomes and assessments of structures. The CQC, NHSE, and DHSC should use these 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.***

76. ***The Government should ensure that the CQC pilot studies are widely disseminated and reviewed. Maximum engagement in the CQC studies will lead to a better inspection regime for ICSs. This will help the CQC judge the extent to which ICSs are acting in line with the spirit, as well as the wording of the 2022 Act.***

100 NHS Confederation, 'CQC's assessment of integrated care systems: what you need to know' (23 March 2023) https://www.nhsconfed.org/publications/cqcs-assessment-integrated-care-systems [accessed 28 September 2023]

101 Care Quality Commission, 'Update on pilot assessments of integrated care systems' (18 July 2023): https://www.cqc.org.uk/news/update-pilot-assessments-integrated-care-systems [accessed 2 October 2023]

102 Q 27 (Jacob Lant) and Q 49 (Prof Sir Chris Ham)

103 Q 48 (Prof Sir Chris Ham)

CHAPTER 4: CONTRACTS AND FUNDING

77. The Committee heard that funding in the health service is excessively concentrated on reactive hospital care, rather than preventative primary and community care. Professor Sir Christopher Ham, Chair of the Coventry and Warwickshire Health and Care Partnership and Co-chair of the NHS Assembly, said: "There has been a relative underinvestment in community services and primary care, and prevention is often at the end of the queue."[104] Siobhan Melia, Chair of the Community Network of NHS providers, said that a lack of "capital funding for primary and community services, enabling investment in estate and digital" was a major barrier to integration. This was because "typically, the first port of call for investment in estate is often acute hospitals."[105] This is a long-standing problem for the health service in England.

78. Despite its disproportionate consumption of resources, the acute sector in England is relatively small (measured in terms of hospital beds) compared to European counterparts.[106] Hospitals face high levels of demand and are routinely operating at maximum capacity.[107]

79. Sir Norman Lamb, a former health minister, stated:

> "In the last two decades, the acute sector has taken a disproportionate share of the total cake. The system of 'Payment by Results' accentuated this trend, incentivising activity in acute hospitals (and the money following the activity). Primary care, community care and mental health had no such financial incentive and lost out."[108]

80. Other former ministers echoed this in their evidence. They emphasised the need to control money and prevent it being transferred back to the acute sector if a change in the balance of investment between hospital, out of hospital care, and population health improvement was to be achieved. Lord Warner, a former health minister, told the Committee:

> "… you need to stop the leakage back to acute hospitals. You need to control the flow of money regionally and locally down … with the agenda of using community-based services, including social care, to drive population health. If we want a health service, not an ill-health service, we have to do something like that."[109]

Lord Hutton of Furness added: "… hospitals are once again the kings of the jungle. They control everything. They suck everything in. There is no room for any other part of the healthcare system to flourish. There just is not. The secondary sector—the acute hospitals—rules the roost. That is wrong."[110]

81. Siobhan Melia further told the Committee: "We have peak demand on all healthcare services in all parts of the sector, and we have a growing need

104 Q 46 (Prof Sir Chris Ham)
105 Q 176 (Siobhan Melia)
106 Q 36 (Ruthe Isden)
107 Q 1 (Prof Kate Walters, Prof John Campbell) and Q 17 (Prof Sally Kendall)
108 Letter from Sir Norman Lamb, former Minister for Care and Support to Baroness Pitkeathley, Chair of the Select Committee on the Integration of Primary and Community Care (20 July 2023): https://committees.parliament.uk/publications/41690/documents/206505/default/
109 Q 232 (Lord Warner)
110 Q 232 (Lord Hutton of Furness)

to invest in the wider determinants, population health and reducing health inequalities. The challenge is how to ease the demand down to create the investment headspace and practical space to do that."[111]

82. This situation reinforces the case for investing more resources in out-of-hospital services. However, it is challenging to reallocate resources from hospitals towards better-integrated primary and community care, due to the constant and increasing pressure that the acute sector is under.[112] In correspondence with the Committee, Sir Norman Lamb stated that "the political challenge of shifting resources is clear."[113] Nonetheless, strengthening out-of-hospital provision would support a more preventative model of healthcare which would reduce pressure on the acute sector in the medium to longer term.

83. Ruthe Isden encapsulated the resulting dilemma as follows: "The question now is whether we invest more in the acute sector to meet those pressures or invest in the primary and community sector in order to ensure that we do not have to keep funnelling money into the acute sector."[114] Former health ministers Lords Lansley, Warner, and Hutton of Furness all agreed that a shift in funding towards primary and community care needed to take place.[115]

84. The overall distribution of funding between healthcare sectors is beyond the remit of this Committee. Some witnesses remarked that the effective use of funds is more of a limiting factor on integration than the overall level of funding. Professor Daniel Lasserson, president of the Hospitals at Home Society, said: "In my experience, funding is much less of a barrier than culture. A lot of things that I have done have not required lots of money, but there is a culture among the perhaps more conservative elements of my profession—medicine—of seeing only risks rather than potential benefits or focusing on risk mitigation."[116]

85. While more funding is always likely to be welcomed by services, this chapter takes account of overarching financial constraints and recommends changes to budgets and contracting which will help improve integration between primary and community care. For the future, however, the Government will need to reconsider the long-term balance of funding between the acute and non-acute sectors to create a more preventative health service.

Contract reform

86. Witnesses stated that multi-disciplinary teams deliver better care to patients, but that current contracts do not do enough to incentivise this model of care for pharmacy, optometry, and dentistry (POD), community or GP services.[117] Ewan Maule, a member of the Royal Pharmaceutical Society's English Pharmacy Board, stated: "What we have at the moment does not necessarily work well for citizens or the healthcare service, so we need more reform in

111 Q 182 (Siobhan Melia)
112 Written evidence from NIHR Policy Research Unit in Health and Care Systems and Commissioning (PCC0025)
113 Letter from Sir Norman Lamb, former Minister for Care and Support to Baroness Pitkeathley, Chair of the Select Committee on the Integration of Primary and Community Care (20 July 2023): https://committees.parliament.uk/publications/41690/documents/206505/default/
114 Q 36 (Ruthe Isden)
115 Q 235 (Lord Hutton of Furness) and Q 236 (Lord Lansley, Lord Warner)
116 Q 86 (Prof Daniel Lasserson)
117 Q 103 (Dr Abhi Pal)

some contracting aspects to free-up the proper integration that we all know we need."[118]

87. Currently, there is a national primary contract which funds GP practices in England.[119] Pharmacy, optometry and dentistry contracts are negotiated nationally and then services are commissioned at a local level. Their incomes are also supplemented by patient purchases.[120] Community care contracts are much more fragmented: there is no national contract for podiatry or physiotherapy, for example. Instead, contracts are negotiated, and services commissioned at an ICS level.[121]

88. Primary and community care contracts predominantly reimburse activity or capitation (the number of prescriptions dispensed, or patients on practice lists) rather than desirable outcomes like long-term public health or integrated working.[122] This form of funding is not designed to incentivise clinicians working across service boundaries and treating patients more holistically. This is because services do not receive sufficient remuneration for working with other services to plan and deliver patient care, as payment is given only for reactive care episodes or by the number of patients on-roll. For example, a pharmacy is remunerated based on the number of prescriptions it dispenses. Therefore, it will not receive funding for time a pharmacist spends meeting with a GP to discuss how a patient could have unnecessary or excessive medications removed from repeat prescription, although such actions could be cost saving.[123] Witnesses also stated that primary and community care contracts should have aligned incentives, so that services are not in competition and are more likely to collaborate.[124]

89. Ewan Maule explained the diversity of the community pharmacy sector to the Committee, from small shops to large conglomerates. He emphasised that while the current contract system benefits many, it particularly favours larger businesses. Ensuring contract reform does not jeopardise smaller community-based pharmacies is crucial, as their loss would significantly affect the broader health service. This delicate balance has deterred major contract changes, often leaving smaller pharmacies at a disadvantage.[125]

90. Mr Maule further warned the Committee that the current contract (which is 10 years old) perversely incentivises "a pill for every ill", rather than a situation where "taking someone off a medicine was as valuable to them as starting someone on medicine".[126] Multi-disciplinary working is less likely to occur if it is not directly funded and therefore primary care contracts must be adjusted to "encourage all those contractor groups to work together in a way that is patient-centred".[127]

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118 Q 103 (Ewan Maule)
119 The King's Fund, 'GP funding and contracts explained', (11 June 2020): https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained [accessed 2 October 2023]
120 The King's Fund, 'Community pharmacy explained', (16 December 2020): https://www.kingsfund.org.uk/publications/community-pharmacy-explained [accessed 2 October 2023]
121 The King's Fund, 'Community health services explained', (14 January 2019): https://www.kingsfund.org.uk/publications/community-health-services-explained [accessed 2 October 2023]
122 Q 65 (Dr Harpreet Sood) Q 110 (Ewan Maule) and Q 111 (Dr Abhi Pal)
123 Q 110 (Ewan Maule)
124 Q 191 (Dr Amanda Doyle) Q 207 (Dr Dheepa Rajan) and written evidence from Guy's and St Thomas' NHS Foundation Trust (PCC0023)
125 Q 112 (Ewan Maule)
126 Q 110 (Ewan Maule)
127 *Ibid.*

91. This problem is not restricted to pharmacy or general practice. Dr Abhi Pal, President of the College of General Dentistry, explained that "prevention is a fundamental part of dental care" but that "the current contract does not enable or support prevention."[128] Again, this is because dentists are remunerated by care episode, meaning they have fewer incentives to be involved in integrated care. This is a loss to the wider health service, because of the significant contribution that good dental care can make to the diagnosis and management of many other conditions and the relationship between good oral health and overall wellbeing.[129]

92. POD and community contracts do not consider deprivation sufficiently when calculating levels of funding.[130] Deprived areas[131] have the greatest health challenges and therefore need integrated, multi-disciplinary care the most. These areas can also be less likely to attract clinicians.[132] If funding for POD does not reflect the levels of deprivation, then it will be harder for the NHS to fund multi-disciplinary teams in primary and community care services in such areas. Mr Maule further added: "We know that … some of the work that has been done on prevention and early intervention, has an impact on some of the most deprived and disenfranchised aspects of society. There is enormous value to that. But … that is not necessarily adequately valued in the contract."[133]

93. **Primary and community clinicians should work more collaboratively at place and the individual patient levels. Their work should put a greater emphasis on public health and preventative health care. Payment by outcome, weighted by the level of deprivation—as well as payment by activity or capitation—should help incentivise integrated and preventative work. This is urgently required, and the needs of more deprived areas should be explicitly recognised.**

94. ***The DHSC and NHSE 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 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.***

128 Q 110 (Dr Abhi Pal)
129 Q 105 (Dr Abhi Pal)
130 Q 65 (Dr Harpreet Sood)
131 For example, the most deprived 20% of the population, which is focused on by NHS England. NHS England, 'Deprivation : What is deprivation health?': https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/deprivation/ [accessed 2 October 2023]
132 NHS England, 'Targeted Enhanced Recruitment Scheme': https://www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment/ [accessed 2 October 2023] and written evidence from the Royal College Podiatrists (PCC0077)
133 Q 110 (Ewan Maule)

Partnership model and estates

95. Professor Hazel Everitt, Professor of Primary Care Research at the University of Southampton, told the Committee: "Communication between professionals is enhanced if you are co-located".[134] The link between co-location and integration was echoed by other witnesses. Ruthe Isden said:

> "In some parts of the country, primary care physicians are fortunate enough to work in an organisation, environment or physical building that has space for consulting rooms in order for them to create multi-disciplinary teams to be able to offer a range of services out of that one location. They can co-locate staff with community staff and services, and they are able to really build that team around the individual."[135]

96. Yet we also heard that the current GP contract and partnership model causes problems with workforce and estates which undermines this integration.[136] GP practices are often too small or dilapidated to host other community clinicians. They often lack the infrastructure for digital integration.[137] The partnership model means that GPs are responsible for managing business premises, as well as delivering healthcare.[138] Prof Walters stated: "If we are going to go for a real integrated model where we try to co-locate things in premises, the issue of estates under the current model will also have to be addressed."[139]

97. The size and condition of the primary care estate was described by several witnesses.[140] Claire Fuller is Chief Executive of the Surrey Heartlands ICS, author of the Fuller Stocktake review into primary care integration and a GP. She explained the difficulties a "neglected" primary care estate caused her:

> "When I go to the practice on a Friday, if everybody is in and nobody is on holiday, I work in a cupboard. We call it the cupboard because there is no couch in it, which means that I have to wait for my friend over the corridor to finish seeing whomever she is seeing if I need to examine someone. Then I will come out and we will swap. Everyone has a story about having consulting rooms upstairs without a lift or having disabled access through the bins."[141]

98. Undertaking building works to make a premises fit for co-located multi-disciplinary working entails partners borrowing or spending money. GPs therefore bear a financial risk or outlay which is not shared with the community services who could use the refurbished building, who might only be charged rent to use the building after works are completed. Although funding is (or has been) available for improvements to estates (through the Estates and Technology Transformation Fund[142], for example), GP partners are still mainly responsible for spending on buildings which should be used by multiple services. The current funding arrangements disincentivise both

134 Q 9 (Prof Hazel Everitt)
135 Q 33 (Ruthe Isden)
136 Q 9 (Prof Kate Walters), Q 33 (Ruthe Isden), Q 58 (Prof Claire Fuller), Q 166 (Dr Alex Thomson), Q 173 (Dr Alex Thomson) and Q 191 (Dr Amanda Doyle)
137 Written evidence from The British Medical Association (PCC0071)
138 Q 33 (Ruthe Isden) and Q 162 (Sian Thomas)
139 Q 9 (Prof Kate Walters)
140 Q 33 (Ruthe Isden) and Q 162 (Sian Thomas)
141 Q 58 (Prof Claire Fuller)
142 NHS England 'Estates and Technology Transformation Fund': https://www.england.nhs.uk/gp/infrastructure/estates-technology/ [accessed 2 October 2023]

building improvements and a wider culture of co-location.[143] The positive impact of policies like the Additional Roles Reimbursement Scheme[144] will be undermined if the primary care estate lacks the physical space to allow community clinician co-location[145].

99. Dr Fuller explained that restrictions on budgets also make funding improvements to estates difficult:

> "The minute you start to deliver integrated care that involves integrating general practice with any other… [sectors] the capital costs then fall in the system capital envelope … We need a longer-term estates settlement to enable us to plan more effectively for premises that are able to deliver integrated working."[146]

Inflexible funding envelopes at a system level make it difficult to fund the estate for co-located services.

100. **GP practices should be housed in buildings that facilitate integration by acting as a physical hub where primary and community clinicians, together with other services, are co-located, sharing space for multi-disciplinary practice, planning, and training.[147] In some areas, it might be appropriate to decouple clinical work from financial responsibility for the premises, in order to facilitate the building improvements required for co-located multi-disciplinary working and attract newly-qualified clinicians. This would make it easier for patients to access a variety of different services from just one health setting. Models of primary-community co-location will vary by geographical setting, the needs of local communities, and the availability of existing buildings for shared use and suitable adaptation. For example, a multi-disciplinary team based around a rural single-handed GP practice might make use of community assets, like a village hall, provided there is requisite privacy.[148]**

101. ***To facilitate co-located, multi-disciplinary working for primary and community care, the 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.***

Budget fragmentation

102. The Committee has heard that fragmentation of funding within and between disciplines makes it harder for multi-disciplinary working at place

143 Q 9 (Prof Kate Walters)

144 "The Additional Roles Reimbursement Scheme entitles PCNs to access funding to support recruitment across five reimbursable roles - clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics". NHS England, *Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance* (December 2019): https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf [accessed 6 October 2023]

145 Q 162 (Prof Kath Checkland)

146 Q 58 (Claire Fuller)

147 Q 9 (Prof Hazel Everitt), Q 33 (Ruthe Isden), Q 191 (Dr Amanda Doyle) and Q 122 (Genevieve Smyth)

148 Q 77 (Nora Corkery)

level, undermining integration.[149] Currently, the different clinicians who could collaborate are funded through different contracts and budgets and are accountable to different leaders and inspection frameworks. The greatest divide is between social care and the various primary and community care clinicians because the former is funded by local authorities and the latter by ICSs.

103. There are currently policies attempting to rectify the disconnect between local government and health service budgets. The Better Care Fund (BCF) "established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams."[150] Minister Whately told the Committee that the BCF "… is proving very valuable in the way it is bringing together local authorities and NHS organisations in working out how best to spend a budget … It is therefore helping to get rid of some of that boundary between the different bits of the system."[151]

104. However, the NAO found that although the Fund has encouraged different services to work together, it "has not achieved the expected value for money, in terms of savings, outcomes for patients or hospital activity."[152] Niamh Lennox-Chhugani, Chief Executive of the International Foundation for Integrated Care, told the Committee that the Fund (and other initiatives like it) have "gone a long way to enabling greater integration by pooling funding, but they are disabled in many of the current payment systems and contracting structures in place in the system today."[153] Currently, Better Care Fund responsibilities are discharged by local Health and Wellbeing Boards, which are a committee of a local authority, in agreement with the local ICB.[154] This means that funding is allocated and co-ordinated at a system and local authority level, rather than a local level.

105. Adam Doyle, Chief Executive of the Sussex ICS, described the challenges of allocating BCF resources across a diverse geographical area:

> "In my system, I have West Sussex, Brighton and Hove, and East Sussex. They are completely different areas. When we look at a local level, how people live their lives in those areas is different. Our job is to work closely with the local authority to find the best solution for these communities."[155]

106. Minister Whately wanted to see ICSs and local authorities choosing to put more money into their local BCF but would not say how this should be achieved.[156] This was because the Government is currently consulting on

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149 Q 218 (Dr Niamh Lennox-Chhugani)

150 NHS England, 'About the Better Care Fund': https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/about-the-better-care-fund/ [accessed 2 October 2023]

151 Q 241 (Helen Whately MP)

152 National Audit Office, *Health and social care integration* (8 February 2017): https://www.nao.org.uk/reports/health-and-social-care-integration/ [accessed 2 October 2023]

153 Q 218 (Dr Niamh Lennox-Chhugani)

154 The Kings Fund, 'Health and wellbeing boards (HWBs) explained': https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained [accessed 2 October 2023] and Department of Health and Social Care, *2023 to 2025 Better Care Fund policy framework* (5 April 2023): https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework [accessed 2 October 2023]

155 Q 57 (Adam Doyle)

156 Q 241 (Helen Whately MP)

how the Better Care Fund and other pooled budgets should operate.[157] The consultation covers the current legal basis for the delegation of place-based commissioning and arrangements for pooled budgets.

107. **Patients in the community should be treated by a multi-disciplinary team of social care workers, community nurses, their GP and other specialist community clinicians like podiatrists. These teams should ideally be co-located with GP practices, share records, and meet to plan patient care. At a local level, staff contracts should consider ways that staff accountability (to managers) and care delivery responsibilities can be separated. This would enable different staff to collaborate and work together around an individual patient's needs without needing to change or review their contracts of employment.**

108. ***The Better Care Fund should be enhanced to cover a larger proportion of relevant NHS and local authority expenditures. Better Care Fund 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. The DHSC should ensure that the current consultation on the Better Care Fund 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, the DHSC must provide an update on its long-term plan for the integration of health and social care budgets.***

Place-based commissioning

109. Witnesses stated that funding for primary and community care is restricted in scope, short-term, and fragmented.[158] This prevents the development of longer-term integration projects which are needed to build good working relationships between services and encourage more preventative and holistic healthcare.

110. Professor Sue Yeandle, Professor of Sociology at the University of Sheffield, told the Committee: "To me, one of the main challenges here is ensuring that all the integrated care systems operate in ways that genuinely engage all members of the integrated care partnerships … and that they properly reflect the diversity and varied challenges that face us at local and regional levels."[159] Ivan Annibal, CEO of Rose Regeneration (an economic development consultancy) recommended that there should be "be greater devolution of decision-making to ICBs to enable them to really shape their services in ways that understand and link to the specifics, on a place-based level, of the challenges they face."[160]

111. Prof Checkland said: "In the current structure … that middle layer at place level is missing—some kind of firm commissioning and planning support to work with local PCNs and community service providers … to help the two

157 Department of Health and Social Care, 'Review of section 75 arrangements: supporting document', (19 September 2023): https://www.gov.uk/government/calls-for-evidence/improving-integrated-commissioning-in-health-and-social-care/review-of-section-75-arrangements-supporting-document [accessed 2 October 2023]

158 Q 130 (Fatima Khan-Shah), Q 164 (Sian Thomas), Q 218 (Dr Niamh Lennox-Chhugani) and Q 236 (Lord Lansley)

159 Q 13 (Prof Sue Yeandle)

160 Q 82 (Ivan Annibal)

groups to work together."[161] She and other witnesses recommended place-level committees to improve the quality of local commissioning.[162]

112. **Devolved, place-based commissioning and funding should be the default option. Local stakeholders have a close knowledge of local needs and understand how services can work together. They have closer relationships that come from geographical proximity and better understand the opportunities for (and challenges of) integrated working in their local areas. Therefore, commissioning should primarily happen at a place, rather than ICS level.**

113. ***The Government should bring forward changes to the Health and Care Act 2022 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 Integrated Care Strategies.***[163] ***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.***

161 Q 157 (Prof Kath Checkland)

162 QQ 161, 164 (Prof Kath Checkland) and Q 205 (Dawn Wakeling)

163 For an explanation of Integration Care Strategies please see Department of Health and Social Care, 'Guidance on the preparation of integrated care strategies': https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies [accessed 2 October 2023] and written evidence from NIHR Policy Research Unit in Health and Care Systems and Commissioning (PCC0025).

CHAPTER 5: SYSTEMS AND DATA

114. Witnesses stated that effective data collection, sharing, and analysis is essential for integrated working within the NHS and with other services.[164] The British Medical Association told the Committee:

> "Integration of information would save time, prevent patients from having to repeat information to multiple clinicians in a GP practice, hospital, or community setting, but it would also improve overall patient safety by minimising delays in care and ensuring doctors have access to the entirety of a patient's medical record."[165]

115. Neil O'Brien, the Parliamentary Under-Secretary of State for Primary Care and Public Health, stated that a "challenge is particularly in IT and data and accelerating the integration there."[166] When asked to name one thing that could bring about better integration, Minister O'Brien suggested improvements to IT and data-sharing.[167] Section 251B of the Health and Social Care Act 2012 imposes a duty on relevant persons to share information about a patient when it is "likely to facilitate the provision to the individual of health services or adult social care in England, and in the individual's best interests."[168] This became a requirement in the Health and Social Care (Safety and Quality) Act 2015.[169] When questioned by the Committee about clinicians being hesitant to share data, Dr Edward Scully, Director of Primary and Community Health at the DHSC, acknowledged the issue but pointed out that cultural and behavioural shifts lag behind the change in legislation.[170]

116. A Single Patient Record (SPR) or Shared Care Record (SCR) represents the panacea of integrated data-sharing. An SPR contains a patient's medical information and can be accessed across multiple health and care services. This means that all clinicians treating a patient across a care pathway have access to their record, reducing the need for repeatedly questioning the patient.[171] All their health information is available—which is especially useful in an emergency or if the patient is unable to communicate, allows holistic treatment, and makes overall care plans easier.

117. Genevieve Smyth, Professional Adviser on Primary Care at the Royal College of Occupational Therapists, summed up what many witnesses told the Committee: "Having a single patient record will be a cornerstone of being able to deliver truly integrated care across health and social care."[172] Although Single Patient Records (SPR) are in use around England they are not yet comprehensive or universal. This is despite the DHSC aiming to implement a "joined-up" health and social care record by 2025.[173]

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164 Q 7 (Prof John Campbell) and Q 37 (Ruthe Isden)
165 Written evidence from The British Medical Association (PCC0071)
166 Q 254 (Neil O'Brien)
167 *Ibid.*
168 Health and Social Care Act 2012, section 251B
169 Health and Social Care (Safety and Quality) Act 2015, section 3
170 Q 151 (Dr Edward Scully)
171 Q 119 (Sallyann Sutton)
172 Q 119 (Genevieve Smyth)
173 Department for Health and Social Care, *A plan for digital health and social care* (29 June 2022): https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care. [accessed 16 November 2023]

118. Insufficient data interoperability is a fundamental barrier to providing more effective integrated care, particularly relating to SPRs.[174] Witnesses were critical of the progress so far, stating that there were few examples of good practice around England to look to, and that data-sharing was a problem across the entire health service.[175] Of all the issues the Committee examined, data-sharing was remarked on most frequently by witnesses. Citing their 2022 survey, the Royal College of General Practitioners stated: "The 2022 RCGP survey revealed that 65% of general practice staff report having IT systems not fit for purpose or of an acceptable standard to exchange information with secondary care … Similar issues might be limiting information sharing with community care."[176]

119. Patients often have several conditions over time and are treated by clinicians across different services. This means that patient health data is recorded on multiple data systems, which are not always inter-accessible. This causes problems for patients, such as:

(a) Patients moving along the care pathway being asked the same basic questions about their medical history by multiple clinicians, each using a different record system.[177]

(b) Clinicians being in danger of missing crucial patient information, such as allergies to medicine, because they cannot access records in a timely fashion, especially during emergency treatment.[178]

120. Sian Thomas, Deputy COO of Division 3 and Partnership Director OneWolverhampton at The Royal Wolverhampton NHS Trust, usefully summed up these twin problems:

> "The number of different systems that are in operation mean that technically it can be difficult … for the back-ends of the systems to talk to one another… for the information to be housed … there is a lot of architecture that would need to be supported but work on that architecture is probably not happening while we do not have the permission at the data-sharing GDPR end."[179]

Mark Fisher CBE, CEO at NHS Greater Manchester Integrated Care, told the Committee:

> "It is things like the single care record that make the most difference to that practical integration, in that we have a whole range of professionals who can use exactly the same data and see exactly the same picture of the patient in front of them, without having to re-ask the questions or go back to the beginning. That is a massive benefit in providing an integrated service."[180]

174 Q 6 (Prof John Campbell), Q 20 (Prof Sally Kendall), Q 68 (Andy Burnham), Q 93 (Gary McAllister), Q 117 (Sallyann Sutton), Q 127 (Fatima Khan-Shah), Q 141 (Tanya Rumney), Q 150 (Dr Edward Scully), Q 158 (Prof Kath Checkland, Sian Thomas), Q 176 (Siobhan Melia), Q 238 (Neil O'Brien) and written evidence from Association of Optometrists (PCC0067)

175 Q 7 (Prof Hazel Everitt, Prof Kate Walters and Prof John Campbell) and Q 127 (Fatima Khan-Shah)

176 Written evidence from Royal College of General Practitioners (PCC0033)

177 Q 7 (Prof Hazel Everitt) Q 70 (Mark Fisher) and written evidence from The British Medical Association (PCC0071)

178 Q 92 (Gary McAllister)

179 Q 159 (Sian Thomas)

180 Q 70 (Mark Fischer)

Technical barriers combine with the rules (or perceptions of them) to make data-sharing and therefore integration more difficult.

Technical barriers: portability and coding

121. Clinicians currently contend with many technical barriers to data-sharing which could be overcome by better digital integration, even though the DHSC acknowledged the importance of digital systems and sharing data and the steps it had taken to address this.[181] Dr Salwa Malik, Vice-President of the Royal College of Emergency Medicine said: "IT integration is key. You cannot integrate if you cannot communicate. I cannot care efficiently and effectively for my patient if I do not know everything about them. That underpins everything."[182]

122. Services across primary and community care—from dentistry to school nursing—use multiple, sometimes incompatible, data management systems. In their evidence, the NHS Confederation said: "Where shared patient records do exist, they are often restrictive with providers only able to see information about the patient linked to their part of the system, rather than the patient's care and health as a whole."[183] The Committee received evidence describing how—for example—NHSE currently commissions nine different eye health electronic referral systems. They have limited interoperability and some primary care providers need to have two or more proprietary systems available in clinics to manage referrals for patients from different areas.[184]

123. Tanya Rumney, a dietician, also told us that she "might have to log into eight systems to review one person … within one organisation."[185] Witnesses stated that some GP practices within the same PCN might not use the same data system, or that patient information recorded by a GP could not be easily shared beyond the PCN itself.[186]

124. Recording data on multiple systems makes it difficult for patients to access their data in one place. This makes it harder for patients to be involved in managing their own care and have oversight of their data.[187] This is a lost opportunity to increase health literacy. If patients can have direct access to their clinical record, it helps them understand their condition and take preventive measures to avoid deterioration. Additionally, a lack of comprehensive data hinders the ability to identify potential improvements in services. In their evidence to the Committee, the NIHR Policy Research Unit in Health and Care Systems and Commissioning said:

> "The lack of data about community service activity is a significant problem. In particular, this makes it very difficult to know what services actually cost and prevents the development of clear guidance about the staffing levels required to provide services for a given population. Whilst new data sets are increasingly available, these remain limited in scope and accuracy."[188]

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181 Written evidence from the Department of Health and Social Care (PCC0061)
182 Q 167 (Dr Salwa Malik)
183 Written evidence from NHS Confederation (PCC0032)
184 Written evidence from NHS Services, Specsavers Group (PCC0044)
185 Q 141 (Tanya Rumney)
186 Q 158 (Prof Kath Checkland and Sian Thomas)
187 Q 93 (Gary McAllister)
188 Written evidence from NIHR Policy Research Unit in Health and Care Systems and Commissioning (PCC0025)

Problems with data-sharing makes it harder to collate aggregated, service-wide data. This makes it more difficult to monitor the efficiency of services.

125. Sometimes services record information in different ways, leading to data portability issues.[189] This has commercial, as well as technical implications. Daniel Hardiman McCartney, lead clinical advisor to the College of Optometrists, remarked that:

> "NHS England spent quite a lot of time investigating APIs [application programming interfaces] to ensure that the two systems could talk to each other, but that has not been progressed … it is such a big project that it is very difficult for a small ICB to handle the huge cost involved in a national API connection between one software system and another."[190]

The Committee heard from Gary McAllister, Chief Technology Officer for One London (a collaboration between London's five ICSs), that ICSs tend to "… get bogged down in managing … contracts with suppliers" of data-sharing software.[191]

126. Unlike in the US, data systems in the NHS often lack the facility to "code for" (and therefore record and communicate) contextual or non-medical patient information, "despite these being the biggest predictors of quality of life and life expectancy."[192] This means clinicians treat patients without a full understanding of the social determinants of their health, undermining holistic and preventative healthcare.[193]

127. Older or outdated data systems are slow to operate. They often lack real-time information and a read-write function, preventing clinicians from adding useful information to a record, as well as viewing it.[194] A system used in Leeds that allowed community clinicians access to a read-write function for health records was referred to as a "beacon of hope" rather than standard practice.[195] Ruthe Isden told us: "a huge amount of time is wasted, frankly, by individual clinicians, healthcare workers and social care workers dealing with very clunky systems that are quite hard to access and to use or that do not provide them with real-time information when they need it."[196]

128. Data loss is another major issue. One in five referrals from GP to hospital care are not communicated because of faults in data systems, with a resultant impact on timely diagnosis and treatment.[197] Mr McAllister stated that: "Individuals are losing their sight because their records get lost, and their referrals do not get expedited."[198]

129. Greatly improved data integration is demonstrably technically feasible—for example, our smartphones constantly exhibit a seamless, rapid, and deep level of digital integration at high scale and low cost, both for health and non-health-related uses.[199] Patients can easily access their Covid vaccination

189 Q 93 (Gary McAllister, Q 105 (Dr Abhi Pal) and Q 117 (Sallyann Sutton)
190 Q 106 (Daniel Hardiman-McCartney)
191 Q 93 (Gary McAllister)
192 Q 119 (Genevieve Smyth)
193 Q 119 (Genevieve Smyth), Q 129 (Ed Davie) and Q 179 (Siobhan Melia)
194 Q 37 (Ruthe Isden) Q 96 (Ben Richardson) and Q 106 (Ewan Maule)
195 Q 84 (Prof Daniel Lasserson)
196 Q 37 (Ruthe Isden)
197 Q 27 (Jacob Lant) and Q 93 (Gary McAllister)
198 Q 93 (Gary McAllister)
199 Q 8 (Prof John Campbell)

via their NHS app or synchronise their calendar or photos from one device to another, choosing with whom they share this information. The limiting factor on digital integration in the NHS is not the supposedly insuperable technical challenge of making systems and data interoperable.

130. Witnesses suggested that patients rarely object to their data being shared with medical professionals for the purpose of their care.[200] Dr Crystal Oldman, CEO of the Queen's Nursing Institute, told the Committee:

> "The general understanding is that patients would have no problem sharing that data. In fact … reluctance about sharing data, the GDPR and the whole question of information governance is coming from the clinicians and the service … I think that if they are asked whether it is okay to share, the vast majority [of patients] will say yes."[201]

131. Many patients are also willing to actively engage in research trials and readily share their medical data. Prof Everitt said that this is high in the context of cancer trials, where patients understand the potential benefits of research for their condition:

> "I think patients are very willing to be in a research trial and have their data shared if they have a cancer diagnosis and go into cancer trials. We need to have a culture of data-sharing and research in primary and community care to be able to harness that data. A lot of patients come into trials very willingly. We do an awful lot of big clinical research trials where they share lots of their data."[202]

132. Dr Neil Modha, Chair of the Data Workstream for the Fuller Review and a GP, added that while the default stance (of the NHS) should be to share data, this does not mean it should happen without patient consent. Dr Modha likened this process to when someone decides not to receive a vaccine:

> "I still think that should be an informed consent, a bit like if someone declines a vaccine. We need to have a conversation to explain why we want to give them a vaccine or why we want to share their data, and what the advantages are. If that person then declines, they should have the ability to do that."[203]

133. Proven technology is easily available to share data securely and selectively.[204] The power of modern computer cloud storage makes legal and cultural barriers to data-sharing easier to overcome, because data can be stored within the system where it was collected and made selectively portable depending on which parts of the record should be accessed and by whom.[205] This, for example, would enable doctors to access the part of a primary care record about a patient's drug allergy, but not more sensitive information like their HIV status. During its visit to Coventry, the Committee heard how selective portability was being used by care teams to maximise both data-sharing and patient confidentiality.

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200 Q 30 (Dr Crystal Oldman)
201 *Ibid.*
202 Q 8 (Prof Hazel Everitt)
203 Q 98 (Dr Neil Modha)
204 Q 98 (Gary McAllister)
205 Q 197 (Dr Tim Ferris)

134. Witnesses were optimistic regarding the feasibility of having more interoperable data systems. Simon Williams told the Committee: "From my experience, I would say that the biggest barriers are cultural rather than technical … in my experience if people really want to create a seamless service for people, they find a way of doing it."[206]

135. **The DHSC must ensure that data-sharing infrastructure, regulation and working culture are ready to respond to the next decade of technological innovation and are proactive in addressing public and professional concerns about data privacy and security.**

136. **Fully integrated care requires seamless, co-ordinated digital interoperability. This would be facilitated by a culture of secure and appropriate data-sharing which has the confidence of staff and the public. Primary and community clinicians should be only "one click away" from securely stored and comprehensive patient information in an SPR, with full read and write access for clinicians (both NHS and non-NHS) across local care systems. The limiting factors to implementing an SPR are related to data portability standards and the purchasing of interoperable systems. The DHSC and NHSE should focus on helping ICSs to resolve these problems. Perceived technological barriers are not an excuse for delayed implementation.**

137. ***The 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 (i.e. record) health information, ensuring that it is accurate, machine-readable, and interoperable with data systems across health care and relevant local government systems.***[207] ***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.***

138. ***One (or multiple) highly interoperable data system/s 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.***[208] ***This will ensure that SPRs can work across geographical and service boundaries, while reducing the expense of more fragmented commercial negotiations at a place or ICS level.***[209]

Cultural and legal barriers: uncertainty

139. Witnesses expressed a variety of opinions on the extent to which non-technical factors limit data-sharing. Some witnesses considered legal barriers to be the biggest problem, while others argued that this was based on a misunderstanding, pointing to a wider cultural reticence to share patient data. Dr Pritesh Mistry, Fellow in Digital Technologies at the King's Fund,

206 Q 199 (Simon Williams)
207 Q 102 (Dr Neil Modha); written evidence from The Care Quality Commission (CQC) (PCC0042) and The British Medical Association (PCC0071)
208 Q 97 (Gary McAllister)
209 Q 76 (Prof Sheena Asthana) and Q 97 (Ben Richardson)

told the Committee: "Culture is a bigger barrier than funding. From what we have seen and, anecdotally, from conversations I have had in the system, the funding tends to be very specific, which prevents full-scale digital transformation in a part of the healthcare system."[210]

140. We were told of a common perception amongst clinicians that data-sharing might contravene data protection legislation, particularly the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR).[211] The multiplicity of different rules on data-sharing (which includes statutory guidance, primary legislation, and Common Law) leads to different interpretations of what data-sharing is allowed, as well as excessive caution.[212] Witnesses remarked that when it comes to data-sharing "the safe answer is always to say no. No one ever got into any trouble for saying no to an information governance request."[213] Unclear data-sharing guidance leads in turn to risk aversion and delays in passing on patient data.[214]

141. We were told that current legislation does "require" ICSs to share records and information between services, rather than simply "consider" doing so, as previously.[215] The Caldicott Principles (which summarise data sharing good practice for health and social care) state that "the duty to share information for individual care is as important as the duty to protect patient confidentiality" in order to ensure that patients are treated properly with all of their medical information to hand.[216] However, Dr Edward Scully gave the opinion that "culture probably lags behind legal changes."[217] The Caldicott Principles have not encouraged widespread, confident and secure data sharing. Dr Neil Modha suggested that "the default position should be that we share information and data" and that clinicians should "ask people and to give them the ability to opt out". Dr Modha added: "If people fundamentally disagree with sharing information or data, we should respect their wishes" but that the presumption should be in favour of data sharing.[218]

142. Prof Sir Sam Everington told us data-sharing "can be opened up by getting people to use the [NHS] app much more and access their notes that way."[219] Allowing patients to access their medical data enables them to take more responsibility for their health, treatments, and recovery. However, while it is easy to access via smartphones, not all of a patient's health data is visible on it.

143. **Clinicians should have the confidence to share patient data usefully and safely. For the individual patient, the sharing of individual data must be a priority for effective treatment and patient safety. For anonymised and aggregated population health data, seamless data-sharing for service planning and public health interventions is**

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210 Q 86 (Dr Pritesh Mistry)
211 Q 30 (Dr Crystal Oldman)
212 Q 30 (Dr Crystal Oldman), Q 68 (Andy Burnham), Q 93 (Gary McAllister) and Q 151 (Dr Edward Scully)
213 Q 93 (Ben Richardson)
214 Q 99 (Ben Richardson)
215 Q 151 (Dr Edward Scully)
216 National Data Guardian, *The Eight Caldicott Principles* (December 2022): https://assets.publishing.service.gov.uk/media/5fcf9b92d3bf7f5d0bb8bb13/Eight_Caldicott_Principles_08.12.20.pdf [accessed 6 November 2023]
217 Q 151 (Dr Edward Scully)
218 Q 98 (Dr Neil Modha)
219 Q 131 (Prof Sir Sam Everington) and written evidence from the British Medical Association (PCC0071)

essential. The DHSC must ensure that primary legislation, secondary legislation, and guidance allow clinicians to easily navigate the tension between data privacy and effective planning of individual and population-level health.

144. **Data privacy and security are of utmost importance. NHS England should ensure that not only is data held securely, shared appropriately, and consensually, but that there is also public confidence that this is the case.**

145. ***The 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.***

CHAPTER 6: WORKFORCE AND TRAINING

146. Resolving overall workforce issues in social care and the NHS (such as staff shortages) lies outside the scope of this inquiry. The Committee has heard, however, that staffing shortages and other workforce-related issues like training and culture are undermining integration within primary and community care.[220] This chapter makes recommendations that can specifically improve workforce integration and are separate from the general issue of workforce shortages.

147. The NHS recognises that workforce is a considerable problem for the service and published its Long Term Workforce Plan in June 2023.[221] The plan found that "without concerted and immediate action, the NHS will face a workforce gap of more than 260,000–360,000 staff by 2036/37."[222] The NHS plans to avoid this shortfall by expanding the workforce, improving retention, and increasing staff efficiency.

Training for multi-disciplinary working

148. The Committee heard that multi-disciplinary working (while not necessarily reducing overall hospital admissions) has been shown to contribute to better quality, and more holistic care, with higher levels of patient satisfaction.[223] Yet witnesses stated that community and POD clinicians are not sufficiently involved in multi-disciplinary working in the community, especially with GPs.[224]

149. Some witnesses remarked that clinical training, especially of doctors, created a hierarchical environment that discouraged multi-disciplinary working. This was made worse by the siloing effect of separate training and career structures, which disincentivises clinicians from working alongside other professions.[225]

150. Clinicians often do not have enough knowledge about other disciplines and agencies, partly because the work of community clinicians frequently takes place in the home and away from the hospital or primary care estate.[226] This is despite the community being where "most of the work takes places and most issues are resolved" for people's health.[227] Fatima Khan Shah, Chair of the People and Communities workstream of the Fuller Stocktake, said that if people "work in the voluntary community social enterprise sector, there have been barriers to even being in the same estate as the GP".[228] Witnesses explained how rotational job roles, which give clinicians experience of different disciplines, act as "a helpful way of overcoming the workforce barrier."[229] However, current contracting arrangements make the funding of these posts difficult.

220 Q 1 (Prof Hazel Everitt), Q 13 (Prof Sally Kendall), Q 23 (Dr Crystal Oldman), Q 176 (Siobhan Melia) and Q 186 (Dr Amanda Doyle)
221 NHS England, 'NHS Long Term Workforce Plan', (30 June 2023): https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ [accessed 2 October 2023]
222 NHS England, *NHS Long Term Workforce Plan* (June 2023), p 12:https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf [accessed 2 October 2023]
223 Q 156 (Prof Kath Checkland)
224 Q 108 (Daniel Hardiman-McCartney) and Q 140 (Tanya Rumney)
225 Q 127 (Prof Sir Sam Everington) and Q 154 (Jason Yiannikkou)
226 QQ 23–24 (Dr Crystal Oldman)
227 Q 1 (Prof John Campbell)
228 Q 127 (Fatima Khan-Shah)
229 Q 176 (Siobhan Melia) and Q 209 (Dr Dheepa Rajan)

151. Prof Campbell cited an example where health visitors, despite being highly regarded by GPs, are progressively being separated from general practice:

> "Health visiting … has been hugely valued by GPs and their teams, but it is now no longer really part of general practice. Sadly, we have lost so many health visitors that we do not know who these people are or where they are. They provide a hugely valuable service, safeguarding and supporting families and people with long-term conditions."[230]

152. Clinicians are not trained sufficiently in understanding and experiencing integration before qualifying and need more time for training in multi-disciplinary teams when working.[231] Dr Tony Dedeu, Senior Adviser at the World Health Organization European Centre for Primary Health Care, told the Committee that GPs in the UK lack training in community care or non-hospital settings and are mainly focused on clinical issues. This contrasts with other countries where "the community end of primary care is embedded in the training of family doctors and nurses."[232] Dr Crystal Oldman told the Committee: "The main integration challenge right now is having a sufficient workforce with the right skills in the right place to enable integration. Nothing will be able to happen unless we have the right skills in the right place."[233]

153. Trust poses a significant challenge in the relationship between the NHS and related services. This challenge arises due to differences in organisational structures. In their evidence, the Royal College of Paediatrics and Child Health (RCPCH) and the British Association for Community Child Health (BACCH) said: "The NHS is at a very early stage of integration particularly with other agencies for example housing, social care, education, and voluntary and private sectors. Often differences in organisational culture and a lack of trust between potential partners can be a barrier to partnership working."[234]

154. Daniel Hardiman-McCartney MBE said to the Committee: "One of the biggest barriers historically that we found was the lack of trust between the high-street professions and the secondary-care traditional medical professions. Where you break that down and have a genuine patient-centric approach around the condition, that is really good for patient outcomes."[235]

155. Contract and funding design means that there are not enough multi-disciplinary training opportunities within PCNs which would improve inter-disciplinary relationships and encourage joint working.[236] Clinical disciplines are siloed and lack opportunities for learning about or experiencing allied services. Initial and continuing healthcare funding is provided by Health Education England. This budget is controlled nationally.[237] In his evidence to the Committee, Andy Burnham, the Mayor of Greater Manchester, called for more of this budget to be devolved to ICSs. This could be used to fund

230 Q 3 (Prof John Campbell)
231 Q 1 (Prof Hazel Everitt), Q 15 (Prof Sue Yeandle) and Q 206 (Dr Toni Dedeu)
232 Q 208 (Dr Toni Dedeu)
233 Q 23 (Prof Crystal Oldman)
234 Written evidence from the Royal College of Paediatrics and Child Health (RCPCH) and the British Association for Community Child Health (BAACH) (PCC0047)
235 Q 105 (Daniel Hardiman-McCartney)
236 Q 23 (Jacob Lant) and Q 193 (Dr Amanda Doyle)
237 NHS Health Education England, 'How we will use our money': https://www.hee.nhs.uk/about/work-us/recovery-delivery-hee-business-plan-202122/how-we-will-use-our-money [accessed 2 October 2023]

"more blended roles between social care and health, and on new pathways for young people into the health and care system."[238]

156. Given that serving health professionals are less likely to have received training for integration in their initial qualification, continuing professional development for integration is required. However, it is hard for clinicians to develop leadership skills for integration when they are faced with high levels of demand that require constant reactive care.

157. **While it is beyond the Committee's remit to recommend general reforms to the NHS workforce, the NHS should implement its Long Term Workforce Plan without delay to avoid shortages undermining integration within the health service. Better integration should reduce long-term strain on the health service as it leads over time to more holistic and preventative care. In addition, multi-disciplinary work should be more collegiate, give greater responsibility to perceived lower-status clinical disciplines, and encourage a problem-solving approach to work. As well as enhancing integration, this would in turn lead to better job satisfaction and retention.**

158. ***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 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 2022 Act. In addition, we recommend that the DHSC investigate whether university medical training should include more experience of integrated working with community clinicians.***

Demand and access to primary and community care

159. Overall workforce shortages are making it more difficult for primary care teams to spare the staff to spend time on proactive integration efforts, creating a vicious cycle, unless staff feel empowered to find new ways of working in response to need.[239] Witnesses highlighted a lack of career progression as a barrier to integration.

160. Professor Goodman cited community nursing as an example, pointing out that progression was limited for these roles. Nurses can choose between management, which is "not necessarily what people want" or specialist roles, which is a "crowded arena". This lack of progression contributes to people leaving the workforce and reduces the incentive to learn new skills for those who remain.[240] This shortage of workforce capability undermines integration strategies.

161. Burnout is also making it harder to attract new recruits to community disciplines which are already short of staff. Professor Sally Kendall, Professor of Community Nursing and Public Health, Kent University, informed the Committee that the visible pressures in community work, including long hours, stress, challenges of working with children and families, and modest

238 Q 74 (Andy Burnham)
239 Written evidence from the Association of Directors of Adult Social Services (ADASS) (PCC0069)
240 Q 18 (Prof Claire Goodman)

pay, have diminished the appeal of university programmes. Consequently, it is no longer viewed as an attractive career option.[241]

162. Witnesses supported the implementation of the NHS England Long Term Workforce Plan without delay to help address this.[242] Additionally, the Committee welcomes the "pharmacy first" component of the Government's Primary Care Recovery Plan, with its plan to widen pharmacists' prescribing rights. This will help reduce demand on GP practices and maximise pharmacists' contribution to addressing primary care needs.

163. However, the Government needs to tackle the wider workforce shortages which threatens successful integration.[243] Where integration can help cut demand, then it can contribute to alleviating workforce shortages.

164. Siobhan Melia told the Committee:

> "… there is a scheme in primary care called the additional roles reimbursement scheme … It was an incentive for primary care networks to recruit more multi-disciplinary team members into local services. The challenge with that is that it means there are multiple organisations looking to employ the same clinical professionals, and there are simply not enough of them to go around."[244]

165. The success of the scheme is therefore being undermined by overall shortages within the community workforce. An unintended consequence of the scheme has been a shortage of clinicians in high-street or hospital settings because they are now employed by GP practices.

166. Dr Amanda Doyle, National Director for Primary and Community Care Services said: "There is no doubt that demand is currently outstripping capacity, particularly in general practice, but widely across the health service there are challenges in the size of our workforce, retaining our workforce and having a workforce that is sufficient for the capacity we need."[245] The British Medical Association told the Committee: "The average number of patients each GP is responsible for has increased by 18%—since 2015 and now stands at 2,285. There are now just 0.44 fully qualified GPs per 1,000 patients in England—down from 0.52 in 2015."[246]

167. **National policy envisages that there should be a general shift towards patients seeking treatment at the earliest opportunity and lowest possible level within the care hierarchy, meaning that conditions are addressed preventatively and before they reach an acute level.[247] To meet this goal, services must be more proactive in supplying (and the public more proactive in seeking) a more extensive range of opportunities for preventative and early interventions. In addition,**

241 Q 17 (Prof Sally Kendall)
242 Written evidence from the Royal College of Paediatrics and Child Health (RCPCH) and the British Association for Community Child Health (BAACH) (PCC0047)
243 Q 152 (Dr Edward Scully)
244 Q 176 (Siobhan Melia)
245 Q 186 (Dr Amanda Doyle)
246 Written evidence from the British Medical Association (PCC0071)
247 Department of Health and Social Care, *Prevention is better than cure: Our vision to help you live well for longer* (November 2018): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf [accessed 6 October 2023] and NHS, *The NHS Long Term Plan* (January 2019): https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [accessed 6 October 2023]

NHS and related services must be able to fulfil such expectations about the availability of such provision so that the public can be confident that they will be seen quickly and receive appropriate treatment.[248]

168. ***More community disciplines should be given independent prescribing and referral rights, going further than the recently announced plans from the government for pharmacists. The 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.***[249]

Helping primary, community and social care support each other

169. Although social care and other relevant services operate under separate governance systems from the NHS, they have a considerable impact on many of its parts. For example, care home residents, who are typically frail and multi-morbid, are more frequent users of emergency hospital care.[250] The Committee has heard how a shortage of social care places leads to delayed discharge from hospital.[251]

170. The service that the primary, community, and social sectors provide to a patient is likely to be uncoordinated, despite the obvious synergies between the care they give. Prof Goodman described an ideal situation as being one where "where social care and community services were setting the agenda together with some reference points to the GP", but this is currently not widespread.[252] Problems include a lack of data-sharing between social care and primary care.[253] This also includes a lack of co-ordination between the NHS and local authorities.[254]

171. A shortage of social care workers in England, especially those with enhanced skills, limits their ability to participate in multi-disciplinary work with other professionals. Prof Yeandle told the Committee:

> "On workforce planning, if we do not establish some kind of parity of esteem between workforce planning for the NHS and for social care services, which are essentially interdependent in the delivery of effective outcomes for everyone involved, we will go badly wrong."[255]

Prof Yeandle went on to say: "Put simply, the pay in the adult social care system is so low that people are leaving in droves because they can earn more elsewhere and cannot make ends meet if they do not."[256]

248 Q 115 (Genevieve Smyth)
249 Royal College of Occupational Therapists, *#PrescribingNow: Q & A* (February 2023): https://www.rcslt.org/wp-content/uploads/2023/02/Q-A.pdf [accessed 6 October 2023]
250 The Health Foundation, 'Emergency admissions to hospital from care homes: how often and what for?' (July 2019): https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes [accessed 2 October 2023]
251 Q 177 (Tom Cottam)
252 Q 13 (Prof Claire Goodman)
253 Q 23 (Jacob Lant) and Q 28 (Dr Crystal Oldman)
254 Q 38 (Ruthe Isden)
255 Q 13 (Prof Sue Yeandle)
256 Q 15 (Prof Sue Yeandle)

172. The DHSC can capitalise on the enthusiasm within the social care sector for greater training and professionalisation that witnesses reported.[257] Yet, social care workers were not included in the DHSC's recent workforce plan, even though staff shortages are an ongoing problem.

173. The Buurtzorg model serves as a prime example of social and community care. This model embodies a comprehensive perspective on healthcare, focusing on both the individual and the wider community. An overview of this approach is provided in Box 4.

Box 4: Buurtzorg Model

Better integration between primary, community and social care can facilitate the creation of innovative multi-disciplinary teams, which help provide better care for frail and vulnerable people in their homes. One such model is Buurtzorg, a model of social care in the Netherlands, where social care workers and community clinicians work in small and highly autonomous teams to provide care to people in their homes. The teams have a very flat management structure, with coaching provided which emphasises problem solving and individualised care plans.

Brendan Martin, Managing Director of Buurztorg UK described the scheme to the Committee as: "… enabling people to support people in the way they need, with clinical and personal care when needed, in a holistic way. Our model is based on supporting people to care for themselves as well as possible, drawing upon and strengthening their own assets … and the assets around them—in their families, among their neighbours and in their local communities."[258]

While this scheme will not be appropriate for all patients or places, equipping the workforce for integration will enable them to use their skills and enthusiasm to design and implement new models of care for their area.

Source: Buurtzorg, 'The Buurtzorg Model': https://www.buurtzorg.com/about-us/buurtzorgmodel/ [accessed 31 November 2023]

174. **An integrated healthcare system would maximise the preventative involvement of the NHS and other out of hospital services, including local authority social services, to prevent older people and others, in domestic and residential settings from becoming ill and being admitted to the acute hospital sector. In addition, social care workers should be empowered to deliver more complex care, through co-created, place-based training, designed to meet local needs. Better qualified social care workers would have increased status and career satisfaction, and would be able to play a greater role in community multi-disciplinary teams, enhancing the links between social, primary, and community health care.**

175. **The DHSC should work towards parity of esteem for social care workers but avoid any perverse outcomes where better qualified social carers end up moving to the NHS, due to its better terms and conditions. Parity of esteem should mean equal terms and conditions for the NHS and social care, which will help facilitate better professional relationships and integration.**

257 Q 86 (Prof Daniel Lasserson)
258 Q 213 (Brendan Martin)

176. ***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 health care 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.***

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Pitkeathley (Chair)
Lord Altrincham
Baroness Armstrong of Hilltop
Baroness Barker
Baroness Finlay of Llandaff
Lord Kakkar
Baroness Osamor
Baroness Redfern
Baroness Shephard of Northwold
Baroness Tyler of Enfield
Lord Watts
Baroness Wyld

Declarations of interest

Lord Altrincham
No relevant interests
Baroness Armstrong of Hill Top
Husband, Paul Corrigan, Consultant, NHS
Husband, Paul Corrigan, Chair, Care City
Baroness Barker
Member, Advisory Board of Rethink Mental Illness Charity
Family member currently in the use of community services
Baroness Finlay of Llandaff
Previous GP
Fellow of the Royal College of General Practitioners
Fellow of the Royal College of Physicians (London)
Fellow of the Royal College of Physicians (Edinburgh)
Vice President, City Hospice Cardiff
Vice President, Hospice UK
Vice President, Marie Curie
Member, The Times Health Commission
Hon. Professor of Palliative Medicine, Cardiff University
Consultant in palliative medicine, Velindre Cancer Centre, Cardiff
Co-chair of Bevan Commission (Wales)
Past President, Royal Society of Medicine
Elected member, BMA Ethics Committee
Co-Chair, APPG Dying Well
Board Member, Living and Dying well
Lord Kakkar
Chairman, Kings Health Partners
Chairman, The King's Fund
Baroness Osamor
No relevant interests
Baroness Pitkeathley
No relevant interests

Baroness Redfern
No relevant interests
Baroness Shepard of Northwold
No relevant interests
Baroness Tyler
Non-Executive Director, Royal Free London NHS Foundation Trust
Lord Watts
No relevant interests
Lord Watts
No relevant interests
Baroness Wyld
Non-executive director, OFSTED
Member of Court, University of Newcastle-Upon-Tyne

A full list of Members' interests can be found in the Register of Lords Interests: https://members.parliament.uk/members/lords/interests/register-of-lords-interests

Specialist Adviser

Professor Gerald Wistow, visiting professor at the Care Policy and Evaluation Centre at the London School of Economics

Honorary Professor, London School of Hygiene and Tropical Medicine

Visiting Professor, London School of Economics

Professor Gerald Wistow's income derives from research grants made to the London School of Economics and London School of Hygiene and Tropical Medicine by the Economic and Social Research Council (ESRC) and Department of Health and Social Care (DHSC)/National Institute for Health and Care Research (NIHR).

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at: https://committees.parliament.uk/committee/649/integration-of-primary-and-community-care-committee/publications/ and is available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session and in alphabetical order. Those witnesses marked with ** gave both oral and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses only submitted written evidence.

Oral evidence in chronological order

*	Professor Kate Walters, Clinical Professor of Primary Care an Epidemiology, University College	QQ 1–12
**	London Professor Hazel Everitt, Professor of Primary Care Research, University of Southampton	QQ 1–12
*	Professor John Campbell, Professor of General Practice and Primary Care, University of Exeter Medical School	QQ 1–12
*	Professor Sally Kendall, Professor of Community Nursing and Public Health, Kent University	QQ 13–22
*	Professor Claire Goodman, Professor of Health Care Research, University of Hertfordshire	QQ 13–22
*	Professor Sue Yeandle, Professor of Sociology and Director of Centre for International Research on Care (CIRCLE), University of Sheffield, and Principal Investigator, Economic Social Research Council (ESRC) Centre for Care. University of Sheffield	QQ 13–22
**	Dr Crystal Oldman, Chief Executive, Queen's Nursing Institute	QQ 23–31
*	Jacob Lant, Head of Policy, Public Affairs and Research, Healthwatch England	QQ 23–31
*	Matthew Walker, Director of Strategy and Digital Health, National Association of Primary Care.	QQ 23–31
*	Emily Holzhausen, OBE Director of Policy and Public Affairs, Carers UK	QQ 32-39
*	Ruthe Isden, Head of Health Influencing, Age UK	QQ 32-39
*	Professor Sir Chris Ham, Co-Chair of the NHS Assembly, non-executive director of the Royal Free London Hospitals NHS Foundation Trust and Co-Chair, NHS Assembly	QQ 40-51
**	Fiona Claridge, Assistant Director (London and East), NHS Confederation	QQ 40-51
*	Adam Doyle, CEO, Sussex Integrated Care Board	QQ 52-65
*	Professor Claire Fuller, CEO Surrey Heartlands ICS	QQ 52-65

*	Dr Harpreet Sood MBBS MPH MRCGP, GP and Board Member, NHS England	QQ 52-65
*	Rt Hon Andy Burnham, Mayor of Greater Manchester	QQ 66-74
*	Mark Fisher CBE, CEO, NHS Greater Manchester Integrated Care Partnership	QQ 66-74
**	Nora Corkery, CEO, Devon Communities Together	QQ 75-82
*	Ivan Annibal, Managing Director, Rose Regeneration	QQ 75-82
**	Professor Sheena Asthana, Professor of Health Policy and Director, Plymouth Institute of Health and Care Research	QQ 75-82
*	Professor Esther Rodriguez-Villegas, Professor of Low Power Electronics, Department of Electrical and Electronic Engineering, Imperial College London	QQ 83-91
*	Professor Daniel Lasserson, President, UK Hospital at Home Society;	QQ 83-91
**	Dr Pritesh Mistry, Digital Technologies Fellow, The King's Fund	QQ 83-91
*	Dr Neil Modha, Chair of the Data Workstream for the Fuller stocktake report, GP partner and Chair, Greater Peterborough Network GP Federation	QQ 92-102
*	Ben Richardson, Managing Partner, Carnall Farrar	QQ 92-102
*	Gary McAllister, Chief Technology Officer, OneLondon	QQ 92-102
**	Daniel Hardiman-McCartney MBE, Lead Clinical Adviser, College of Optometrists	QQ 103-113
*	Ewan Maule, Member, English Pharmacy Board, Royal Pharmaceutical Society's, and Lead Pharmacist, North East and North Cumbria ICS	QQ 103-113
*	Dr Abhi Pal, President, College of General Dentistry	QQ 103-113
**	Dr Lindsey Cherry, Associate Professor and Podiatrist, University of Southampton	QQ 114-122
*	Sallyann Sutton, Professional Officer, School and Public Health Nurses Association	QQ 114-122
**	Genevieve Smyth, Professional Adviser on Primary Care, Royal College of Occupational Therapists	QQ 114-122
*	Fatima Khan-Shah, Chair, People and Communities Workstream for the Fuller Report	QQ 123-134
*	Professor Sir Sam Everington, Barrister, MBBS, MRCGP, OBE, Professor and GP at Bromley-by-Bow Partnership	QQ 123-134
*	Ed Davie, Policy and Public Affairs Lead, Centre for Mental Health	QQ 123-134

*	Julia Weldon, Health Inequalities Lead, Association of Directors of Public Health, and Director of Public Health, Hull City Council	QQ 135-141
**	Tanya Rumney, Dietitian and Member, British Dietetic Association (BDA)	QQ 135-141
**	David Buck, Senior Fellow, Public Health and Inequalities, The King's Fund	QQ 135-141
*	Dr Edward Scully, Director, Primary and Community Health, Department for Health and Social Care	QQ 142-155
*	Mark Joannides, Deputy Director, General Practice, Department for Health and Social Care	QQ 142-155
*	Jason Yiannikkou, Director, Systems, Integration and Reform at Department for Health and Social Care	QQ 142-155
*	Helen Causley, Deputy Director, Community Health Care, Department for Health and Social Care	QQ 142-155
*	Professor Kath Checkland, Professor of Health Policy and Primary Care Health Organisation, Policy and Economics Research Group, Centre for Primary Care & HSR Division of Population Health, HSR and Primary Care, University of Manchester	QQ 156-164
*	Dr Jane Harvey, Clinical Director, Hyde Primary Care Network, and General Practitioner Principal and Partner, Dukinfield Medical Practice	QQ 156-164
*	Sian Thomas, Deputy COO, Division 3, Royal Wolverhampton NHS Trust and Partnership Director at OneWolverhampton	QQ 156-164
*	Professor Catherine Evans, Professor in Palliative Care, King's College London	QQ 165-173
*	Dr Salwa Malik, Vice-President, Royal College of Emergency Medicine	QQ 165-173
*	Dr Alex Thomson, Vice-Chair of Liaison Faculty, Royal College of Psychiatrists	QQ 165-173
**	Siobhan Melia, Chair, The Community Network	QQ 174-183
**	Tom Cottam, Head of Health and Resilience Policy, British Red Cross.	QQ 174-183
*	Dr Amanda Doyle OBE, National Director of Primary and Community Care Services, NHS England	QQ 184-197
*	Dr Tim Ferris, Director of NHS Transformation, NHS England	QQ 184-197
*	Councillor Tim Oliver, Leader, Surrey County Council	QQ 198-205

*	Dawn Wakeling, Co-Priority Lead for Sustainable Personalised Health & Care Systems, Association of Directors of Adult Social Services, and Executive Director of Communities, Adults and Health, London Borough of Barnet	QQ 198-205
*	Simon Williams, Director of Adult Social Care Improvement, Local Government Association	QQ 198-205
*	Dr Toni Dedeu, Senior Adviser, WHO European Centre for Primary Health Care	QQ 206-212
*	Professor David Peiris, Acting Chief Scientist, and Director of Global Primary Health Care Program (Better Care), George Institute for Better Health	QQ 206-212
*	Dr Dheepa Rajan, Health System Specialist, European Observatory on Health Systems and Policies	QQ 206-212
*	Mr Brendan Martin, Founder and Managing Director, Buurtzorg Britain and Ireland	QQ 213-218
*	Dr Niamh Lennox-Chhugani, Chief Executive, International Foundation for Integrated Care	QQ 213-218
*	Dr Sebastien Moine, Visiting Research Fellow, Primary Palliative Care Research Group, University of Edinburgh.	QQ 213-218
*	Rt Hon Patricia Hewitt, Chair of the Hewitt Review and Former Secretary of State for Health (2005–07)	QQ 219-229
**	James Bullion, Chief Inspector of Adult Social Care and Integrated Care, Care Quality Commission.	QQ 219-229
*	Rt Hon Lord Lansley CBE PC DL, Former Secretary of State for Health (2010–12)	QQ 230-236
*	Rt Hon Lord Hutton of Furness, Former Minister of State for Health (1999–2005)	QQ 230-236
*	Rt Hon Lord Warner, Former Parliamentary Under-Secretary of State for Health and Minister of State for National Health Services Delivery (2003–05)	QQ 230-236
*	Helen Whately MP, Minister of State, Department for Health and Social Care (DHSC)	QQ 237-254
*	Neil O'Brien MP, Parliamentary Under Secretary of State, Department of Health and Social Care (DHSC)	QQ 237-254

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Anonymised	PC0004
Dr Judith Allanson, Executive Member, British Society of Rehabilitation Medicine	PC0074
Lawrence Ambrose, Head of Policy & Public Affairs, The Royal College of Podiatrists	PC0077

*	Mr Ivan Annibal, Managing Director, Rose Regeneration (QQ 75–82)	
	Dr Roland Appel, Health IT Consultant, Maycroft Consulting, Dr Barbara Gale, Health Consultant, BG Consulting, Dr Ian McNicoll, Clinical Informatician Consultant, freshEHR Consultancy, and Mr Ewan Davis, Digital Health Consultant, Woodcote Consulting	PCC0050
	Association of Directors of Adult Social Services (ADASS)	PCC0069
	Association of Optometrists	PCC0067
*	Professor Sheena Asthana, Director, Plymouth Institute of Health and Care Research; Co-Director, Centre for Coastal Communities, University of Plymouth, Dr Felix Gradinger, Senior Research Fellow, Plymouth Institute of Health and Care Research, Professor Sheela Agarwal, Co-Director, Centre for Coastal Communities, University of Plymouth, Professor Richard Byng, Professor in Primary Care Research/PenARC Deputy Director, University of Plymouth, Dr Julian Elston, Senior Research Fellow, Plymouth Institute of Health and Care Research, Dr Matthew Fox, GP Locality Clinical Director, Integrated Care Service (Dawlish and Teignmouth, South Devon), and Ms Judy Hargadon, Non-Executive Director, Devon ICB (Primary Care and Prevention), Devon Integrated Care Board (QQ 75–82)	PCC0011
	Dr Joanne Atkinson (Head of Dept of Social Work, Education and Community Wellbeing at University of Northumbria at Newcastle); Prof Amanda Clarke (Professor of Nursing at University of Northumbria at Newcastle); Dr Angela Bate (Associate Professor of Health Economics at University of Northumbria at Newcastle); Dr Sonia Dalkin (Associate Professor of Applied Health Research, University of Northumbria at Newcastle, Dr Caroline Jeffery, GP and Senior Lecturer, University of Northumbria at Newcastle, Dr Kathryn McEwan, Lecturer in Health and Social Care, University of Northumbria at Newcastle, and Dr Paul Paes, Consultant/Reader in Palliative Medicine, Newcastle Medical School	PC0048
	Professor Stephen Barclay, Professor of Palliative Care, University of Cambridge, Professor Mike Kelly, Honorary Senior Visiting Fellow, University of Cambridge, Dr Ben Bowers, Wellcome Post-Doctoral Research Fellow, University of Cambridge, Dr Alessandro Bosco, Research Associate, University of Cambridge, and Ms Susannah Browne, St Luke's Hospice PhD Fellow, University of Cambridge	PCC0049

	British Association for Sexual Health and HIV	PCC0064
	British Dietetic Association	PCC0045
	British Geriatrics Society	PCC0055
*	British Red Cross (QQ 174–183)	PCC0019
	Bupa Global & UK	PCC0021
*	Rt Hon Andy Burnham, Mayor, Greater Manchester (QQ 66–74)	
	Professor John Campbell MBE, Professor of General Practice and Primary Care, University of Exeter (QQ 1–12)	
*	Care Quality Commission (QQ 219–229)	PCC0042
*	Helen Causley, Deputy Director, Community Health Care, Department for Health and Social Care (QQ 142–155)	
	Professor Christina van der Feltz-Cornelis, Chair of Psychiatry and Epidemiology, University of York, Dr Fidan Turk, Research Associate, University of York, and Dr Jennifer Sweetman, Research Associate, University of York	PCC0028
	Centre for Care - University of Sheffield	PCC0022
	Hannah Chamberlain, CEO, Design in Mental Health Network	PCC0073
	The Chartered Society of Physiotherapy	PCC0043
*	Professor Kath Checkland, Professor of Health Policy and Primary Care Health Organisation, Policy and Economics Research Group, Centre for Primary Care & HSR Division of Population Health, HSR and Primary Care, University of Manchester (QQ 156–164)	
	Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation	PCC0041
*	The College of Optometrists (QQ 103–113)	PCC0065
*	The Community Network (QQ 174–183)	PCC0026
	Compassion in Dying	PCC0017
*	Ms Nora Corkery, CEO, Devon Communities Together (QQ 75–82)	PCC0002
*	Dr Hajira Dambha-Miller, Lecturer, University of Southampton, and Dr Glenn Simpson, Senior Research Fellow, University of Southampton (QQ 114–122)	PCC0058
	Dr Charles Daniels, Medical Director, St Luke's Hospice	PCC0003

★	Ed Davie, Policy and Public Affairs Lead, Centre for Mental Health (QQ 123–134)	
★	Dr Antoni Dedeu, Senior Advisor, WHO European Centre for Primary Health Care (QQ 206–212)	
	Department of Health and Social Care	PCC0061
★	Mr Adam Doyle, CEO, Sussex Integrated Care Board (QQ 52–65)	
	Dr Amanda Doyle OBE, National Director of Primary and Community Care Services, NHS England (QQ 184–197)	
★	Professor Catherine Evans, Professor of Palliative Care, King's College, London (QQ 165–173)	
	Professor Sir Sam Everington OBE, Professor and GP, Bromley-by-Bow Partnership (QQ 123–134)	
	The Faculty of Sexual and Reproductive Healthcare	PCC0057
★	Dr Tim Ferris, Dr Tim Ferris, Director of NHS Transformation, NHS England (QQ 184–197)	
	Mark Fisher CBE, CEO, NHS Greater Manchester Integrated Care (QQ 66–74)	
★	Professor Claire Fuller, CEO, Surrey Heartlands ICS (QQ 52–65)	
★	Rt Hon The Lord Hutton of Furness, Former Minister of State, Department for Health and Social Care (QQ 230–236)	
	General Medical Council	PCC0009
	Dr Anna Gkiouleka, Research Associate, University of Cambridge, and Dr John Ford, Senior Clinical Lecturer and Honorary Visiting Fellow, Wolfson Institute of Population Health and University of Cambridge	PCC0010
★	Professor Claire Goodman, Professor of Health Care Research, University of Hertfordshire (QQ 13–22)	
	Guy's and St Thomas' NHS Foundation Trust	PCC0023
★	Professor Sir Chris Ham, Chair of the Coventry and Warwickshire Health and Care Partnership, non-executive director of the Royal Free London Hospitals NHS Foundation Trust and Co-Chair, NHS Assembly (QQ 40–51)	
★	Daniel Hardiman-McCartney MBE, Clinical adviser, The College of Optometrists (QQ 103–113)	PCC0075
★	Daniel Hardiman-McCartney MBE, Clinical Adviser, College of Optometrists (QQ 103–113)	PCC0078

*	Dr Jane Harvey, Clinical Director, Hyde Primary Care Network and General Practitioner Principal and Partner, Dukinfield Medical Practice (QQ 156–164)	
	Herefordshire General Practice	PCC0037
*	Rt Hon Patricia Hewitt, Chair, Hewitt Review and former Secretary of State for Health 2005–2007 (QQ 219–229)	
	Emily Holzhausen OBE, Director of Policy and Public Affairs, Carers UK (QQ 32–39)	
	Ms Gemma Hopkins, Representative, BMA (British Medical Association)	PCC0071
	Huntington's Disease Association	PCC0007
	Independent Healthcare Providers Network	PCC0059
	Institute of Health Visiting	PCC0013
*	Ruthe Isden, Head of Health Influencing, Age UK (QQ 32–39)	
*	Mark Joannides, Deputy Director, General Practice, Department for Health and Social Care (QQ 142–155)	
	Dr Helen Jones, GP, NEL ICS	PCC0016
*	Professor Sally Kendall, Professor of Community Nursing and Public Health, Kent University (QQ 13–22)	
*	Fatima Khan-Shah, Chair, People and Communities Workstream for the Fuller Report (QQ 123–134)	
*	The King's Fund (QQ 135–141)	PCC0020
	Rt Hon The Lord Lansley CBE PC DL, Former Secretary of State, Department for Health and Social Care (QQ 230–236)	
*	Jacob Lant, Head of Policy Public Affairs and Research and Insight, Healthwatch (QQ 23–31)	
*	Professor Daniel Lasserson, President of the Hospital, Home Society (QQ 83–91)	
*	Dr Niamh Lennox-Chhugani, Chief Executive and Director of Research, International Foundation for Integrated Care (QQ 213–218)	
*	Dr Salwa Malik, Vice President, Royal College of Emergency Medicine (QQ 165–173)	
	Marie Curie	PCC0054
*	Mr Brendan Martin, Founder and Managing Director, Buurtzorg Britain and Ireland (QQ 213–218)	

*	Ewan Maule, Member of the Royal Pharmaceutical Society’s English Pharmacy Board and Lead Pharmacist, North East and North Cumbria ICS (QQ 103–113)	
	Patrick Mayne	PCC0008
*	Mr Gary McAllister, Chief Technology Officer, One London (QQ 92–102)	
*	Dr Neil Modha, Chair of the Data Workstream for the Fuller Stocktake report, GP partner and Chair, Greater Peterborough Network GP Federation (QQ 92–102)	
*	Dr Sébastien Moine, Visiting research fellow, Primary Palliative Care Research Group, University of Edinburgh (QQ 213–218)	
	moMENtum Devon CIC	PCC0070
	National Care Association	PCC0014
	National Community Hearing Association	PCC0053
	National Pharmacy Association	PCC0066
	National Voices	PCC0056
*	NHS Confederation (QQ 40–51)	PCC0032
	NIHR Policy Research Unit in Health and Care Systems and Commissioning (PRUComm)	PCC0025
	Neil O’Brien MP, Minister for Primary Care and Public Health, Department for Health and Social Care (QQ 237-254)	
	Dr Crystal Oldman, Chief Executive, The Queen’s Nursing Institute (QQ 23–31)	PCC0072
	Professor Emily Oliver, Professor of Behavioural Sciences, Newcastle University	PCC0039
*	Cllr Tim Oliver, Cllr Tim Oliver, Leader, Surrey County Council (QQ 198–205)	
	Optum UK	PCC0038
*	Dr Abhi Pal, President, College of General Dentistry (QQ 103–113)	

	Dr Tanuka Palit, GP trainee, NIHR Academic Clinical Fellow, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol, Dr Olly Clabburn, Senior Research Associate, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol, Dr Lucy Selman, Associate Professor of Palliative and End of Life Care, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol, Dr Charlotte Chamberlain, Palliative Care Consultant, Honorary Clinical Lecturer, Accredited Consultant in Public Health, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol, Dr Lucy Pocock, Academic GP, NIHR Doctoral Research Fellow, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol, and Dr Alice Malpass, Senior Research Associate, Palliative and End of Life Care Research Group, Population Health Sciences, University of Bristol	PCC0051
*	Professor David Peiris, Acting Chief Scientist & Director, Global Primary Health Care Program, The George Institute for Global Health, Professor, Faculty of Medicine, UNSW Sydney (QQ 206–212)	
	Policy Connect	PCC0062
	Dr Toby Quibell, CEO, North East Wellbeing, Dr Alex Battersby, Consultant Paediatrician, Great North Children's Hospital, Newcastle Hospitals Trust, and Dr Jenna Charlton, Senior Researcher, Newcastle University	PCC0012
*	Dr Dheepa Rajan, Health System Specialist, The European Observatory on Health Systems and Policies (QQ 206–212)	
	RCSLT	PCC0052
	Rethink Mental Illness	PCC0023
*	Ben Richardson, Managing Partner, Carnall Farrar (QQ 92–102)	
	RNID	PCC0068
	Professor Esther Rodriguez-Villegas, Professor of Low Power Electronics, Department of Electrical and Electronic Engineering, Imperial College London (QQ 83–91)	
	Royal College of General Practitioners	PCC0033
	Royal College of Occupational Therapists (QQ 114–122)	PCC0027 PCC0076
	Royal College of Paediatrics and Child Health	PCC0047

	Dr Anna Ruddock, Research Associate, University of Liverpool, Dr Bethan Evans, Senior Lecturer, University of Liverpool, Dr Alison Allam, Research Associate, University of Liverpool, Dr Morag Rose, Lecturer, University of Liverpool, and Dr Ana Be Pereira, Senior Lecturer, Liverpool Hope University	PCC0030
	Tanya Rumney, Dietitian, British Dietetic Association (QQ 135–141)	PCC0079
	Joan Saddler, independent co-chair, NHS England Equality and Diversity Council	PCC0031
*	Dr Edward Scully, Director of Primary and Community Health, Department for Health and Social Care (QQ 142–155)	
	Skills for Health	PCC0040
	Jean Hardiman Smith, Chair Health and Care Working Party, National Pensioners Convention	PCC0029
	Society of Occupational Medicine	PCC0036
	Dr Harpreet Sood MBBS MPH MRCGP, GP and Board Member, NHS England (QQ 52–65)	
	Specsavers Group	PCC0044
	Matthew Spencer, Senior Account Manager, PLMR Healthcomms, and Sophie Figueiredo	PCC0015
	Sue Ryder	PCC0034
*	Sallyann Sutton, Professional Officer, School and Public Health Nurses Association (QQ 114–122)	
*	Ms Sian Thomas, Deputy COO - Division 3 and Partnership Director OneWolverhampton, The Royal Wolverhampton NHS Trust (QQ 156–164)	
*	Dr Alex Thomson, Vice Chair of Liaison Faculty, Royal College of Psychiatrists (QQ 165–173)	
	TPP	PCC0060
	VCSE Nutriri	PCC0006
*	Dawn Wakeling, Co-Priority Lead for Sustainable Personalised Health & Care Systems at the Association of Directors of Adult Social Services and Executive Director - Communities, Adults and Health, London Borough of Barnet (QQ 198–205)	
*	Matthew Walker, Director of strategy, National Association of Primary Care (QQ 23–31)	
*	Professor Kate Walters, Clinical Professor of Primary Care and Epidemiology, UCL, IRIS (QQ 1–12)	

*	Rt Hon The Lord Warner, Former Parliamentary Under-Secretary, Department for Health and Social Care, and Former Minister of State, National Health Services Delivery (QQ 230–236)	
	Dr Stuart Watson, Consultant Psychiatrist, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Mrs Linda Davison, Care Pathways Enhancement Clinic co-ordinator, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Ms Beth Hall, Higher Research Assistant, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Dr Katharine Taylor, Consultant Psychiatrist, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Dr Apoorva Peddada, Higher Trainee (ST5) Adult Psychiatry, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Dr Mourad Wahba, Higher Trainee (ST6) Adult Psychiatry, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Dr Ben Greenhalgh, Higher Trainee (ST7) Psychiatry, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Dr Barbara Salas, Core Trainee (CT1) Psychiatry, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, and Prof Hamish McAllister-Williams, Consultant Psychiatrist, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	PCC0035
*	Julia Weldon, Lead for the Health Inequalities policy advisory group, Association of Directors of Public Health (QQ 135–141)	
	Helen Whately MP, Minister for Social Care, Department for Health and Social Care (QQ 237-254)	
	Dr Richard West MBE, Chairman, Dispensing Doctors' Association	PCC0046
	Mrs Denise Williams	PCC0005
*	Simon Williams, Simon Williams, Director of Adult Social Care Improvement, Local Government Association (QQ 198–205)	
*	Professor Sue Yeandle, Professor of Sociology and Director of Centre for International Research on Care (CIRCLE), and Principal Investigator, Economic Social Research Council (ESRC) Centre for Care, University of Sheffield (QQ 13–22)	
*	Jason Yiannikkou, Director of Systems, Integration and Reform, Department for Health and Social Care (QQ 142–155)	

APPENDIX 3: CALL FOR EVIDENCE

The House of Lords' Special Inquiry Committee on the Integration of Primary and Secondary Care Committee, chaired by Baroness Pitkeathley, was established to consider the integration between primary and community care within the wider health and care system. Primary and community care services provide vital support to millions of patients every day but, like much of the NHS, are now under considerable strain. A longstanding challenge for primary and community care is how to adapt existing healthcare structures and better integrate services to deliver care that meets the needs of a changing population.

A central question for the Committee then is how better to integrate the delivery of effective primary and community care services to improve health resources and outcomes for patients. The Committee wishes to produce an inquiry that is useful and does not duplicate the work of previous reports. It therefore intends to focus on the integration between primary and community care within the short time that has been allocated, with due consideration given to community care provision as a neglected and underdeveloped policy area.

The inquiry will focus on community care rather than social care but will consider the impact of developments in social care on the delivery of community health services. The Committee aims to conclude with practical and deliverable recommendations that will add value by effectively contributing to innovative policymaking in the area. It hopes that this inquiry will outline core principles expected to be delivered across services in the community to avoid duplication in patient care.

The Committee would like to hear from a range of organisations and individuals who have direct experience of accessing primary and/or community care services. This includes patients, carers, and families, as well as the voluntary sector. The Committee is also keen to hear from health professionals and researchers who have expertise in this area or are involved in the delivery of these services, especially in relation to integrated care. The Committee is interested in the experiences of people from a wide geographical area and across different age groups.

1. What are the main challenges facing primary and community health service? What are the solutions within the current framework? What steps should be taken to improve support for the long-term management of complex conditions in the community, and respond to the needs of patients and communities?

2. What are the key barriers preventing improved integration, and how might these be overcome? Could you provide examples of successful or innovative models of integration between primary and community care, either in the UK or internationally? How have they gone about achieving their aims of integration? How could these models be replicated and further developed to ensure consistency in the delivery of services across England? Could you give an indication of where integration has not worked well, and the reasons for this?

3. Pressures on primary care have been well documented. How would you assess the current state of community care, in particular the integration between both areas? What is the impact of developments in social care on other community health services?

4. What are the implications of the Government's long-term workforce plan for the NHS on primary and community care staffing?

5. What is the impact of recent structural changes to the NHS in England (enacted through the Health and Care Act 2022) on integration between primary and community care services? To what extent are the policy interventions aimed at integrating services delivering the results expected of them? What do these changes mean for patients in terms of access and satisfaction?

6. Is the current primary care model fit for purpose and servicing the needs of patients? As it is currently configured, can the model of primary care deliver on the ambition of providing more care outside the hospital setting? To what extent does the current model enable working in partnership with other services? How does the current model secure parity for mental health provision?

7. How successful have Primary Care Networks been in facilitating joined up working between primary and community care provision, and other parts of the system? Are you aware of any alternative models elsewhere? What proportion of primary and community care services are accountable to local and regional level?

8. To what extent could improved access to out of hours and 24/7 services contribute to alleviating pressures on the health system?

9. To what extent have Integrated Care Systems (ICSs) been able to deliver the aims they were set up to achieve? To what extent are they sufficiently equipped to support the delivery of local priorities relating to better prevention and early intervention? To what extent has primary and community care relied on the voluntary sector, and how appropriate has the balance been?

10. Could you provide examples of how primary and community care have contributed to tackling health inequalities, including international comparisons? To what extent does the picture vary across England, for instance between urban, rural, and coastal areas?

11. In what way could the existing infrastructure be enhanced to improve the use of health technologies, and what are the possible benefits for patients? What are the main barriers to increasing the sharing of information and data across different health services? What can be learned from approaches to using technology during the COVID-19 pandemic? How could technology harness ways to empower patients to take responsibility for their own health?

12. Could you please outline one key change or recommendation you would like to see to enable effective and efficient integration in the delivery of primary and community care services?

APPENDIX 4: SUMMARY OF VISIT TO PIMLICO

Purpose

On Thursday 11th May 2023, the Committee visited Pimlico Health at The Marven, a GP surgery. The Marven Surgery refers to the premises, while Pimlico Health is the name of the current multi-disciplinary team of GPs, nurses, and other health professionals operating the surgery.[259]

Pimlico Health at the Marven is close to the Churchill Gardens Estate. This is a large housing estate, developed by Westminster City Council between 1946 and 1962. By the standards of the time, the housing stock (mostly flats and maisonettes) was of high quality and the social backgrounds of the residents mixed. Over recent decades however, the estate has suffered from social deprivation and physical dilapidation.[260] Today, the estate is very ethnically and linguistically diverse, with an elevated level of social deprivation.[261] Parts of the estate are in the bottom 10% of areas in England, ranked by deprivation. In contrast, areas just east of the estate are less deprived than average. Pimlico has high levels of deprivation inequality and the areas served by the Marven vary considerably in their levels of wealth.[262] The Committee visited the Marven to see the multi-disciplinary projects, run from or with the practice, which aim to address the health needs in Pimlico.

Community health and wellbeing workers

Pimlico Health at The Marven and Westminster City Council are running a pilot project where Community Health and Wellbeing Workers (CHWW) will be employed in the Churchill Gardens estate. The National Association for Primary Care explains:

> "The role of Community Health Workers (CHW) was developed in Brazil which has the largest primary care system in the world. It is a community household approach to population health which offers insight into the factors that determine an individual's health and wellbeing. CHWs provide universal, comprehensive, and integrated health and social care support to all households in a defined geographical area, usually around 200 households. They are recruited from these areas, are paid full time and are members of the local primary care team. CHWs are trained at a low technical level to support their households with a broad range of activities. By visiting households at least once a month irrespective of need, CHWs proactively identify any new illness or problems and to provide support."[263]

Brazil's CHWW programme is "one of the largest in the world, has helped the country reduce under-five mortality by 75 per cent, maternal mortality by nearly

259 Pimlico Health, 'Pimlico Health @ The Marven': https://www.pimlicohealth.co.uk/about-us [accessed 10 October 2023]

260 A London Inheritance, 'Churchill Gardens and Battersea Power Station': https://alondoninheritance.com/london-infrastructure/churchill-gardens-and-battersea-power-station/ [accessed 10 October 2023]

261 Community Health and Wellbeing Worker, *Translating the Brazilian model of Community Health and Wellbeing Workers into primary care in the UK* (January 2023), p 14: https://www.napc.co.uk/wp-content/uploads/2023/01/Community-health-worker.pdf [accessed 10 October 2023].

262 Westminster City Council, 'Ward Profiles - Pimlico South': , https://www.westminster.gov.uk/media/document/pimlico-south-ward-profile---2022 [accessed 10 October 2023]

263 National Association of Primary Care, 'Community Health Workers: the eyes and ears for Primary Health Care in the community': https://napc.co.uk/wp-content/uploads/2021/09/NAPC-Community-Health-Worker-leaflet.pdf [accessed 10 October 2023]

60 per cent, and has helped the country achieve nearly universal immunization."[264] The scheme has helped reduce health inequalities, thereby reducing the difference the geographical location or socio-economic background makes to the level of healthcare the population receive. CHWWs are highly integrated into the primary and community care system and generously funded by central and local government.[265]

CHWWs each have a small "geographical allocation" in which they work. In Brazil, this is typically 100–200 households. It is slightly more in this Westminster pilot, as there are fewer people per household in the UK. The Churchill Gardens estate has been split into different areas, each covered by a CHWW. The workers fulfil distinct roles within their "patch". These include delivering health promotion information, helping residents access services, informal counselling and engaging vulnerable residents.

The Committee heard how the CHWW act as a link between the GP surgery, local authority services, and voluntary groups to co-ordinate care for residents. They help the GPs care for residents who did not speak English or would not have otherwise availed themselves of primary care services. They also act as advocates for residents and help ensure that they have access to the care they need.

The Child Health Hub

The Child Health Hub (or Connecting Care for Children) scheme consists of multi-disciplinary teams (MDTs) across the North West London Integrated Care System (NWL ICS). The programme aims to bring "more specialist expertise on child health within easy reach" of patients.[266]

This is done by the MDTs, called "hubs" which are based in GP practices. They link primary and community clinicians with paediatric experts. MDTs consist of GPs, paediatric consultants, health visitors, child, and adolescent mental health services (CAMHs), early years teams, school nurses and paediatric dietitians. Specifically, the programme consists of three "innovations":

(a) "GPs have open access to children's health specialists at St Mary's hospital, with a phone line and email for advice.

(b) Child health GP Hub (specialist outreach clinics and multi-disciplinary meetings with GP hubs every 4–6 weeks).

(c) Building relationships and working with champions in the community to improve the health of local populations".[267]

The MDTs are able to create care around patients, rather than patients having to move through different parts of the system. This ensured that care is provided more swiftly, preventing health problems becoming more serious.

Pimlico's approach to integration

The two schemes illustrate the importance of both formal structures and good working culture to support well-integrated multi-disciplinary teams. The Committee was struck by the close working relationships between professionals

264 Exemplars in Global Health, 'Community Health Workers in Brazil': https://www.exemplars.health/topics/community-health-workers/brazil [accessed 10 October 2023]
265 *Ibid.*
266 Connecting Care for Children, 'Child health GP hubs', https://www.cc4c.imperial.nhs.uk/child-health-gp-hubs [accessed 10 October 2023]
267 *Ibid.*

from different teams. It was obvious that informal relationships, built on trust and shared aims, are as important as formal structures for encouraging integration.

APPENDIX 5: SUMMARY OF VISIT TO COVENTRY

Purpose

The Committee visited Coventry on Monday 3rd July 2023 to hear about the work in the city to support the integration of primary and community care. Coventry has the status of a "Marmot City," one of seven in the UK, where the government wants to tackle health disparities and improve health outcomes. The Committee met with stakeholders involved in the delivery of healthcare to understand the successes and challenges they have faced when integrating health and care services.

Meeting 1–community led responses to health inequalities

The first session focused on health inequalities, community projects and wider VCSE partnerships. The Committee was told about the importance of local, place-based approaches to addressing health inequalities and improving outcomes for residents.

The Committee received presentations from:

(a) Allison Duggal: The Marmot Partnership and Coventry's approach to tackling health inequalities.

(b) Dr Chris Newton: Population health management for people living with back-pain.

(c) Bridget Atkins and Jane Wright: emotional wellbeing support for children and young people.

(d) Tim Morris: Sowe Valley PCN and Moat House Community Trust Partnership.

Meeting 2–Coventry and Warwickshire's approach to integration

The second session explored the approach taken to ensure integration strategies in Coventry were well-coordinated and impactful. There was an explanation of the Care Collaborative, Proactive Care, Urgent Community Response, and Improving Lives approaches.

The Committee heard from:

(a) Phil Johns: Chief Executive, Coventry and Warwickshire ICB

(b) Pete Fahy: Director of Adult Services, Coventry City Council

(c) Justine Richards: Chief Strategy Officer, University Hospital Coventry and Warwickshire

(d) Dominic Cox: Director of Strategy and Development, Coventry and Warwickshire Partnership Trust

(e) Deepika Yadav: GP and Clinical Director for Integrated Care

(f) Nelofer Ali: GP and ICB Partner

(g) Allison Duggal: Director of Public Health, Coventry City Council

Coventry's approach to integration

The Committee was told about the strength of the professional and inter-service relationships in Coventry, coordinated by the local authority and ICS. The result has been a productive approach to tackle health inequalities with an aligned vision and understanding based on a citizen-centric focus. This is exemplified by the

place-based approach from the Coventry team that enables action to be proactively taken where it is needed using a multi-agency approach. Effective integration does require constant liaison between community groups and agencies for confidence and maintaining good relationships.

Challenges and policy opportunities

The Coventry team did however underline areas which have created barriers for more integration to take place.

Funding is an issue due to a lack of long-term sustainability. The inability to receive long-term funding (and the demand in competition for funds) has resulted in a loss of trust amongst the service recipients. Change can only come from long-term reliability in funding, as this will increase incentives to provide more opportunities to integration.

Participants told the Committee that flexible use of funds, with fewer spending criteria, would also bring benefits to the entire population. The Coventry team noted that the funding had to be returned if they did not follow the criteria.

The issues surrounding the changing nature of governance and reporting from the NHS and social care reform has hampered innovation and partnerships. Stability is needed after the recent establishment of ICBs for partnerships and sustained integration opportunities to be maximised.

The Committee heard about the importance of data sharing, especially at a community level with non-statutory partners. Rules set out by the Government are vague concerning sharing records at a community level relationship. A transparent policy guidance on data sharing is required to form an effective relationship between partners and community groups.

The Committee also heard that health policy beyond the NHS and adult social care provision needs to be considered. Community assets, the importance of wellbeing and prevention, voluntary carers, and other services like housing must be considered as they also play a key role in ensuring patients receive the care and support they need. Recognition of these wider influences by providing support and resources are imperative towards greater integration.

Shared role development is currently lacking. NHS and Social Care workforce plans are separate from each other, and this hinders functioning integration. Having a national workforce strategy would help towards bridging that gap.

APPENDIX 6: SUMMARY OF ROUNDTABLE EVENT

On Monday 24th July, the Committee hosted a roundtable event for stakeholders at the Palace of Westminster. The event was designed to solicit the views of clinicians, health professionals, and experts by experience. There were 21 attendees, who visited from across England and represented a diverse range of healthcare sectors.

Informal discussions were held in small groups, composed of 2-3 Members and five attendees. Members asked questions on attendees' experience of multi-disciplinary teams, training for integration, data sharing, contractual barriers to integration, and work with VCSE organisations.

Attendees told the Committee that data sharing was a major barrier to carrying out integrated care, where in some instances information was still being recorded and shared on paper. They noted that a care record accessible across various services would be highly beneficial. The Committee heard multiple stories of patients having to repeat the same information to health professionals because systems did not link up.

The roundtable also made clear that integration relies on good relationships. Attendees told us about projects that worked because there was trust and warm professional relationships between practitioners from different services. The opposite was also true: a perceived hierarchy of professions and roles also made it harder to plan patient care in a truly collegiate way.

Many attendees were from community disciplines such as occupational therapy and physiotherapy. They emphasised the need to make better use of community specialists to reduce demand on general practice, and ultimately hospitals.

Another major theme was the way that voluntary organisations can support health and social care services through social prescribing. The Committee heard how links with the VCSE sector could reduce demand on the health service by providing preventative activities in the community.

APPENDIX 7: ACRONYMS AND GLOSSARY

Acronyms

API	Application Programming Interfaces
ASC	Adult Social Care
BACCH	British Association for Community Child Health
BCF	Better Care Fund
BMA	British Medical Association
CCG	Clinical Commissioning Groups
CHWW	Community Health and Wellbeing Workers
CNSGP	Clinical Negligence Scheme for General Practice
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
DLUHC	Department for Levelling Up, Housing and Communities
GP	General Practice
GDPR	General Data Protection Regulation
ICB	Integrated Care Boards
ICP	Integrated Care Partnerships
ICS	Integrated Care Systems
LGA	Local Government Association
NAO	National Audit Office
NHS	National Health Service
NHSE	National Health Service England
PCN	Primary Care Networks
PCT	Primary Care Trusts
POD	Pharmacy, Optometry and Dentistry
RCPCH	Royal College of Paediatrics and Child Health
SCR	Single Care Records
SPR	Single Patient Record
STP	Sustainability and Transformation Partnerships
VCSE	Voluntary, Community and Social Enterprise

Glossary

Administrative/ Functional integration	Merging non-clinical support and back-office functions, for example accounting mechanisms or sharing data and information systems across organisations.

Acute services	A Secondary Care which focuses on providing treatments to serious injuries or illnesses that requires immediate attention. They are often treated in Accident and Emergency departments in Hospitals or acute wards in Mental Health Hospitals.
Clinical integration	Co-ordination of care into a single or coherent process, either within or across professions, for example involving shared guidelines or protocols across boundaries of care.
Community Care	Providing holistic care in people's homes, schools, clinics, and community centres. This may also include services that are not provided by the NHS.
Coterminosity	Having a shared boundary such as between Integrated Care Services and Local Authorities.
Clinical Negligence Scheme for General Practice (CNSGP)	A scheme which protects primary care clinicians from financial liability in the event of medical negligence.
Integration index	A framework for accountability and performance that gauges the perceptions of patients, caregivers, and the public regarding the quality of care provided by the local health service and its associates, focusing on the effectiveness of their integration.
Interoperability	the ability for computer systems to exchange patient information, particularly between different health services.
Marmot City	A city working in-depth to reduce the social gradient in health by following the six policy objectives recommended in the Marmot Review often referred to as the 'Marmot Principles'.
Multi-disciplinary working	Involvement of multiple disciplines across health services to come together to understand and provide support for service user need(s).
Organisational integration	Focusing on co-ordinating structures and governance systems across organisations, for example organisational mergers or developing contractual/ cooperative arrangements.
Patient Pathway	Sequential episodes of care that a patient experiences as they move through the healthcare system.
Place	in the context of the health service, this typically refers to geographical areas smaller than an ICS, such as large towns or local authority districts.

Term	Definition
Place-based partnerships	Collaborative arrangements between organisations responsible for planning and providing health and care services within a local area typically covering populations of around 250–500,000 people. This requires cooperation between the NHS, the local government, and other non-governmental local organisations.
Primary Care	First point of contact for providing health care. Generally delivered in healthcare settings in places like general practices, pharmacies, dental and optometry services.
Secondary Care	Medical care provided by a specialist doctor upon referral from a primary care provider.
Service integration	Co-ordination of different services such as via multi-disciplinary teams, single referral structures, or single-clinical assessment processes.
Social Care	Providing a care service towards those in need of help, personal care, support and/or protection from harm.
Tertiary Care	Higher level of specialty care that require various types of surgery or transplants.
Virtual wards	Patients are given more acute care at home instead of at hospital, provided by a multi-disciplinary team.