

Integration of Primary and Community Care Committee

Corrected oral evidence: The integration of primary and community care

Monday 6 March 2023

3.55 pm

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Members present: Baroness Pitkeathley (The Chair); Lord Altrincham; Baroness Armstrong of Hill Top; Baroness Barker; Baroness Finlay of Llandaff; Baroness Osamor; Baroness Redfern; Baroness Shephard of Northwold; Baroness Tyler of Enfield; Baroness Wyld.

Evidence Session No. 2

Heard in Public

Questions 13 - 22

Witnesses

I: Professor Sally Kendall, Professor of Community Nursing and Public Health, Kent University; Professor Claire Goodman, Professor of Health Care Research, University of Hertfordshire; 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.

Examination of witnesses

Professor Sally Kendall, Professor Claire Goodman and Professor Sue Yeandle.

Q13 The Chair: Good afternoon. I welcome our witnesses to this committee on the integration of primary and community care in the House of Lords. We are grateful to you all for taking time to join us. I think you have had some idea of the questions that we will ask you, but, as ever, my colleagues may chip in with all sorts of awkward ones that we have not given you prior notice of.

I will start the questioning in the usual way. In your view, what are the most significant pressures on community care at the moment, and how are those problems—you might want to call them barriers—affecting the successful integration of primary and community care services? As Professor Yeandle is with us online, perhaps I will start with her first and then come to our two colleagues in the room.

Professor Sue Yeandle: I am sure the other witnesses will speak in more detail about primary and NHS care. Of course, integration is the key agenda between health and care services at the moment. 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, particularly including people who need and use support and services, including carers and the voluntary sector, and that they properly reflect the diversity and varied challenges that face us at local and regional levels.

A critical element is establishing the mutual respect and understanding that is necessary for that to work effectively; in particular, establishing trust in the exchange of information and in ways that do not place undue burdens on patients and people using services, and on carers. Critically, however, it will be about listening to each other, building trustful relationships and delivering what is agreed. Those are important aspects at the moment.

To me, the fundamental issue that is massively problematic—and which, in my view, risks scuppering the whole integrated care agenda if we are not careful—is the workforce challenges. I am sure that members of the committee are very familiar with the recruitment and retention difficulties that are being experienced in all parts of the NHS sector. 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. There is a risk that the

whole agenda could be scuppered by failing to properly address the workforce issues.

Professor Claire Goodman: I have just been jotting those points down, and I think there will be a degree of repetition here.

On the challenges, there is the conceptual challenge that integration is a good thing and that, if we look back 30 or 40 years, there has always been work to develop integration, whether that is standard assessment frameworks or bringing health and social care together at practice level, commissioning level and policy level. We see that happening all the time.

I will draw on my research with older people and people living with dementia. In a study that we recently completed, we looked at different models of integrated working between primary care and community care delivering services into care homes. That is the perfect storm of a GP responsible for medical care, and the CCG as it was then, before it moved to being an ICB, being responsible for community care services but those services being delivered by a private or not-for-profit organisation, all having to work together for the benefit of people who are in the last two years of life, and probably therefore deteriorating by definition, and aiming to sustain, maintain and improve where they could.

We looked at different models of working in three geographical areas. Our argument was that it does not really matter how you organise it; it matters what the principles are within the model that you are using. The biggest challenge is that the rescuer arrives on a big white horse and says, "This is what we need to do, and we need to reconfigure these services", or, "We need to put this person in charge".

We found, however, that you could have a GP-led service or a delegated community care service. Ideally, you could have a service where social care and community services were setting the agenda together with some reference points to the GP, but it had to be based on trust and relationally based. If you did not have that as your core principle, it did not matter how you reconfigured the service delivery. That echoes the earlier point about trust.

The other challenge—this reflects work that we are currently doing—is data and information about people. People do not stay with one service, as we know, and they are not solitary. In my world of older people care, particularly people with dementia, they are dyads of care—they are carers and informal support. We do not have data integration that enables practitioners and commissioners to track what is happening to particular populations in their area.

With the Health and Care Act we have a mandated minimum operating dataset, and, as I understand it, the department is working quite fast on that. But, again, we know that the biggest challenge is how that becomes the basis for the language of how you work together rather than the administrative task of filling in information, which is then not trusted by the people you are working with so they will want their own assessment, outcome measures and so on. That is my starter for 10—I could go on for longer.

Professor Sally Kendall: Coming third in line to this question, there will be some overlap. I would like to start by reinforcing the point that one of the major challenges, as already identified, is the workforce. We might come back to that in later questions. There have been huge issues, not just in the workforce itself; we have challenges in the education and training of our workforce, particularly nurses and in our general practice. That leads to issues with the recruitment and retention of staff, which is a fundamental problem.

Alongside that, as Professor Goodman has alluded to there is also the conceptualisation of what we really mean by integration. We have had years of different policies looking at how we can bring different parts of the services together. If I look back to the work that the Nuffield Trust did on this, it argued that the patient experience needs to be at the centre of any discussion of integrated care. That is sometimes where we face the challenge of not engaging sufficiently with the people on the ground to have a bottom-up understanding of what we really mean by integrated care. Patients, the public and carers know what they want, but they do not know how to describe it in the way policy often offers it.

I wonder if I might be permitted to give a recent personal example that illustrates this. My 90 year-old father was recently admitted to hospital following a fall. He went through A&E, was given treatment for a broken finger and remained in hospital because the care package that was being put in place through the NHS was not available. They kept him in hospital—in a private room, I might add, at great expense—until he could be discharged to care. The care package that he was offered was withdrawn within days of his arriving home, because they should have a workforce of 40 members of staff but only have 11. It was a perfect example of being retained in hospital unnecessarily and then not being able to have the care that was on offer in the community.

The Chair: And a familiar example to many members of this committee.

Professor Sally Kendall: I am sure. It is an illustration from the ground that the need cannot be met, partly because of the workforce.

The Chair: Thank you. We go on to our next question, from Baroness Osamor.

Q14 **Baroness Osamor:** To what extent could improved integration between community care and other parts of the health service, including primary care, help the sector to meet some of the challenges that you outlined in your answer to the first question? How successfully are primary and community care services currently integrated within the wider health service? Are you aware of any successful models of integration in the UK or internationally, and if so, why they have worked well?

Professor Sally Kendall: This comes back to some of the issues that have already been raised, such as trust and being able to work across services in a way that engages with understanding each other's roles and understanding the workforce resource and the challenges of that.

Over time, going right back to the 1990s and probably before that, a great deal of research has been done on what creates a strong primary care system. That work has identified four key areas that we really need to think about if we want successful integration: continuity of care, first-contact access, comprehensiveness, and co-ordination. It has been shown internationally that, where those four key pillars are in place, you get better and stronger health outcomes for populations. We need to look at how we integrate that typology of strong primary care with the other community care services.

When we talk to patients, carers and parents, as a number of our studies do—I am currently involved in several studies concerned with health visiting, which is the children's end of community care, and I am undertaking another study with older people on COPD—and ask them what they want, they are looking for continuity and co-ordination and being treated across a system as one person. They do not want that sense of being divided up into different parts of their body or their problems.

The Chair: Are you saying that the same typology that you talked about for primary care would also apply to community care?

Professor Sally Kendall: Yes, it applies, and these are areas that we need to be concerned with if we are looking at integration.

Baroness Osamor: Do you have any examples, in the UK or

internationally, that work well?

Professor Sally Kendall: There are so many different models across Europe, for example. They seem to have some success in the Netherlands, where they have a different kind of community nursing service that can work autonomously but between community and primary care.

We might have missed a trick with the new models of care. In the evaluation of primary care models there was a real effort to look at how different models could be developed in the UK to develop a more integrated service. Something seems to have drifted on those new models of care, some of which were working very well. That was back in 2015, I think.

Professor Claire Goodman: On the question of how successfully primary care and community care are integrated with other parts of the health service, I would go back to the earlier point that it is about whether an infrastructure enables people to find the places to talk to each other and to plan together.

Taking again the example of primary care and community care teams and care homes, we found that the East Midlands had a dedicated care home team—physios and district nurses, so community services—delivering care into care homes but not being left alone. In another area, a very similar service was commissioned to go into care homes, but it was seen as, “Well, that’s it, sorted”.

We observed that in the East Midlands set-up they were delivering wraparound care. They may be the people going in and doing the assessment, but they could also access the dementia specialist services and the falls prevention service, which, from memory, was run from the hospital. They were a dedicated care home service, but they were recognised; they were not seen as a solution to the NHS’s problem. That is the message. We found that, if you are going to create new roles to facilitate integration and address the gaps in service, they have to be valued by whoever is commissioning the service. They cannot be single posts. They cannot, as I say, just be trying to sort something out like preventing people falling in care homes, which is a classic example. You need a more enlightened vision: that they are part of the economy of care. The GP role needs to be really clear, because they are the ones in charge of referrals. You may have nurses prescribing, but that does not mean that GPs will relinquish their prescribing.

We found that there was clarity about different roles in that landscape—good integrated care, a drop in urgent and emergency use, and the same resources used compared to the other models. It is about how you understand each other, and this seemed to be suggesting that this was really important. Some of that work fed into the Enhanced Health in Care Homes framework and the responsibility handed over to the primary care networks. Of course, the endless challenge is that something looks very tidy, neat and clear in research, but you just get drift and dilution as the principles migrate into boxes and forms. That is the big challenge.

You asked for international examples. You can see some very good examples in the United States from health maintenance organisations of case management, where one person in an organisation is designated to co-ordinate the care of people identified as being at risk and to liaise with everyone. However, that is all predicated on no primary care. We tried to bring that system in with the Evercare model, but it was very difficult to superimpose on existing services.

There are models that clearly work, but they have to fit with the infrastructure—with how GPs understand their role. One recommendation is that there has to be a reconfiguration of that so that those in the workforce understand their responsibilities towards each other. There is also something about integration in single services. We did a very small piece of work with one CCG and found that the integrated team had to answer to different human resources requirements; internally, they were not integrated. I suppose that is a system issue.

I come back to data. If we look at evidence of where countries are using minimum datasets—everybody is completing the same information about the person, it is not done purely for financial remuneration, and it becomes the reference point for discussion—it appears that certainly the western provinces of Canada would say that they weathered some of the pandemic better in long-term care settings because they had that. That was a bit of a natural experiment. We are post pandemic; people have learned to talk to each other in very different ways, and we could capitalise on the fact that there is a greater openness to online platforms and meetings than there ever was.

Professor Sue Yeandle: I do not disagree with anything that has been said, and I agree that data is incredibly important, and that data at the local level is important.

I want to refer to a different aspect of integration: the governance frameworks for integration and getting those right. I do not know

whether the committee is intending to interview Professor Chris Ham. He wrote a wise and important paper for the NHS Confederation about a year ago about governing health and care system integration, and it would certainly be of benefit to look at some of what he had to say there. In particular, he gives examples both of success and of warnings from other systems.

I remember thinking when reading the paper that there were some very interesting examples from the USA, particularly some of the transformations of the veterans' services, and some interesting examples from Australia and Sweden. There will be things that we can learn from other countries, but I absolutely agree with the previous witness that we cannot import systems from elsewhere. Some of the peculiarities of our system are also some of our major problems, and sometimes we cannot even learn from Scotland, Wales and Northern Ireland. There are things that we can learn from all those systems, and it is important that we do, but England has some very specific historical arrangements that make it quite difficult for us to simply import from other examples.

Those are the key things that we need to think about when we think about how we get that step change in commitment to integration and the belief at local level. It is that locally agreed strategic vision, and the aims, that fits the needs of the local community, that looks at the diversity of that community and the specific aspects of it, and looks at outcomes and at failings in the system, where we are getting unequal outcomes and unfairness and particular groups of people are continually coming up against problems. That is where the local integrated partnerships have the potential to be transformative.

There are some really encouraging and potentially highly beneficial features in the system that was introduced through the 2022 legislation, but we have to be careful to think about it as having important resonance at local level and that the same solution may not apply everywhere in the country. We may come later to urban and rural differences, but that is my main point.

The Chair: Indeed. We have a question about the integrated systems later.

Q15 **Baroness Redfern:** Professor Yeandle and Professor Kendall, how important is workforce retention, and how can we try to address that? Do you have data stating whether people are retiring, going abroad or going into the private sector? Do we have that data before we can start moving forward on retention?

Professor Sue Yeandle: I cannot answer for NHS personnel, but in the social care system we know quite a lot about the issues. That is why it is so important that we focus on some kind of parity of esteem between community service support that is provided through the NHS and in the adult social care system. 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.

Baroness Redfern: Are they going into the private sector?

Professor Sue Yeandle: They are not necessarily going into the private sector in care. Very often, they are leaving the care system either temporarily or permanently. This is also an issue of skills, which we will probably come back to. One of the tragedies of the last 20 years has been that when we have thought about the kind of workforce we need in adult social care services—the local authority-funded part of the system, which now includes all the people who are self-funding their adult social care—we have thought that it does not really matter whether those people are trained other than to a very basic level. That has been a fundamental error.

It is vital that we create career structures and ambition in that sector and that we support people to become specialists in different areas. Being a care sector worker for young people with learning difficulties involves a very different set of skills from providing support for people through home care who live alone in frailty and old age, for example. We are not respecting those skills and are not retaining people because we are not treating what they do as something that they can learn to do better and share by training others. They can see some of the solutions, because they are at the coalface day in, day out. It has been a fundamental issue for us that we have not trusted that workforce sufficiently to invest in them, retain them and bring out the best in them.

What is heartening but also tragic in a way is that many people who work in that sector are utterly dedicated to what they do and are very proud of the work they do, but they feel badly treated and have little future in that work as a career because there is no proper structure in it. That is different from some of the NHS-funded community positions. If we do not get that right, we will continue to have this long-term problem, which we have been grappling with for a quarter of a century now and, I would say, making almost no progress. That cannot be allowed to continue.

Professor Sally Kendall: I want to respond on the other end of the healthcare system: children. We have evidence in the health

visiting and school nursing service, for example, that since 2014 the health visiting workforce has seen a reduction of 37%. This is a workforce that is out there to promote the health of children, to prevent problems, to identify developmental delay, to promote vaccination—all the things that are very early-stage and that obviously promote their health and well-being later on in life. We have evidence, collected through the Institute of Health Visiting's annual survey of the health visiting workforce, of this very severe reduction in the workforce, which is leading to real problems in health visiting and school nursing being able to deliver on what should be a universal service to every child.

The Chair: Thank you. We come to Baroness Redfern's main question.

Q16 **Baroness Redfern:** We have touched on this question a bit, but I would like you to elaborate. What do recent structural reforms in the Health and Care Act, such as the creation of the primary care network and integrated care system, mean for primary care? Professor Goodman, you mentioned data and how important that is. How can we improve the integration more quickly?

Professor Claire Goodman: I am heartened by that question, because one tyranny is that we have this political cycle whereby something gets set up and something else gets changed. If we work with what we have, that would be great.

The primary care networks are an insightful way of encouraging practices and primary care and community care to work together in identifying people to co-ordinate. But, of course, the devil is in the detail in how people interpret it, and whether they just see it as a moving around of resource and incentive payments so that the actual activities do not change, or whether they see it as an opportunity to beginning to streamline the delivery of services for particular groups.

In a way, integrated care has to tussle with that. Who are we delivering integrated care for? I echo Sally's point about having the patient, or the client, at the centre. There is the lovely quote: "What matters most to us, not what is the matter with us". All the services are about what is the matter with you, but there is not such a good narrative about the thing you really want to be dealt with. There is some excellent work on minimally disruptive medicine and the burden of care, and trying to tease out which of your services is the best one for that person. As we have seen, increasing numbers of people are living with dementia. That will be more of an issue, because there will be trade-offs all the time

between how one enables people to live as well as possible at key stages.

The primary care networks have huge potential. People learned, post pandemic, how to co-operate. There is a need for digital literacy and that people begin to see it as a skill for care and not something that takes them away from care, which historically is how it has been seen.

Baroness Redfern: Not an add-on kind a thing.

Professor Claire Goodman: That is right. At the moment, for a lot of people the digital element and the change from paper to e-records is an administrative shift. Actually, we know from our evidence that if people begin to see that it is enabling them to deliver care and to make decisions, you will get better integration, but not if it is just an add-on.

Q17 **Baroness Shephard of Northwold:** I declare an interest, in that my husband is a self-funding resident in a care home.

We were given a lot of clues in answer to earlier questions, but what are the most pressing gaps in the community care workforce, and what could be done to address that? I was terrifically struck by the references to health visitors, who are regarded as key, not only in the health service itself but in social services across the board.

I wonder if you might start your answers by talking about health visitors in particular and the difficulties in keeping them, and indeed in attracting them in the first place.

Professor Sally Kendall: I could probably respond to that quite quickly. I have already mentioned the huge reduction in the workforce. The research that we are currently undertaking is showing that health visitors who are mandated to have five initial contacts with children and families under the Healthy Child Programme are having huge difficulty in meeting those mandated contacts, so children are missing out on those services. They are also asked to show how they can provide additional services to meet six high-impact areas for children and families, which include things like breast feeding, transition to parenting, transition into school, and school readiness, all of which the committee will recognise are really important for the children's longer-term health and well-being, development, longer-term opportunities in employment, and so forth.

All of this is being undermined by the workforce reduction and the ability to attract young people into the education that is required to become any kind of community nurse, although I am talking

specifically about health visitors and school nurses at the moment. The attraction of the university programme has been undermined by the pressures in the community that people can see for themselves: the work hours required, the burnout, the stress that is implied in working with children and families, and the pay, which is not fantastic. It is just not seen as a positive and exciting career move any more.

There are things that we could do in the education system to change that and to attract them back into that service. Much of that applies to other parts of the community nursing service as well, and I am sure that Claire can say more about the district nursing service. It is the same for community mental health nursing, community children's nursing, community learning disability nursing. All these specialities are understaffed and have great difficulty recruiting into university courses.

Q18 Baroness Shephard of Northwold: Is it obvious to people who are perhaps interested in doing this kind of work that there are also career-structure opportunities for advancement, for inventive work? Is that obvious, or is there not, indeed, an obvious career structure?

Professor Claire Goodman: That is a very good question. One of the retention issues is that we have an ageing district nursing workforce, which is a major issue. It is a paradox that if you work in the community, you are not visible. You do your best work behind a front door or a clinic, and you are not even visible to your own colleagues.

That has characterised some of the problems of district nursing. Interestingly, district nursing gets a lot of recognition and affirmation in end-of-life care in enabling people to die at home. It is a really good example of where primary care, community care and social care work incredibly well, because everybody understands what they are doing. Also, sorry to be a bit dark, but this kind of integrated working is time-limited, so you are not making open-ended commitments, which is always a challenge for the different services: if you get involved, does that mean that you are compromising your commitment to somebody else?

Reflecting on your question about career progression, that is a major issue for this workforce, because there is a specialist nursing qualification—you become a district nurse or a health visitor, and above that is management, which is not necessarily what people want—or there is a probably slightly better-remunerated specialist role, but that is quite a crowded arena, and there is a lot of

opaqueness about how these specialist roles all work together, there can be duplication of effort.

That would be a really good thing to focus on and to ask how we frame what you need to know and how you should be remunerated for the different skill sets, which an earlier witness talked about, and how you then mentor and supervise. At the moment, in community care, it is common that you see a problem and create a new nursing role. We have lots of good specialist roles, but that does not make for integration and good work. It makes for champions and people who are incredibly good at what they do but get tired and go, and you go back to the beginning.

Q19 Baroness Barker: One of the key issues that you all highlighted in answer to our first question is co-ordination and navigation. Whose job is it to be responsible for co-ordination and navigation?

Professor Claire Goodman: Welcome to the turf wars. It is who is the right person for that patient or client, so it may not be the GP or the district nurse. How you negotiate that goes back to what we were talking about earlier: trust and relationships, shared-assessment ways, and agreed methods of knowing what an outcome is. You can just cut through and say, "Oh yes, it's the GP", because the buck stops with them in diagnostic and clinical decision-making, but realistically that does not work for the individual family, patient, and so on. You have to have a system whereby, if you are working in an integrated team, there is sufficient trust and confidence to enable you to say, "Yes, you are the lead person for this as the social worker, the district nurse or the health visitor", depending on what is going on with that person.

Baroness Barker: If you have any examples of that working anywhere, either with GPs or, interestingly, with people other than GPs, we would be delighted to see them.

Professor Sally Kendall: I gave you the example earlier of my father. The person who enabled the navigation of his care in the end was the physiotherapist.

The Chair: Can we come to Professor Yeandle about career progression, particularly in the community care sector?

Professor Sue Yeandle: I agree with what has been said. It is incredibly important that we get away from the idea that the care sector is full of dead-end jobs, particularly in home care and in the work that goes on in care homes. We are teaching - in FE colleges up and down the country - we have lots of young people who want to go into the care sector, but we are not giving them a vision of a career that will be full of opportunities where they can do their best

and shine and contribute to the way the workforce develops and changes.

I was struck by a witness earlier in the panel referring to a lot of this work being delivered invisibly behind closed doors. It is invisible to the rest of the sector, but, of course, that is the very bit that is visible to the patient and to the carers, which is why it is so important. We also need to recognise that those who are going into the home and regularly seeing the same patient or home-care client—sometimes daily, and perhaps several times a week if it is a nurse doing wound dressings and those kinds of things—are potentially the eyes and ears of the whole system and how we will ensure that this particular client or patient is getting the best service and the best out of life that they can. We need to value the work that goes on behind closed doors.

We have to think about where it is not working well—where the visits are not happening, or people feel that they cannot get hold of the doctor or physiotherapist or that they will have to wait weeks and weeks for any podiatry services they might need, or they are wondering how on earth they will be able to see a dentist now they are over 85 and are probably struggling with all sorts of aspects of their oral care and with all sorts of multi-morbidities—and how these issues are also piling up pressures on unpaid family carers.

If we are not careful, there is misery for the person at the centre of all this who is supposed to be getting personalised care, and there is misery and huge pressure and stress on family carers when our systems are not delivering. They are not delivering partly because we have people on huge waiting lists. I too have an elderly parent who recently had a fall and spent time in hospital and in reablement and is now in a care home, and I have been absolutely frustrated by the number of small things that could so easily have been better but which nobody has thought about. Given that this must be happening week in, week out to other people, I could not understand how there were not better systems and understanding of the things that people need to know and the connections that need to be made for them.

This is the critical aspect of the integration, but it is also about valuing what the home-care worker and the district nurse see when they turn up to see the patient, have the opportunity to talk to them and find out that there are three other things that they are concerned about that are making their daily life very difficult and frustrating. There are so many ways in which, by creating better pathways between some of these roles, all that could be part of the career structure. But we also need to recognise the intrinsic skills—

the complexity of what we are expecting people to deliver to people at home in the current period. That is where there is a need for proper thinking about how we can recognise those skills.

The Chair: We hope to be doing some proper thinking here but, as always, time is against us, so we must move on to Baroness Tyler's question.

Q20 **Baroness Tyler of Enfield:** I will declare before I start that my mother is a long-term care home resident and before that had care packages at home for many years.

We have already talked about this quite a bit, but do you want to add anything briefly on the extent to which the current issues and problems in social care—delayed discharge, unnecessary emergency admissions, and things like that—are affecting other community health services?

Professor Sally Kendall: A lot has already been said about this. Going back to the data issue, we need to pay attention to how data is shared across the different parts of the system so that people can understand, from a patient-carer perspective, what has happened in A&E, what has happened in hospital, what then happens when they get back into the community, and how the care package can be delivered to meet the needs of the patient alongside any sort of social care, which might be delivered in a care home, through the private care sector or whatever.

One problem is the navigation that was referred to. A lot of these data systems just do not speak to each other. For example, the GP system cannot access the data for somebody who has been seen in urgent care, so—and I know this for a fact—the patient has to tell the GP what happened in urgent care. There is no electronic record of that; this is recent evidence.

The same thing happens across all these different systems. The community care part of the system uses a data system such as SystmOne or Rio, which records their activity, but that too is not recorded in a way that general practice or the social care side of things can access. So we lose the integration just because electronic systems do not talk to each other.

Alongside that is everything that has already been raised, such as understanding roles, having individuals who can take leadership and navigational roles, and how that is decided. It all impacts, in the end, on the patient-carer experience.

Q21 **Baroness Tyler of Enfield:** I have follow-up question about the role that community care can play in prevention, tackling health

inequalities, the public health agenda, and all that, particularly given the significant cuts in local authority public health budgets in recent years. I am only looking for one person to answer, but I do not know who is best placed to answer it.

The Chair: Somebody jump in with their view.

Professor Sally Kendall: Sorry, it is me again. One of the big problems from a health inequalities perspective is that we know that the thing that has the most impact on child health is poverty. We know that from the Royal College of Paediatrics and Child Health report, and from other reports. We know that the health visiting and school nursing service is not sufficient to be able to identify those needs and therefore to prevent the problems that those children have. Therefore, we cannot offer a quality universal service to the level required to ensure that we can overcome some of those health inequalities for children and young people. That goes across the board at the moment, whichever part of the country they are in.

Q22 **Baroness Wyld:** I have the wrap-up question. What key recommendation would you like to see the committee make when we report? Having listened very carefully to everything you have said, I wonder whether there is also just a bit of tension between saying, "Give us time to let the structures bed in. No more upheaval", and the acknowledgement that they are not really working. Feel free to be as bold as you like, and we will take it from there.

Professor Claire Goodmn: There is the recurring theme of data, and there are initiatives involving social care records, standardised measurements and so on. This could be a really good time to say, If you're going to introduce all this, then invest in the workforce's ability to use it so that it does not become just another chore for data capture.

That might sound quite trivial, but you need to target key groups and ask whether we can make this work. In my world, dementia sits in social care and gets some community care support, and there are responsibilities for primary care to review people with dementia every year, by definition. They also rely heavily—picking up earlier comments—on family carer and informal support.

I would almost choose groups such as children living in poverty and people from black and minority ethnic communities, who historically have not had equitable access, and say, "Right, use these as your canaries in the coalmine"—that is the wrong image—to see whether we are making improvements, rather than this blanket "We're going to demonstrate that we're improving

integration". Choose your key exemplar groups to test integration and develop outcome measurement that can say, "Yes, we can see improvement". The work on integrated care pilots, showed that everybody enjoyed working together but it made no difference to patients' outcomes. That is going to be the problem: that you can improve your systems, but you have to tie it to patients' outcomes.

Professor Sally Kendall: I do not have a huge amount to add, but I would like to use the word "empowerment", because if we can grow an empowered workforce that can do the job that it values and wants to do, and wants to deliver high-quality care, we will empower our patients and carers to respond and be able to develop their own abilities towards enablement in the community.

This is not an easy task. We have talked a lot, particularly in the health visiting world, about how you grow an empowered autonomous workforce that feels skilled, knowledgeable and able to deliver what it wants to deliver. To do that, we need good evaluation and good outcome measures. We are only just now starting to be able to do that in the research world.

Baroness Wyld: Thank you. May I just say that I had a brilliant health visitor about 12 years ago, so I fully endorse from personal experience all that you have said?

Professor Sue Yeandle: I agree about data and about an empowered workforce. I would add that, because we are talking about community care, which involves essentially thinking about the local authority-funded and supported aspects of care and the unpaid people who are providing that care, we have to think about empowerment across all of that, enabling those people to embrace the things that in every other walk of life are changing things and making lots of things work more effectively and efficiently. That involves using technology.

We have to think about how we ensure that those who work in people's homes, whether they are care homes or the homes they live in, and people with long-term conditions and particularly people with complex co-morbidities have the advantages of technology but also have the support to use them. The workforce that is supporting them also needs support to make that effective.

Investing in a radically improved workforce strategy now would be a massive issue for the future. In fact, I would go so far as to say that it would be crazy to say that we cannot afford to do this. We cannot afford not to do this. Millions of people's quality of life, and in some cases their actual lives, depends on this.

We are badly letting people down in droves at the moment across the health and care system, and if we do not address the problems and invest in making the step changes that are needed in the next couple of years—if we have another set of reforms that have not been properly implemented, have not addressed prevention and inequalities, have not done the well-being work that was so strongly indicated in the Care Act 2014 and is again emphasised in the legislation for health and care in 2022, and have not delivered on that—it will be utterly tragic.

It is really important that we support that empowerment but also remember that we have to empower and support unpaid carers; otherwise, they will start falling over, and if they fall over too, the whole system will become completely unwieldy and our problems insurmountable.

The Chair: That is very powerful note on which to end the session. Thank you very much indeed. On behalf of the committee, I thank you so much for your thoughts. We could probably have gone on talking to you for a lot longer, but the clock is always against us. We would always be glad to have evidence and examples from you on anything that you have referred to, and I am sure we will be in contact again on many of the subjects that have been brought up this afternoon. In the meantime, thank you very much indeed, all of you.