

Integration of Primary and Community Care Committee

Corrected oral evidence: The integration of primary and community care

Monday 13 March 2023

3.05 pm

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

Evidence Session No. 3

Heard in Public

Questions 23 - 31

Witnesses

I: Dr Crystal Oldman, Chief Executive, Queen's Nursing Institute; Jacob Lant, Head of Policy, Public Affairs and Research, Healthwatch England; Matthew Walker, Director of Strategy and Digital Health, National Association of Primary Care.

Examination of witnesses

Dr Crystal Oldman, Jacob Lant and Matthew Walker.

Q23 The Chair: Welcome to this Select Committee on the integration of primary and community care. This is another all-evidence session. We have two panels today, and I am very pleased to welcome Dr Oldman, Mr Lant and Matthew Walker to the first. As you answer the first question, perhaps you could also say a few words about yourself.

As you will know, we will take it in turns to question you, but I would like to ask each of you first to outline briefly—I say briefly, because we always have time problems—how to address the main challenges facing primary and community care within the current NHS framework. How would you assess its current state? As you

know, we are focusing on the integration between the two. I come to you first, Dr Oldman—can I call you Crystal?

Dr Crystal Oldman: Yes, Crystal is absolutely fine. 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.

It is also about understanding community. I do not think we understand what happens in community services. A lot of the feedback and evidence we have is about nurse-led services in the community not being understood—it is work as imagined, rather than work as done.

The Chair: Could you say a brief word about the Queen's Nursing Institute?

Dr Crystal Oldman: Yes, the Queen's Nursing Institute is—I love to say this—the oldest nursing charity in the world. It was set up by William Rathbone, with help from his friend Florence Nightingale. It was originally set up to create the standards and training for all nurses who worked in the community at that time, across the whole of the UK, and it now exists to support all nurses who work in any setting in the community.

Jacob Lant: I am the head of policy at Healthwatch England, which, if you do not know, is the statutory part of the system responsible for going out and speaking to patients and care users about their experiences of services. We use the insight we gather to inform service change.

From my perspective, I would take the first question from the point of view of the user and their experience of integration. So, while others might focus on workforce and funding, I will focus on information and communication. This, for me, is the number one issue we hear back from patients about their experiences of care. They do not know what services are on offer. When they are referred into different services, they are provided with very little information or detail about when they will be seen, what support they will receive or what to expect from their care. This means that patients cannot make good choices about the care they receive; they cannot make decisions about what care is right for them at a particular time.

On a very basic level, making communication better and allowing more staff time for communication could help make the service—the NHS and social care—significantly more efficient for the staff delivering it. In order to do that, we need a significant boost in the

number of administrative staff working in the services to support the clinicians to focus on what they do best.

Matthew Walker: I am the director of strategy at the National Association of Primary Care. We are focused on supporting people in the health service and other organisations to deliver population health improvement, health creation and integration. Our definition of primary care as an organisation actually incorporates your committee's definition of primary and community care, which I think says something about our views on the subject.

I agree with Jacob and Crystal about the challenges they raised. I would add that there is predominantly a focus on organisational rather than population allegiance at the moment. We know that a lot of our members and clinicians in the wider system find that frustrating personally, and it leads to challenges for patients, as Jacob has outlined, with a fragmented system that is not easy for the workforce or the population to navigate.

The Chair: Thank you for those very helpful introductory answers. I should have pointed out that three of our committee members—Lady Redfern, Lady Tyler and Lady Shephard—are participating remotely today. I hope you can see them on the screen; they can certainly see you.

As Lord Watts has unavoidably been detained, I very swiftly ask Lord Kakkar to take the next question.

Q24 **Lord Kakkar:** What impact do you believe improving access to out-of-hours and 24-hour care in the community might have on alleviating the broader stress in the system?

Jacob Lant: One problem with urgent and emergency care—if you have a care need outside normal working hours—is that one of the main things people want is reassurance. They want to know that there is somebody in the system they can contact who is aware of their needs and can direct them to the best service for them. At the moment, I do not think we have a very good system for doing that.

There are a range of different routes for out-of-hours care. As a patient, you might decide to go to A&E. We know that it is not a great place for people to end up right now, particularly if you do not clinically need to be there. People can also call 111. We know that there is a high awareness of 111, and people really like the service, but they are not aware of the full range of things that it can provide to help keep people out of more intensive care environments.

In terms of contacting your GP surgery out of hours, we know that patients experience significant problems in being able to register a concern out of hours with their GP practice. A common complaint raised with Healthwatch is that online systems for raising medical concerns with your GP surgery are switched off overnight. There are very good reasons why a GP practice might do that—for example, to manage caseload or to make sure that urgent cases are not sat unanswered in an inbox. At the same time, from the user point of view, it is incredibly frustrating that a new digital system for interacting with care is shut off outside of working hours. Saying, “The app is now closed”, does not make sense from a user point of view.

It can be really confusing as a user to know where to go to get that reassurance that care is available for you. Right now, with the pressures we see in A&E, which are reported in the news almost on a daily basis, we need to reassure the public that the NHS is there for them in their moment of crisis and that we can get them to the point of care that they need as quickly as possible.

Dr Crystal Oldman: I absolutely agree. Understanding how to navigate the system out of hours is really confusing. The other thing we do when we try to solve problems is to layer on new services. We say, “Right, let’s have a virtual ward. That sounds like solution to out of hours”, or, “Let’s have urgent care response within two hours”. Then, in a way that is very challenging to the existing services, we say, “Well, they’ll be 8 am to 8 pm Monday to Friday, or possibly 8 am to 8 pm seven days a week”. The patients who need those services do have a service that is 24/7—generally, it is called the district nursing service—but we have layered another service on to an existing service without thinking that we could invest in an existing service. That is well known and well understood by the patients who may be receiving those services 24/7.

Matthew Walker: I quite agree that complexity is a significant issue. There are obviously different requirements for access. For some people, fast access is their predominant requirement, whereas for others it is more of an issue of continuity and perhaps less rapid access but access to the right person at the right time—for example, if you have a long-term chronic condition. Some of the primary care home sites that we have worked with in the past have triage approaches, and their thinking is about whether they send someone down an access route or a more appropriate continuity route.

In terms of the potential of technology, I agree with Jacob that there are a lot of limitations at the moment and that it is not done well consistently. It is done well in some places, and some technologies are useful and provide the opportunity for much greater access and many frequent small episodes of access rather than infrequent bigger ones. However, it needs to be much more consistent across the board.

Nigel Edwards, who I think has spoken to your committee, said to me a couple of weeks ago that he sometimes asks how many single points of access there are to a system. There are lots of single points of access in many systems. That is incredibly confusing for patients but also for the workforce who have to help patients to navigate that.

Lord Kakkar: If I may come back to the point about layering a new service on top of an existing service, Crystal kindly used the example of district nursing services. What is the current pathway for the district nursing service—if I understood correctly, district nursing is much more available on an out-of-hours basis—being able to drive forward a GP referral, particularly out of hours, and indeed referral through to an integrated hospital system for the management of chronically ill or chronic comorbidity patients?

Dr Crystal Oldman: I think what you have just described is the skillset of a trained district nurse—a nurse who has undergone postgraduate training to lead and manage a team, with additional skills. Most—not all—services now have 24/7 district nursing services. There is a challenge there for the workforce, but the frustration for the nurses who work in those services is that other services are layered on top of them. If you have a challenge with workforce in your existing service and you layer another service on top of it, you deplete the existing workforce, because they go and work for a shiny new service that often has better terms and conditions. That is the absolute reality for the nurses we talk to in our networks and our Queen's nurses: they feel frustration. They say, "Could you please just invest in what you have?" They are fantastic services with highly skilled nurses who are used to managing the risk of quite significantly ill people at home.

Lord Kakkar: Finally, if I may, how is this understanding of district nursing communicated in the new integrated care systems that we have? Are they represented? If not, how do you think these important observations are best communicated at a local level?

Dr Crystal Oldman: Quite often, the easy solution is seen as something new, without going to the district nurses or the services. I would argue that there are not enough of them to be there to

say, “We can do this”. That is why the logic is that another service is needed, because there are not enough of them.

As I said right at the beginning, community services and community nursing services are not well understood because they are behind closed doors. You do not see the building of the hospital—you can imagine what happens there, and it gets a lot of media coverage. What fantastically skilled AHPs, nurses and carers do in people’s homes is not well understood; nor is the potential of that to be built upon to be part of an integrated service. District nurses work very closely with their GP colleagues in the neighbourhood.

Q25 Baroness Tyler of Enfield: I have a specific follow-up question for Jacob. I was very struck that when you referred to the 111 service you said that people really like it. When I have talked to people—okay, they are friends, family or acquaintances—I have had a much more mixed picture than that. I have to say that my personal experience of using 111 has also been pretty mixed. I just wondered what your evidence base or sources are for saying that people really like it.

Jacob Lant: The evidence base is twofold. First is the evidence we hear through local Healthwatch, which is shared with Healthwatch England on a regular basis. That could come from unsolicited conversations with members of the public over the phone, or from local Healthwatch reports and investigations into out-of-hours care services. We also did some national polling, right at the beginning of 2022, looking at people’s experiences of 111. You are right: the experiences are mixed. However, it is really positive where it gives people reassurance that they have been able to check in with someone.

Where it tends to fall down is when it refers to other services—for example, the planned rollout of 111 First. That was designed to enable 111 to book you into a slot in A&E so you did not have to wait for hours in the A&E department. Instead, you could wait at home and turn up when you were ready to be seen. That has been an absolute disaster of a rollout, because the services were not in place when it was communicated. The user experience was that people were turning up to A&E departments that had no record of them having called 111 or their pre-booking, so they had a really negative experience.

I made the point that people do not really know the full range of services on offer. Actually, I do not think 111 always knows the range of services on offer in its own service, and the rest of the

NHS does not know. That leads to a poor experience when you get through to the more detailed elements of care.

So there are two stories happening simultaneously with 111. It takes a lot of people out of the urgent care system by providing some reassurance, but those who need to go deeper and access services often have a more complicated experience.

Q26 Baroness Redfern: We have just heard that good informative communication is important. I think Matthew said previously that we need to have a consistent approach to good communication, particularly at local levels. What needs to be done in the very short term?

Matthew Walker: First, one of the biggest challenges is the implementation of these approaches. As Crystal said, there is no shortage of ideas, and a lot of the ideas have been around for a long time. It is implementation that is usually the challenge. It can be quite difficult to dictate the specific model in a local area at a national level; I think we have seen that over the last few years.

Baroness Redfern: Sorry to interrupt, but is it making it difficult where some areas are better than others? Is that an issue?

Matthew Walker: Yes, I think it is natural that some find it easier to implement than others. In almost any organisation, industry or walk of life, there are different abilities in different places. In addition, local areas are dealing with different levels of deprivation, for example, or different challenges. There is certainly a challenge in tackling some of the issues we are talking about in areas with greater deprivation.

When we talked about the bigger challenges in the system, we did not talk about demand. It is well known that demand is overwhelming and has gone up in general practice in particular in the last few years. I think that was in the IFS report and the health Select Committee report last year. That is even worse in areas of deprivation, so we have to do things to support those areas. We can come on to what some of those solutions might be; there are some specific ones that we are involved in at the moment.

Baroness Armstrong of Hill Top: Who does not understand the complexities? Is it patients and other professionals, or just one group?

Dr Crystal Oldman: I would say that patients do understand, actually. If you receive a service from a nurse—whether it is a district nurse, a community mental health nurse or a general practice nurse—you understand what they are capable of. However,

generally, it is our colleagues who do not always understand what we do.

Baroness Armstrong of Hill Top: I thought that was the case, but that was not clear from what you were saying.

The Chair: Thank you for confirming that.

Q27 **Lord Altrincham:** As we prepare our report, we note that there have been multiple policy interventions aimed at improving integration between primary and community care. In your opinion, which of these has brought about the most positive change? Could you also comment on the current measurement of outcomes and the governance of integration?

Matthew Walker: Obviously, as you say, there have been a number of recent interventions: the long-term plan, the vanguard programme and the primary care home programme, which we ran as an organisation. As you will know, in the Fuller Stocktake there are quite a lot of examples of positive integration, although, as I said, there is a risk that they are individual spots across the piece. Nevertheless, they are very informative about what can be done and perhaps what should be done.

Returning to my point, there is no shortage of ideas, innovators and people who are very positive about how to make change happen, although our members tell us that some of them are increasingly frustrated. But it is the implementation that makes this challenging. So all the examples I cited happened in patches, and the spread has not happened consistently across the piece.

On your governance question, the incentives in the system can make it difficult to make the integrated teams work consistently. You often find that systems have been put in place as a one-off, as an organisation between two organisations: the chief execs have perhaps met, talked and worked it through together, but it is not built into the existing governance. To my first point, that makes it difficult for the workforce that is delivering to be focused on population health and health creation, rather than on its organisational incentives and loyalties.

To be specific, organisations—or individuals, in the case of primary care—will sometimes lose income if they do what could be perceived as the right thing for patients and the population. That cannot be helpful for delivering integration in the future.

Dr Crystal Oldman: On initiatives and the intentions for shared records and interoperability, if we could make that happen, it would be a massive step towards what looks like integration to the service

user and the patient if you could tell your story once and clinicians could see what is happening to one patient across their services, and could then contribute. You may have come across a great example of GP patients in Greater Manchester who have held and had access to their records for a very long time. That is an initiative of Dr Amir Hannan that started a long time ago and has been incredibly successful: 75% of his patients have full access to their records. That is incredibly helpful for clinicians as well: if GPs can see the data that nurses in the community enter, and vice versa, that can only help to demonstrate that one integrated service is providing a service to patients.

On governance, I absolutely agree that you have the challenge of GPs that are small businesses, and you have community services, which are, in the main, NHS Providers, CICs and social enterprises. The levers and incentives to encourage that integration are quite different for both.

Jacob Lant: On the measurement of integration, our current system still measures performance based on individual conditions or services. We see that in the headline stats reported in the papers, in what you see in NHS England's reports and so on: they focus very much on siloed reporting of performance, rather than on the gaps between services. In many ways, we need to look at and measure what is happening in the gaps to really understand integration, particularly from a user's point of view.

For example, on the referrals process from GPs either to community care or to secondary care, there is very little understanding in national performance data of what is happening with referrals. We can see how many referrals are made and rejected, but we cannot see how long it takes for those referrals to be processed, what information is being given to patients and how many of the referrals go missing and have to be chased up by patients. Only organisations like Healthwatch look at those gaps in the middle.

Our recent work on referrals has found that as many as one in five referrals that GPs make end up getting lost in the system, and the patients end up having to chase their GP to find out what has happened to them—so they go back to the GP. That is a terrible patient experience, and all sorts of bad clinical things can happen to you in the period when your referral is lost. It is also really inefficient and frustrating for the system, because you have to have an extra GP appointment and there is lots of chasing around the edges of what is going on. If we looked at patient experience as the gaps between services, that would tell us how well integration is

working, and that is missing from the current debate. The King's Fund and the Picker Institute have done interesting work on an integration index to support NHS England, but it is very much in its infancy.

On governance, there is still a challenge with the user voice being involved in the governance of big decisions in health and social care. About half of ICSs now have a representative from their local Healthwatch on the integrated care board, bringing user voices into the system, which is great. But, in the other half, it is less clear where that is happening.

At a very local level, it is currently unclear the extent to which PCNs and GP practices rely on or use their patient participation groups to draw more insight from communities to make sure that community voices are involved in their governance. We need much more significant investment in user voices to make sure that they are playing their part in the big decision-making on integration.

The Chair: I remind the witnesses that we seek good examples, so, if you have any, we would be glad to hear them.

- Q28 **Baroness Armstrong of Hill Top:** All of you have in some way mentioned better information for patients, technology and ways into that. Matthew mentioned that, very often, the financial flow, in a sense, does not help anyone pursuing a technological way forward. I am very interested in that and may come back to it. How might primary and community care services benefit from further deployment of health technologies? Do you see any drawbacks? I am thinking particularly of drawing on the lessons from Covid, where there was a little more venturing into this. I am also thinking of the whole issue of capturing and sharing data more effectively.

Dr Crystal Oldman: During Covid, we did quite a lot work on what was happening in care homes and general practice, with nurses who work in both. The governance on data sharing fell away, which was very interesting to see and can only be to the benefit of the residents and patients. It has been reported to us that this is beginning to climb back in again—the barriers are coming back. We should learn from what happened: the sky did not fall in when it came to governance and data protection. From the patients' and residents' point of view, surely that should stay. That has been our experience, and I will give some written evidence to the committee on that.

Matthew Walker: There are huge and increasing benefits from digital healthcare. That almost goes without saying, but it needs to be said. A lot of that is about empowering the workforce, but it is

also about empowering patients. There are digital exclusion issues that need to be tackled—Jacob’s organisation does a lot of good work on that, so I will not speak about it. But we should consider that a generation—or generations—does not just tolerate digital but expects it, and we have to get on top of that. The same is true of the workforce: a generation of the healthcare workforce wants and expects it, and finds it baffling that it is not able to deploy it as it might for digital banking, for example, or what it sees in other places.

The biggest potential comes from things like long-term condition management and rehabilitation, which can shorten stays and give much greater continuity of care. There are some really interesting examples of technology supporting the system as well; for example, from a security of data perspective—using facial recognition for doctors who are signing in in hospitals. I know that Milton Keynes hospital is doing that. There are also things that are sort of obvious, like using apps to rearrange your appointments instead of getting a letter with a fixed appointment.

It is hard to deny the concern about the risks to data safety. However, no system is completely secure, and it assumes that there is no risk as we are currently. Anecdotally, we know from our members and clinicians in our organisation that there were examples during Covid where things were caught because the data was allowed to flow a bit more easily. We need to consider that when we are being very restrictive.

Jacob Lant: First, on the use of the NHS app itself and how people are managing referrals and understanding where they sit in the system, I have hope that it will improve—

Baroness Armstrong of Hill Top: Eventually.

Jacob Lant: Yes, eventually. It being the NHS app, I think a lot is carried with that brand. People trust it and will buy into it better than they bought into the multiple apps that are currently available for managing processes at a local level. So there is great hope here.

In terms of a practical example that we have seen in recent years, we saw a huge appetite from patients to buy into the NHS’s blood pressure at home scheme, with the rollout of remote blood pressure monitoring. I think we underestimate at times the extent to which people are interested in managing their own health conditions. If we help them—if we give them the right tech, support and development—they really buy into it. That is an example of where this has worked really well.

The counterchallenge to that is when the system sometimes loses interest—something is no longer the shiny initiative this week, so it will move on to something else. Actually, those patients still need that support and continued help to use the technology.

However, I think this has huge potential—not just tracking the readings, but proactively intervening when something changes in them—to make patients feel like the service is offering them continuity and looking out for them without always having to see the same doctor at their GP surgery every time they have an appointment. Building on some of those examples, there is good potential with technology.

Baroness Armstrong of Hill Top: Crystal, can you say a bit more about the workforce? My husband chairs a CIC, which is a domiciliary care company. It trains its workers to do UTI tests and blood tests, which are then sent back to the GP daily and prevents people from going to hospital. However, those people need to be trained. Nobody pays for this, or for the technology.

Dr Crystal Oldman: I would comment on some of the work we have just published. It is the third time we have done our survey on nursing in the digital age, and we spoke to around 1,000 nurses. We did the same five years ago, and five years before that, so we are tracking where we are at with digital and nursing in the community. One figure that shows some very basic things that are problematic for them is that 32.7% talked about a lack of compatibility between different computer systems, which then means that time is taken entering data and that there is duplicate data entry, and it does not speak to the GP's system.

Where it works well, and you have the GPs and the community services, that is great—they can each enter the data once. You then get to care services. What happens with social care, independent care, a hospice-at-home charity or Marie Curie, with its night-sitting service, where they cannot see the records because they are all digital? So this is not without its problems either. Those problems are well documented. As Matthew said, we are not short of ideas, but we need investment in making those good ideas happen so that it is a much better experience for patients and residents. In a way, it would become self-fulfilling—you will not need staff to double enter, so you will save money later.

Q29 **Baroness Barker:** Following on from that, Dr Oldman, in your opening remarks you went straight to workforce, which is where we would like to focus for a moment. What do you see as being the most pressing gaps, and how should they be filled?

What you are describing to us is not so much care pathways but a fragmented system of help that is not well planned. How does professional development fit into that scenario?

Dr Crystal Oldman: On the gaps, the workforce and what sounds like a chaotic and disconnected service, there are areas where it works really well. The clinicians on the ground make sure that it happens, because they develop the relationships regardless of whatever system and governance is in place. They make it happen.

We talked about the levers and barriers, and what does and does not make it work. Those clinicians on the ground—the GPs, district nurses, mental health nurses and community children’s nurses—make it work. They develop relationships. So in spite of whatever the system might say about integration, they are focused on the patient. They wrap the service around the patient and make sure that it works. However, that takes time and investment into those relationships.

Baroness Barker: Can you point us to some good examples of that?

Dr Crystal Oldman: Certainly, in the written evidence. I can give you some really good examples of that. We always say that the clinicians will be focused on the patient, and, where they can, they will make it happen. The challenge is where your workforce is so thin on the ground. As I was saying earlier about our research looking at the additional hours that nurses are doing, which is unpaid overtime, research that we published at the end of last year showed that district nurse team leaders are doing an extra 25% of their hours per week—so additional to their working week—unpaid. They want to make it work for the patients, and they do, but there is only so long that you can carry on doing that, especially post Covid.

Jacob Lant: To add to the workforce point, I talked in my opening remarks about the need for more administrative staff. From both a user point of view and the system point of view, they could make a huge and very quick difference to the whole performance of the system. We were talking before we came in about the fact that not all the work district nurses are doing is clinical work. Some of it could be done by admin support staff, who could be more specialised in understanding how those admin processes work, so they could actually become more efficient and better at doing that than the district nurses themselves. That applies to all the different clinical roles: lots of admin work could be done by specialist people in that space.

Recruiting admin staff to provide care navigation support for patients to help them to understand and navigate this complex system would be really helpful. We have been trying for ever to design a nice, simple system that is easy to understand. We are 75 years into it, and we do not have one. Employing staff to help patients to navigate the system might be the best and most practical way forward. However, that requires us to spend more time and money and have more investment and training in admin support staff for the NHS and social care.

Baroness Barker: There have been care navigation projects before. Do we have evidence from those?

Jacob Lant: We have evidence. A theme from Healthwatch work is that when people talk to us about the care navigator, they really like it. It feels helpful. They have a single point of contact that they can go to if they have any questions. That person helps them to make choices about where they go, but it is spread all across the system. It is not a consistently rolled out service, so it is difficult to piece it together into a single evaluation. Certainly thematically when care navigators come up, the feedback is overwhelmingly positive.

Q30 **Lord Watts:** First, I apologise for being late, but my train started to fill up with smoke, they had to throw us out and I had to get another train. That is a new one for Avanti.

There seem to be an awful lot of initiatives taking place, but they do not seem to be co-ordinated. Do you think there are too many different people trying to do different things and that nobody is co-ordinating and bringing them together to get the best benefit out of any changes that might happen?

It seems to me that this is driven very much by a GP in a particular area or an individual, and that there is no common thread between making sure that everyone does the same thing and making sure that everyone gets the same benefits throughout the system. Am I being unfair about what is going on at the moment?

Matthew Walker: I think it is okay for people to do things differently, as long as we are clear about the outcome that we are trying to achieve. I think it is inevitable that different local areas will find different ways of working with the people in their community, the voluntary sector organisations, the different organisations to focus on the needs of that population.

At the same time, people are sometimes too reluctant to learn from each other and from what has been done in the past. As we have said a lot, there are sometimes layers and layers of new initiatives

where you may be able to go back and look at things that have been achieved before.

Jacob Lant: You are putting your finger on the tension between the national instruction to the system—that it should do everything consistently in one way—letting a thousand flowers bloom across the NHS, and doing what is right for the local populations. They are pulling at each other all the time.

I think the answer is to change how we measure success. Rather than having a national or a local system that says, “This is how we’re going to do it”, the ICSs, the local systems, decide how they do something. In that way, we measure whether patients are getting the experiences and outcomes they need. So rather than the national system trying to say, “You’ve not delivered X number of this type of appointment or X number of surgeries”, it is about giving ICSs the freedom to set how they are going to do it and about the measures of success being how people experience the system and the outcomes they get.

Lord Watts: Is your worry about data protection coming from the patients, or is it noise coming from organisations outside the patients? It seems to me that the patients may well be more inclined to share that data than other people want them to have that facility.

Dr Crystal Oldman: The general understanding is that patients would have no problem sharing that data. In fact, they think that GPs would share records with the nurses in the AHPs who are delivering services in the home, and that the reluctance about sharing data, the GDPR and the whole question of information governance is coming from the clinicians and the service. I do not think that patients have a problem with that. I think that if they are asked whether it is okay to share, the vast majority will say yes.

Lord Watts: So it is the fear of falling foul of the Data Protection Act.

Dr Crystal Oldman: Yes.

Q31 **The Chair:** Or perhaps professional reluctance sometimes. I did not say that. We have heard a lot about patients being very reluctant to have to tell the same story five or six different times.

I have one last question for you, and I ask each of you to be brief. What key recommendation would you like to see this committee make in relation to the integration and continuity of care between the primary and community health sectors?

Dr Crystal Oldman: I was briefed on this question, so I have a very long answer.

If I can say one thing, it is to involve in decisions the clinicians who deliver the care—those who are working in the GP practices, in the care homes, in the communities. Ask them what they think would work. We must be asking the patients, the carers, the parents, the families, children and young people. We should be asking everybody, “What would make this better for you?” So often, those who deliver the care are not involved in, for example, the creation of a new digital device or the way in which data is collected. They are not even asked; they are just given.

I also have to mention the workforce. We are a depleted workforce.

Matthew Walker: I would also recommend that we think differently about the workforce and, following on from what Jacob said, think about supporting the integrated multidisciplinary team and the way they share information among themselves, and think about supporting the leadership of those teams, because leading a dispersed team across different organisations is harder than leading a normal organisation.

We should think about workers who span the wider biopsychosocial issues. Less than 2 miles from here in Pimlico there is a community health workers’ scheme that has had a big impact on the population there and is focused on deprivation and the geography rather than individual diseases. So, yes, we need to focus on the workforce and the things that support them.

Jacob Lant: I will finish by saying: measure what is happening in the gaps between services—the point of transition between primary and community care or primary and secondary care. That is where we will understand from users, both in quantitative and in qualitative insights captured at that point, how well integration is actually working. That, for me, is the thing that is invisible at the moment and where I would concentrate on trying to understand whether we are achieving what we are trying to achieve as a system. That could include things like extending existing patient surveys, such as the GP-patient survey, to look at things like the referrals process or the hospital inpatients survey and the discharge process. We should be asking questions about the gaps between services, which will shed more light than we have at the moment on how well we are doing.

The Chair: Thank you very much for those succinct answers, which have given us a lot to think about. Thank you very much for your time today. We really do appreciate your thoughts. I repeat again

that if you have any other evidence, suggestions, examples to send us, we would be more than pleased to hear it. On behalf of the committee, thank you very much for your evidence this afternoon.