HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: The integration of primary and community care

Monday 13 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; Lord Kakkar; Baroness Osamor; Baroness Redfern; Baroness Shephard of Northwold; Baroness Tyler of Enfield; Lord Watts.

Evidence Session No. 4 Heard in Public Questions 32 - 39

Witnesses

I: Emily Holzhausen, OBE Director of Policy and Public Affairs, Carers UK; Ruthe Isden, Head of Health Influencing, Age UK.

Examination of witnesses

Emily Holzhausen and Ruthe Isden.

Q32 **The Chair:** Welcome to the second panel of the Integration of Primary and Community Care Committee, which is firmly focused on patients and carers. We have Ruthe Isden, head of health influencing at Age UK, and Emily Holzhausen, director of policy and public affairs at Carers UK. As you will see, many of my colleagues are in the room, but three members—Baroness Shephard, Baroness Redfern and Baroness Tyler—are joining us remotely and will of course have the opportunity to ask questions. Witnesses have had some advance notice of questions, but my colleagues are certainly not immune to jumping in with others. I declare an interest: I am vice-president of Carers UK.

I will take the chair's privilege and ask the first question. I emphasise that this relates to the current infrastructure, because we could all talk about throwing the structures out and starting again. What steps should be taken within the current infrastructure to improve the long-term management of complex conditions—we hear a lot about comorbidities—to respond to the needs of patients and carers? I know that both of you are very concerned with those issues.

Ruthe Isden: Thank you for inviting us. A big part of the challenge we describe when we look at this issue is, of course, ageing and the things that come to all of us: most of us can expect to experience a period of poor health and disability in the last decade or so of our lives—that morbidity period. Some people have a more intense and complex set of needs, but for others it will be relatively more straightforward to manage this period. Either way, we know that this is when people are most likely to need health and social care services, and when they probably have the most need for integration and the services working together—and when they find them the most important.

By way of background, by the time people reach 85, over 46% have one or more needs for assistance with daily living, and most of those people—about two-thirds—will also have one or more health conditions. The bit I will highlight, which often gets overlooked in this conversation when we focus on health conditions, is the impact of frailty, which is a particular physiological state that people often experience in the latter phase of their lives. This is not just about diagnosed health conditions; it goes to the heart of the question about why people's health becomes that bit more fragile. People lack the reserves and resilience to get up from the knocks, infections or falls—it becomes

much harder for them to recover from incidents that might occur. Around 35% of older people live with some degree of frailty, so it is important to take that into account.

I welcome this investigation, because this is a really interesting area where we happen to know an awful lot about what does not work very well for people, about what does work and about the steps we should take to fix some of those issues. The question is: how do we create that paradigm shift in the ecosystem of health and social care to ensure that that is delivered consistently across the piece?

In the last session, you noted that there are a lot of different initiatives out there and you asked how we bring those together. I emphasise that this is about not re-engineering the whole system but having a paradigm shift, valuing things differently, investing more in what we know works for this group and shifting towards a different way of thinking about carer support, one that is not pathway-based or about linear single conditions, and one that is much less focus on the acute sector. It is really about valuing bringing teams together around the person in the community in a much more consistent way.

So what do we know? Older people talk to us clearly about some of the issues, but, on what needs to change, we need to think about how to do much more to promote well-being and independence, and to invest in services that do that. We need to look at the role of population-based proactive anticipatory care and the services that get in there in advance and look at structured assessment and reviews. We need a strong system of urgent community response so that, when something starts to go wrong, there is a quick response that does not result in people ending up in the acute sector. We need to invest much more in rehabilitation and intermediate care to make sure that people can recover. For people with more long-term complex needs, we need to make sure that we have a consistent approach, with community-based multidisciplinary team services that wrap around that individual and stay with them through that journey towards the end of their life.

Emily Holzhausen: I thank the committee for inviting me to join my colleague Ruthe Isden to talk about unpaid carers, by which I mean family members and close friends who care for people who need support. I will give their perspective—Ruthe set out a good road map. Carers in the NHS are not necessarily systematically identified, so if you are a family member trying to negotiate your way through the NHS, you are not necessarily given the right

information and advice to care safely and well. This matters, because families provide the bulk of care in the country: pre pandemic, it was £132 billion a year—the equivalent of the NHS—and, during the pandemic, it was about £530 million per day.

How social care treats families is important. It treats families in the way of the legislative architecture—with parity of esteem, so equal rights. The rights base that carers have in the NHS is very different. It is much smaller, in fact. We have the last Health and Care Act—with the help of your Lordships, for which I thank you, particularly the chair, Lady Pitkeathley—to thank for the extra rights to be involved and consulted at the point of hospital discharge. There are duties for ICBs to involve carers with strategic discussions and to promote involvement in decisions about the patient. But that is it; there are no other rights. It drives a whole challenge for us in primary and community care services and throughout the whole of the NHS when carers are not systematically identified, supported and given the right information and advice.

On the knock-on effects, we asked our members what their experiences were, and half were not given the information and advice to care safely and well—sometimes putting their own health and the person they were caring for at risk. They would really like to be treated as partners in care and for their role to be recognised.

Looking at the management of long-term conditions, of course carers do all these tasks like medication management, and they do a lot of care tasks at home. They want to understand diagnoses and treatment. They arrange appointments. Really, what we need is a systematic way of identifying carers, to have them properly logged on summary care records and shared care records, and to have professionals actively using that.

I heard information governance being raised before. There are no real materials on information governance for carers and sharing information. To add to the important things that Ruth was underlining, if we do not get that right for families, we are making mistakes in the system as well as building up pressure on families to provide this care. That would be our recommendation.

Q33 **Lord Watts:** As you probably heard from the back in the previous session, we are looking at what more can be done to tackle the barriers preventing effective integration between health services to benefit patients. Are you aware of any successful initiatives that demonstrate integration between primary and community care, and any examples of where it has gone wrong, where lessons need to be learned and where mistakes have been made?

Ruthe Isden: That is a really good question. There are a number of very good examples from around the country. We could talk, for example, about the work done in Sheffield with the Team Around the Person model. That is very much about having an integrated MDT community-based service that supports individuals identified to be living with complex health needs in the community. There is also the GeriPall service in Sutton, which is about supporting people as they come towards the end of their life—those living with very severe frailty. Again, it is very much about the MDT and building a team around the person in the community. There are a broad range of examples that demonstrate the real value that this kind of approach delivers. We absolutely know what the ingredients of best practice look like.

Again, we also see examples with things like the Jean Bishop centre in Hull, which is an integrated out-patient centre—a one-stop shop, if you like—that works to stop people who have been identified as living with complex conditions and frailty having to bounce around the system seeing all sorts of different professionals in the acute sector and going to different out-patient appointments. Instead, it is a geriatrician-led service that supports people in one location.

The Chair: I know it is very difficult to talk about places where it has gone wrong. We are not expecting you to name places, but could you just say some of the things that have gone wrong?

Ruthe Isden: Yes, absolutely. I suppose this is a bit about what has gone right. Where it goes right, it is often MDT-based, with professionals working together very much in the spirit of coming together and co-ordinating around the person—critically, for the older community, often with geriatrician involvement.

It goes wrong often where you have a notional MDT—perhaps an MDT on paper—but people do not come together, build relationships or discuss the patients and the circumstances in which they are living. It becomes very difficult. There are still barriers to professionals to refer, so occasionally you see teams that are notionally MDTs but where everything still goes back around the roundabout of the GP in order to go from one form of referral to another, even within the same team.

What gets to the heart of this is whether they are working genuinely as a team. Do they have shared access to records? Do they have access to the same information? Do they have access to shared services and facilities, or are they notional teams that are spread across the piece who are not given parity of esteem and do not have the same access to the same data and information and

are not really working together around the individual? In my experience, and in some of these examples, they do not necessarily have to be employed by the same organisation, but they do need to work as a team. However, sometimes those organisational barriers get in the way.

Lord Watts: I do not want to put words in your mouth, but you seem to be suggesting that these initiatives are better driven at a local level than a national one. Do you think we have spent too much time trying to fix the national model and that we should have decentralised to smaller groups where we could make more progress? I do not know your view on that, but we have heard people say that they do not think it is possible to do what we are proposing to do from the top down and that it needs to be from the bottom up.

Ruthe Isden: I would very much agree with the comments made by my colleague Jacob Lant in the previous session. I do not think it is either/or; I think it is a bit of both. As with anything when we are talking about making change or transition and transformation in the health service, we have to start from where we are. We are not starting with a blank sheet of paper. We have to work with the capacities, skills and assets that already exist in different communities, and they will look different in different places.

By way of example, the primary care estate is a significant barrier to some of these issues. 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 multidisciplinary teams to be able to offer a range of services out of that one location. They are able to co-locate staff with community staff and services, and they are able to really build that team around the individual.

In other parts of the country, that is simply not possible. The nature of the primary care estate is such that there really is not the space or capacity to do some of that, so they have to think about working in a different way. The size and scale of primary care is also a factor in that. Larger primary care practices may have an opportunity to diversify and offer more services than perhaps quite small ones.

In every locality, we need to work through those specific challenges and find ways to deliver that universal service and experience that we know that people need.

Emily Holzhausen: We have a number of different pieces. I just wanted to pick up on some of the challenges. We also have

examples of good practice, which we are very happy to send in, where some nice work goes on between the voluntary sector and different primary care services. That gets to the heart of really tailored working. In a very deprived area of Hastings, for example, there is targeted work to try to identify carers—particularly male carers, who are underrepresented in services. We are very happy to send some examples of those sorts of things to the committee.

When talking to carers about things like the role of primary and community care and emergency admission to hospital, just under half of carers who had had an emergency admission in the last year felt that it could have been prevented. Some 22% said that their emergency admission to hospital could have been prevented with more care and support—so more social care services—and 21% talked about more health services at home. I can come to virtual wards later, if you like.

Q34 **Baroness Barker:** Like me, you might be able to recall the time when the answer to everything was "Torbay". For those who do not know, there was a period of time when there was a huge focus on Torbay's attempt to integrate the primary, acute and voluntary sectors there to work, at a population level, with Torbay's older population profile. This was done to see whether we could do everything we have talked about: identify people, give support, take the strain off, avoid emergency admissions and have care navigators to make sure that people get around the system. What happened to all the work and resources that went into that? What was learned, and were there savings in the acute sector that could be redeployed into the community? What happened?

Emily Holzhausen: I do not know the answer to that very interesting question. I remember that because Torbay was integrated it led in areas of carer identification, for example. It was keen on supporting employees who were juggling work and care—the last staff survey showed that one-third of the workforce were doing that to provide unpaid care. That is an interesting question, because everyone was envious of Torbay's integration of health and social care, not just acute and primary care.

Baroness Barker: If it worked, it must have dealt with the problems that we keep running into: a lack of consistent computer systems, data and all that kind of stuff. That is what I am trying to dig out, and I know that Age UK was heavily involved in that.

The Chair: If we do not know, we can certainly ask our staff to find out. It would be interesting to find this out, because it goes back a long way in Torbay.

Ruthe Isden: There is a range of lessons to be learned not just from Torbay but from a range of other examples of where we have tried to do this in the past. One lesson that we need to draw from that is that the job is never done: there is no perfect configuration of health and social care services that will deliver that level of integration and co-ordination around an individual patient, as an experience for them. So we need to take lessons from where people have attempted to do this, in Torbay and elsewhere. This an interesting area for ICSs, because in some ways in going forward to look at integrated care systems, we have drawn on those lessons on bringing together providers, the local authority and NHS commissioners into forums where we ask them to develop a joint strategy.

The Chair: I will stop you there, because the next question will refer to the recent changes in structure.

Q35 **Baroness Osamor:** What do recent structural changes introduced by the Health and Care Act 2022 mean to patients and carers, especially in relation to access and the expectations of service users? What is the impact of development in social care on other community health services?

Ruthe Isden: As the Chair said, this treads into the territory we just explored. In the way the Act changed some of the systems, it created different opportunities—I suppose this goes to the heart of Baroness Barker's question about what we can learn. Bringing together institutions, organisations and commissioning structures into forums where they can do things differently does not necessarily deliver the long-lasting change we are looking for, so it is important that we are considered about the opportunities or benefits that ICSs will potentially deliver to patients. This has opened up a range of opportunities, and it will now be up to individual systems to think about how they grasp those opportunities and take them forward, because it would be entirely possible for an ICS to continue to operate services in its area and for nothing to change for patients. So we need to look at how ICSs will take that opportunity.

We talked about the types of services and the paradigm shift that we will look to see on behalf of older people. The fact that social care is now involved in systems is important, but there are still questions about whether it has parity within them in order to make a significant impact. As Emily said, social care will be a very significant part of this solution and of delivering these different models of care.

This partly goes back to how we measure them and what success for an ICS in a system looks like. This goes back to the heart of the questions about where things have or have not worked in the past. It is perhaps partly because we have asked the wrong questions about what success may look like. When we looked at integrated care in the past, the question was always: does this reduce hospital admissions and traffic into the acute sector?

The experience of some of the previous integrated care examples is that it has not necessarily done that, so it has not necessarily been considered successful or sustainable. The question we ought to be asking is: has it delivered better care, outcomes and experience? Are patients healthier, happier and receiving better services? Are staff more satisfied with the services and the work they do? That is the prize we need to focus on.

It is about not just less resource use but better resource use that is delivering better value for the patients and carers that it seeks to support. This may not always translate through to less acute sector activity. So that may be some of where we have asked the wrong questions in the past, and it is where we need to ask the right questions and set the right expectations if we are to deliver the potential benefits of the Act for patients.

Emily Holzhausen: The structural changes in the Health and Care Act are interesting. Some of the duties for carers are carried over from the 2006 Act, and there is a new duty to involve carers in strategic decisions. The ICSs and ICBs are moving at different speeds. Where we see good engagement, we have clear leadership at a national level, and clear appointments in teams and carers are in the objectives, and it has been like this for some time. Places like West Yorkshire and Surrey Heartlands are the leaders, building on a good basis, but there is little strategic engagement in other areas. Carers have yet to experience a lot of these changes, because some of the structures are so new, and it will come down to some of the existing work.

As Ruthe said, one of our challenges is that we have very little data on, or measurement of, carers' outcomes in the health service; the GP patient survey shows that their health is poorer. So, in fact, unless we do surveys, we cannot measure how that is for all the people who provide unpaid care. We also cannot measure how efficient systems are or whether we are putting additional pressure on families or supporting them to care.

Q36 **Baroness Armstrong of Hill Top:** I would love to cover more of that, but the problem with what Ruthe posed is that, unless those who take decisions about the system can find ways of diverting

from the most expensive care—hospital care—community and domiciliary care will always be second best. How do you square that with the way you talk about the questions we should ask?

Ruthe Isden: It is partly about recognising that we may have run to the end of the road with some of that thinking. For a very long time, the drivers of integration and our thinking about new models of care were very much about how we take beds out of the acute sector and how we reduce resource use in it in order to redistribute that resource into primary care, community-based services and social care, exactly as you said.

We now know that, by head of population in England, we have one of the smallest acute sectors in comparable countries in Europe—one of the smallest bed bases and some of the fewest doctors working in the acute sector. So we need to reduce the pressure on the acute sector, but we cannot necessarily see this as releasing resources. Instead we now need to look at how by doing some of these things we are not going to increase the pressure on the acute sector.

The second point to make in connection with why this does not deliver some of the changes in the acute sector, and the acute resource utilisation that we might have expected and hypothesised when people looked at delivering integrated models of care, is that it is partly because we are uncovering more need—we are finding need that was hitherto unmet and we are now meeting it. We have to understand that that is a good thing in itself. This goes perhaps to Emily's comments about how well we were supporting carers and families or how much of it we were just ignoring and expecting carers to pick up, to their own detriment. So there is an element of that.

There is also a question of time: it will take time to see some of these changes realised in the acute sector. So when I talk about a paradigm shift, I do not think we will necessarily see a huge amount of benefit in relation to pressure in the acute sector because we set up one clinic or one MDT. We will have to take a very different approach to thinking about how we care for a growing cohort in our population who are ageing with complex needs, and how we support them at home.

There is another area where we also run out of road and are now experiencing the challenges of having ignored this problem for a long time. We have already shifted a huge amount of care out of the acute sector and put it into the social care sector, so the acuity of people who are being supported in care homes or by domiciliary care workers in their own home is an order of magnitude greater

than it would have been 20, 30 or 40 years ago. A lot of these services have already absorbed a huge amount of the pressure building up in the acute sector, so I am not sure that there is a lot of extra space for that.

That might be something that we just have to accept. 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 social care in order to ensure that we do not have to keep funnelling money into the acute sector.

The Chair: Or, indeed, into preventive services.

Ruthe Isden: Yes, to get further upstream.

Emily Holzhausen: I want to add a proof point to Ruthe's earlier points about the movement of the acuity in the community. In the most recent census, the question was changed and the overall number dropped, but we also saw an increase of 410,000 in the number of carers providing very substantial care, 50-plus hours, to 1.5 million people. That is a really substantial increase in 10 years.

The only group of carers to have grown was the over-85s. We really need to think about this transfer of care to families and the community and the complexity of tasks that we are asking people to undertake, and about the impact on their health and well-being and their work, given that, pre pandemic, around 600 people a day were giving up work in order to care. So this does have an impact in the wider economy. I know that is not a focus of your committee.

The Chair: You have already indicated that many of the people giving up work to care are in the care industry and in health anyway, so that provides more acute workforce problems.

Q37 **Baroness Redfern:** You emphasise, Ruthe, the need to reduce traffic into the acute sector. In what way could the increased use of health technologies benefit patients, and are there any limitations?

Ruthe Isden: Absolutely. That is a really interesting question. There are two parts to this for me. There is a huge amount more that we can do to use technology to improve the back-office functions and the way in which teams across the NHS and in care services are able to work. We know that 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. I know that colleagues in earlier sessions have touched on the question of information

governance and patients' records and relevant information about them, their families and their situation being passed in a timely manner to the professionals who are working to support them.

Over and above that, we need to do more to enable the team working that I am describing, part of which is about breaking down some of the barriers so that people have common systems and look at common datasets, and can communicate and have conversations about what they need to do on a real-time basis to support an individual who they are working with. There is a whole range of things there.

We then move on to things like monitoring technology—telehealth and telecare-type technologies in people's own homes. I absolutely think they have a role to play, but we need to tread a little more carefully when we are talking about asking individuals to interact with and to use the technology, because we need to understand that not all individuals will welcome them.

I know from experience that even basic things like pendant alarms get tucked in drawers. Look at it from an older person's perspective: one day they are living independently, although perhaps things are getting more difficult and more of a struggle, and then something happens—a fall or a spell in hospital—and suddenly all hell breaks loose: their life gets turned upside down and lots of people rush in to tell them what they need, what they want and what is good for them. That has often involved bringing in technology at that point, which people then find does not suit them or find it quite hard to adapt to in those circumstances.

We need to think about the really useful technologies and how we support people to use them while also accepting that they will not be for everybody and will not work for everybody in every circumstance. It is about deploying them where they have a value, where you have had that conversation with the patient and their family, you have talked about the benefits and you are looking at how you can support them to use them best, while also not taking away avenues of support and care and people being able to access what they need and want, when they are quite clearly telling us that those technologies are not quite what they are looking for at that time.

Exactly the same principle applies to things like remote conversations and remote appointments. They are really valuable, and we need to do so much more to roll them out to enable professionals to talk to each other—to enable domiciliary care workers to consult clinical teams and to enable people working in

care homes to get real-time access to clinical expertise and to talk about what is going on for somebody they are supporting.

There is much more that we can do to support informal carers to have access to some of those conversations and tools, but we are respectful about the fact that remote consultations might be really good and might really work for some groups of patients but not for other groups of patients. There is probably no one size fits all. No technology will work for any group of people all the time. It will always be a moveable feast; some people will be comfortable about doing some things some of the time and not at other times.

Baroness Redfern: So, in your opinion, who should be responsible for ensuring that that data is accessible and secure and can easily be shared across different parts of the health service?

Ruthe Isden: This is one of the most significant challenges that we know ICSs need to take up as part of their system strategy. It is not just across the health service. In an ideal world and a world where we are supporting people to do what we know they want to do, which is to have access to the support and services they need, and with continuity of care that is responsive, in their own homes, that also needs to involve social care services. ICSs at an individual level need to look at their strategy for sharing data and governance across the piece, and at how they are enabling the voluntary and community care sector to come into that picture.

Taking it up a level, there is a really important role for the national, because it does not seem to me that a single information technology solution for the entirety of the NHS and all social care providers, especially when we get out into the much more mixed market that is the social care market, will be the solution.

Baroness Redfern: There is no overarching system, is what you are really saying.

Ruthe Isden: Probably not one overarching system, but clearly we will need overarching standards for what systems do and whether they are interoperable—all those types of things—to make sure that a system on which a social care provider is organising its services is interoperable with the system the community health services are using, and that that system is interoperable with the GP's system. Those sorts of standards and protocols need to be set nationally.

Emily Holzhausen: We asked carers what tech makes their life easier and what makes it harder—just another proof point for Ruthe. Some 41% said that remote healthcare appointments made caring easier, but 11% said that they made caring harder. One

group was neither here nor there, and some did not use them. Some 18% said that remote monitoring, which Ruthe talked about, made their lives easier, only 1% said it made their lives harder, but the vast majority—71%—did not use it. Some 61% were not using the NHS app.

There is also the potential here for change. When we asked carers how confident they felt, age was a factor, but so was being in work. People who were not in work, or on a lower income, or older had challenges. They also had challenges such as whether the technology was appropriate, whether the person had a learning disability or a condition like dementia and could not use it, or was older and their preference was not to use it.

Baroness Redfern: Or had hearing difficulties, or something like that.

Emily Holzhausen: Absolutely. There were some really good examples of that and the appropriateness of the technology. Sometimes people felt that they just needed a human conversation to come back in the round.

There is potential for both, but it needs to be tailored.

Q38 **Baroness Shephard of Northwold:** Do you think that integrated care systems are sufficiently equipped to support the delivery of appropriate local priorities, and can they tackle health inequalities?

Before you answer, where are we on setting up ICSs? How many are up and running? What is the state of play? You may not have come equipped to answer that—in which case, please keep yourself to the first question.

Emily Holzhausen: As I said before, the ICSs are moving at different speeds. Some are very well developed and have been developed for quite some time, and there are others that have only just been established and are getting their grounding. So it is quite difficult to say where we are. The CQC, of course, has new responsibilities under its assurance programme to look at ICSs, which obviously needs to happen at an appropriate time.

On the question of whether they are sufficiently equipped, there is some support and some leadership out there, but there are definitely challenges in the system, as Ruthe said earlier, around data and digital structures and information governance, as well as workforce issues.

I could not be here without mentioning social care, which is the other really important partner in this, and the development of the

voluntary sector such as local Age UKs. Local carers' organisations can be invaluable members of these teams. In some areas, their budgets have come under quite a lot of pressure, which makes joint working harder if you do not have that headroom to be able to do that. Ruthe might have something to add to that.

Ruthe Isden: Absolutely. On your point about ICSs, your questions are very clearly related. Formally, they are in being across the country but at different levels of maturity and moving at different speeds. By way of example, I spoke to a local Age UK chief executive last week whose patch cuts across two ICS areas, so she deals with two separate ICSs and has two completely different experiences.

One is quite a long way down the track in thinking about its ageing well strategy; it has clear goals that it wants to work to, it has understood its population and it is thinking about how it will work with providers and local systems across the patch in order to deliver on some of that. The other is still in the very early stages of thinking through some of those challenges and of engaging with their VCSE colleagues.

There are really different experiences in different parts of the country, which I suppose goes to the heart of your question about whether they are equipped to deliver on local priorities. Some are moving ahead and thinking about how they want to work with the capacities that they already have in their area and how they want to develop and build those into the future.

There are, for examples, areas where health and social care are coming together around recruitment. They have a single recruitment hub, so they are thinking about their workforce across health and social care as one piece and how they do the things that are in their gift locally, although of course the workforce is a much bigger challenge. In other places, the relationships between different parties in the ICSs are still perhaps not very well developed. There is quite a lot of tension in those relationships, and the conversations, the population health management and the way in which they understand their data and their populations are not as well developed.

ICSs are also starting from different positions, not just in their own capabilities but in the depth and breadth of challenges they are facing in their communities and areas and the resources they are able to leverage and work on.

One thing we notice, which I think has been echoed by colleagues across social care and other VCSE organisations, is that 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. So if there is one thing that we could do to move ICSs forward and give them more scope and support to focus on their local challenges, it would be supporting the really good relationships at statutory level.

Baroness Shephard of Northwold: That is very helpful. I suppose it is the answer that all of us would have expected. It is a bit disappointing, but it is early on, and I hope the committee will have the chance to ask for more information from ICSs themselves.

The Chair: Thank you. We go on to Baroness Tyler's question, which is the last in this session. It actually follows on from what Ruthe was just saying.

Baroness Tyler of Enfield: Thank you very much, Chair. I would like the witnesses to provide highlights, if they would—

Q39 **The Chair:** There is a bad echo. Can you do anything about it? If not, I will ask the question.

We would like the witnesses to suggest one key recommendation that you would like to see the committee make—one key change that would enable carers to deliver better co-ordinated care and to improve outcomes for patients. I have to insist that it is one.

Ruthe Isden: Universal access to multidisciplinary teams based in the community for those with complex needs or at the end of their life.

The Chair: That was admirably succinct.

Emily Holzhausen: I would add systemic identification and support for unpaid carers.

The Chair: Thank you very much indeed for those easily achieved goals, which will be very important to the committee. Thank you very much for your time this afternoon, for giving us such thoughtful presentations and for responding to our questions. I emphasise that we are seeking examples—I think you understand that—and that any other evidence you want to give us or suggestions you want to make to us will be very gratefully received.