HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 20 March 2023

3 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. 5 Heard in Public Questions 40 - 51

Witnesses

I: Professor Sir Chris Ham, Co-Chair of the NHS Assembly, non-executive director of the Royal Free London Hospitals NHS Foundation Trust; Fiona Claridge, Assistant Director (London and East), NHS Confederation.

Examination of witness

Professor Sir Chris Ham and Fiona Claridge.

Q40 **The Chair:** Good afternoon and welcome to this public session of the Integration of Primary and Community Care Committee of the House of Lords. We will take it in turns to ask our witness questions. We are delighted to have with us today Professor Sir Chris Ham, co-chair of the NHS Assembly and many other things, and well-known, I think, to several of our panel members; and Fiona Claridge, assistant director of the NHS Confederation. Two of my colleagues have interests to declare.

Baroness Finlay of Llandaff: I declare publicly that I co-chair the Bevan Commission, and we are delighted that Sir Chris Ham is one of our commissioners and actively contributes. I will not ask questions in this first session.

Baroness Tyler of Enfield: I took over chairing the Royal Free foundation trust's population health committee fairly recently. It is a position that I took over from Chris, who used to chair that committee but stood down as a non-executive.

Q41 **The Chair:** Does anyone else have any interests to declare at this point? No. We will go straight into the questions.

As you know, integration is the focus of this committee. Can you give us an idea of how highly integration ranks as an effective policy, intervention and focus for improving patient outcomes? If you could, please couple with that how much of a priority you think it is with the NHS leadership.

Professor Sir Chris Ham: On your first question, I would say very highly. My work takes me literally all around the world, virtually as well as sometimes in person, and I have been struck by the way in which health ministries in very many countries in Europe, North America, Australasia and south-east Asia have been embracing integrated care as a strategy for their healthcare systems.

The reason is very simple. We are all confronted with a growing ageing population, so the disease burden is shifting to chronic conditions and the challenge of multimorbidity in particular. Healthcare systems cannot respond effectively if they remain fragmented and disjointed, hence the argument for moving in this particular direction.

We have seen a growing interest in integrated care over a number of years in this country. There have been many different policies under different Governments, particularly on piloting what integrated care might look like for different patient population

groups. In the last five or six years, especially since the publication of the NHS five-year forward view in 2014, the long-term plan in 2019, and the recent government White Paper on integrated care, it has become a very high priority indeed. The recent Health and Care Act formalises informal arrangements that have been under way for several years.

The Chair: That is a very encouraging answer for this committee, thank you.

Fiona Claridge: I agree with Chris. I think it is rated very highly, partly because all the leaders acknowledge that we cannot continue in the same way. We have such a challenged system at the moment that things need to change, and they see integration as the way of doing that.

Also, there has been a shift in focus away from just trying to address the current issues of the day, which we know are problematic, to thinking, as a health centre, much more about population health, prevention and education. We have already seen some fantastic examples of people doing that, particularly during Covid, when collaboration and integration happened. In Leeds, for example, they are working community-wise with the primary care team. They have an MDT. We can see a lot of examples of where people are taking up that opportunity and are working together collaboratively.

Nationally, the policy focus has been very strongly on integration. That is not to say that there are not barriers to it—of course there are challenges; there are capital, commissioning and funding challenges—but the appetite is certainly there, even if the mechanisms are still being developed to support it.

The Chair: It is interesting that you mentioned Covid, because a few witnesses have told us that some of the collaboration and integration that happened perforce during Covid has slipped back a bit in more recent months. Is that your impression?

Fiona Claridge: I think Covid gave a real focus for integration. Some of the challenge recently, and maybe why some of it has slipped potentially, has been that we have had such a challenging winter, and such a challenge in the pressures and the demands on the centre and on the system, that people who are able to work in that integrated way are focused just on dealing with the issues of the day. That makes it more difficult to work collaboratively, to build those relationships, to take the time to do that.

Collaboration takes time. It is a big cultural shift in the way the NHS would normally work, which has been very much about competition. Now we are now working through collaboration, and it takes time to change those cultures and build those relationships. If you are focusing on the day to day and the demand and the pressure that the NHS is focusing on at the moment, it is difficult to do both.

Q42 **Baroness Osamor:** How has the Health and Care Act 2022 changed health integration in England? In which sectors or areas of the NHS has integration improved?

Professor Sir Chris Ham: The Act has basically formalised and put into statute arrangements that were already well under way. Predating the integrated care systems becoming statutory entities, we had the sustainability and transformation partnerships. I chaired one of those in Coventry and Warwickshire. The law effectively formalised what was already happening through voluntary arrangements in 42 areas of England, and I think it was very much welcomed. It has been quite different for many NHS reorganisations, which have often been imposed top down by the Government of the day and the Department of Health. This emerged much more from within the NHS with the support of clinicians, NHS leaders and, indeed, local government leaders, who are very important partners in these arrangements.

Progress is being made, but it is quite variable across the country. There are some advanced examples of systems that are making a difference. Channelling what Fiona said just now, Leeds in the West Yorkshire system is an example of one of the most mature and advanced partnerships developing real improvements in outcomes and care for the large population—over 3 million people—that it serves. Equally, I could think of examples of systems that are just getting going now and need more time to build the collaborative relationships and the understanding between the different agencies on which they will succeed or fail.

Also echoing what Fiona said, we have come from a history in the last 20 years in the NHS of successive Governments believing that there is a need for more choice and more competition between hospitals and healthcare providers. What is happening under the current legislation is going in the opposite direction. You cannot flick a switch and say collaboration now and competition in the past. It will take more time to develop everywhere the relationships that will, I hope, deliver better health outcomes and improve patient and care experience.

Fiona Claridge: Building on what Chris said, he talked about local government, and one shift has been much greater focus on what happens at place and supporting the population in that place as opposed to the organisations that exist. That is one of the really strong things that is coming through under the Health and Care Act and the way in which integration is working, which thinks about bigger agency and involves people like the voluntary and community sector.

We are starting to see some great examples of that. Near to here in Kensington and Chelsea there is the My Care, My Way project. That is a joint case management service across primary and community care but also involves the voluntary and community sector and other partners. We are starting to see a much greater shift in that integration being based on the people and where they live as opposed to being just about integration between NHS organisations. The Act gave a strong focus on that being a much broader partnership—things like integrated care partnerships inviting in other agencies and seeing how we work around the population as opposed to how we work around what our organisation is focused on.

Q43 **Baroness Redfern:** Sir Chris, you mentioned Leeds was working well. Can you tell me why some areas are below the curve and not working as well? What is stopping them working well, like you say Leeds is?

Professor Sir Chris Ham: The legislation is necessary, but it is far from sufficient. What really makes a difference in the areas that are working more effectively is that they have been able to build much more collaborative relationships between the leaders of the different organisations and, more importantly still, the teams delivering care to the local population. They have done that, because they have said that the future here is much more about how we work together for the greater good.

Going back to what we said about the response to the pandemic, that galvanised people to come together because there was an unprecedented common threat that helped to create the collaboration that was needed to deliver the mutual aid between hospitals and between general practices and to get local government on board as well. We need to do in peacetime—the phrase I use, which may not be appropriate—what we managed to do in wartime in fighting the pandemic. That is proving harder, as Fiona alluded to. In some places, things have slipped back.

The difference is that the relationships have been built more collaboratively and more effectively, because the leaders of the

public sector agencies and the NHS, local government and the voluntary sector have found common cause around their joint commitment to use their resources for the good of the population they serve. They invested the time and the effort in coming together in that way.

Q44 **Lord Kakkar:** In areas where this is not happening as successfully as Sir Chris has described it happening in some areas, what is to be done? How are these leaders to be encouraged to get to that place if it is not by more legislation? Where are the levers to encourage these leaders to work more closely and effectively together?

Fiona Claridge: The levers are there, so there are mechanisms in place. We are seeing that increasingly in the legislation and the policy guidance on integration that is coming down—things like enhanced health and care homes, which are actively supporting community and primary care to work together. So there are some mechanisms and levers in place now.

Chris is absolutely right that, where that has not been happening, it is often because that is the way it has been historically in relationships and because with newer relationships there might have been changes in personnel. One thing that we could do, and which is part of what the confederation does by being a membership organisation, is share some of that best practice and some of those lessons and look at what others are doing and how we build on the way they have developed that.

Going back to the example of Leeds, Leeds developed that and has built those relationships, potentially despite some of the other arrangements. They have been able to work around those and find common ground. There might be challenges like capital, or not being able to have a multidisciplinary team because they do not have the space to co-locate. There may be a challenge in coterminosity: different geographical boundaries exist between different organisations, so forming some of those partnerships is quite difficult because they are not working across the same geographies.

When we start to find ways around some of those challenges, that makes it easier for organisations to come together. We are doing a lot in organisations like the confederation and the community network, which is a joint network between us and NHS providers, where we try to support all those organisations to share that learning and to look at how they can build upon what others have done.

Lord Kakkar: Is there anybody with a statutory responsibility and

powers, if it is not working, to say to these different organisations and the organisational leaders, "You must make it happen"?

Fiona Claridge: Chris will know better than I do about the integrated care systems, but we have new integrated care systems that are doing exactly that—looking at what is happening in their area and trying to support the organisations there to integrate and to do everything that we have already described in the way that people are working. The integrated care systems are relatively new in their formal statutory responsibilities, but that is still developing. We have ongoing reviews such as the Hewitt review, which will look at who is playing that statutory governance role and holding them to account.

Professor Sir Chris Ham: I will add a couple of points. At the moment, the arrangement is that NHS England is responsible for overseeing how well each of the integrated care system does. It then ranks them in a ranking system from one to four based on its judgment of how well systems are performing. There is then intervention and oversight by the NHS England teams, hopefully in the form of support, although there may need to be a change of leadership to move them in the right direction.

The Government's plan is that the Care Quality Commission will also have a role in inspecting and assessing CQCs. That is still in the process of development, so it is not a current mechanism. I have written about this for the NHS Confederation, and my view is that we have one of the most highly centralised healthcare systems in the developed world and have relied far too much on regulation, inspection and top-down performance management.

David Nicholson, a former chief executive of the NHS, said that we need to look out more and look up less. He was talking about the leaders of integrated care systems, hospitals and community services. David, of course, was quite right. I would like to see a much stronger emphasis on how integrated care systems can help each other. The expertise on what it means to work in partnership, in collaboration, is in those systems themselves. We are not very good at creating the networks to share that learning and to help those that are further behind to improve more rapidly. Often we have relied far too much on highly paid management consultants. This is an opportunity to do something very different by sharing what we know in the public sector better and more effectively.

Baroness Armstrong of Hill Top: I am a bit anxious that you think that local government is fully integrated. In a previous committee, people told us that if the NHS is in the room, they think they are the most important. It took this House to change the

legislation in order to get local government at the table in the governance arrangements.

Also, we have not talked much about patients. I do not see the voice of patients and the thinking of local communities, other than through their councillors, being heard at all in this debate. Some of us quite like choice and many patients liked choice. Now we are back to a system that seems to be saying, "It's all right. We know best what you need". Where are we going?

Professor Sir Chris Ham: I agree that there are still issues with getting local government involved as a full and equal partner in the arrangements that we are talking about today. There have been some missteps along the way. All I would say from my own experience in Coventry and Warwickshire, when I chaired the Integrated Care System, is that we were blessed by having fantastic relationships with the county council in Warwickshire and the city council in Coventry, both of which worked very closely with each other as well as with the NHS, and their health and well-being boards were at the centre of what we were doing. We had a head start because of the leadership the local authorities had shown.

I am aware, of course, and I very much take the point, that that is not universal. There is a risk in the work of integrated care systems that a very narrow NHS set of issues dominates and local authorities feel that they are at the margins rather than part of the mainstream. We have to work hard to make sure that does not happen. The way to do so is start from what have been defined as the core purposes of integrated care systems, one of which is to improve health outcomes for people and local populations, which you can do only if the NHS is willing to work genuinely as a partner with local authorities, the voluntary sector, businesses, universities and all the other agencies that have a huge contribution to make.

What that requires, in my view, is much better clarity about what key outcomes will be used to assess how well integrated care systems are operating. If those outcomes are broadly based on the issues that local authorities have a leadership role on, there is less likelihood of them being marginalised. But it is an ever-present risk, and we need to guard against that. I do not want to be overly optimistic about this, because there are genuine risks. Likewise, this will be worthwhile only if people who are receiving care—patients, carers and families—see that things are improving for them.

Some of that is about improving health and tackliing inequalities in health outcomes in local populations. Some of it is about giving people choice, making sure that we are making faster progress in

reducing backlogs of elective care and so on. The litmus test of all this must be not just changing the organisational arrangements—we can rearrange the deck chairs as much as we like when it comes to how things are organised—but whether those arrangements make it better and easier for the staff delivering care to improve care for the people who, at the end of the day, are the most important recipients in all this.

The Chair: We would certainly emphasise that in this committee.

Baroness Redfern: Sir Chris, should staff working at the centre and in the regions be reduced substantially to enable integrated care systems to fulfil their potential system leaders—yes or no?

Professor Sir Chris Ham: Yes, I do. I would certainly welcome the numbers that have been put out—a 30% to 40% reduction in headcount. I think the confederation has welcomed it as well. Devolving more responsibility locally to people who are close to their places and communities requires more room for manoeuvre for the leaders in those places—Yorkshire, Leeds, Coventry, Warwickshire—than they have had in the past. That means reducing the overhead in the regions and the centre to something that is more appropriate in a world where integrated care systems have a stronger local leadership role.

Q45 **Baroness Redfern:** My question again is to you, Sir Chris. In your 2022 report to the NHS Confederation, you list some simple rules for integrated care systems to follow. Can you explain your approach to these rules and how they relate to integration?

Professor Sir Chris Ham: As somebody who has researched integrated care and advocated it for about 25 years now, the rules are a distillation of what I have learned, the experience I have seen in other countries in North America, Europe and so on, and my involvement more recently in integrated care systems. A large number of those simple rules are things that we have touched on already, including giving time and space for those systems to take local decisions that respond to local need. It seems a very obvious and simple thing to say, but that has not been the case up to now because of the highly centralised nature of the NHS. The flexibility that systems are beginning to have to say, "In our area, we want to bring down long waiting times, but we also have a number of local issues that ought to receive much more attention", is very important.

What progress is being made in implementing those simple rules? There has been some progress, but there is a huge amount still to be done. The progress has come from NHS England under Amanda

Pritchard and her colleagues developing the new operating framework, as it is called, for NHS England, setting out how it plans to work in future to cut back on some of the centralised approaches and to create more scope for local decision-making, including by cutting back on the number of staff it employs for that purpose.

Let me be again clear about this: we are not there yet. The words on the paper are all the right ones. The behaviours that we need to see—trusting local people, supporting them, encouraging much more collaboration and sharing between systems—are still a work in progress. That relates to the more general point that we need to allow time for the systems to embed and show what they can achieve. Too often in the past, in my experience, government has put in place a new set of organisational arrangements and decided far too early that they are not working and that they need to go in a different direction. I believe we are on the right track, so I would urge patience and consistency of purpose and giving them a fighting chance to work the arrangements on behalf of patients and communities. That is a relatively long-term prospect. Having worked in government myself as a temporary civil servant for a time, I am aware that saying that is easy, but delivering it will be difficult.

Baroness Redfern: Do you not think that working to timescales is so important? It focuses people's minds that they have to get it done.

Professor Sir Chris Ham: They have to get it done, but I would refer the committee to the important work of the National Audit Office and the Public Accounts Committee in the House of Commons, which produced reports on the setting up of integrated care systems and what is now being done. The NAO in particular said that integrated care systems had been born in the most challenging context in the whole history of the NHS. Three-quarters of integrated care systems started with financial deficits. Some of those have got worse rather than better, not through mismanagement or any lack of urgency, but because that was the inheritance they had from the old fragmented system. I am sure everybody would like to be ambitious and see things happening very quickly, but there needs to be a degree of realism built into this too.

Fiona Claridge: On the point about time, making a fundamental shift away from the current focus, which is very much on treating disease and once people are already ill, towards prevention, education, early intervention is a much longer-term project. You

cannot achieve that very quickly, so we have to allow longer to see those outcomes and to give time for that to be embedded.

That is about whole-lifestyle change, which is where some of the things you were talking about earlier—working with local government and with patients—come into play. We want to be able to say that there are certain things that can be achieved within certain timescales, and absolutely we need to make commitments to some of those, but in order to change the way we work and to think about prevention and education we need to allow time for those to be embedded in the way we work. That is a big shift in the way we currently deliver care.

Baroness Redfern: When you say time, do you mean five, 10 years?

Fiona Claridge: I think we would need to look at the different things that we are measuring. I know that integrated care systems are looking at different measurements and the way they will work around population health. Some things are already in place where people are doing this and are making significant changes. Things like having integrated data in the way we share in-patient records is a really positive step, because it allows us to measure things differently. At the moment, our measurements are very much based on how we treat people on the day, as opposed to whether we have changed the outcomes for them in the future. It is very difficult for us to talk about actual changes in people's healthcare outcomes as opposed to, "We've seen them within four hours and they have been treated in that way".

There are different measures that we would put in place and it is difficult to say. I know that integrated care systems will be doing this and looking at what we want to achieve from population health outcomes and what we will measure. There are some great examples of this already where they are looking at things like obesity and measuring how we have intervened, what we have managed to change, what the outcomes are, and they will continue to do that. But some of those are quite small-scale, and we need to start building that at scale.

Q46 **Baroness Armstrong of Hill Top:** What level of resource under the current budgets is going into this long-term work of integration rather than dealing with the crises?

Fiona Claridge: I cannot give you exact figures, and I do not if Chris will be able to, but primary and community care have not had the same level of attention or investment as other areas of the health centre have. For community care in particular, we would say

that there has not been enough understanding or focus on what community care does, what it covers. One of my members who is delivering community care has over 4,000 staff across 400 different sites and is delivering 80 different clinical services. There is a real lack of understanding of what community care actually does and what it delivers.

A third of all organisations delivering community care are voluntary and community sector organisations. There is not always a level playing field when it comes to the levels of funding coming down to them. I think the intention is absolutely there, and we have seen it in all the documentation. There has been some additional funding such as the funding that has gone into things like the urgent community response and virtual wards, and there has been a real focus on and some direct funding for the elective backlog, but there has been no additional funding to address the large community backlog, so there are a lot of people, particularly children, waiting in the community for care and no funding to address that.

The Chair: Do you have an answer on the resources question, Professor Ham?

Professor Sir Chris Ham: I do not have an answer, but it is the right question to be asking. I think the answer will be a disappointing one. If we could be very precise about it, investment in long-term change that will have an impact on population health outcomes would probably be less than 10% and closer to 1%. I believe that Patricia Hewitt's review, which is due to report very soon, may well be making recommendations on requiring integrated care systems to publish in future what share of their overall spending is going in that direction. If you look back at the recent past, the additional money that has been going into the NHS has been biased particularly towards acute hospital services. There has been a relative underinvestment in community services and primary care, and prevention is often at the end of the queue. We need to be measuring, and I hope that if Patricia does come forward with that recommendation, that will be a positive start.

Q47 **Baroness Shephard of Northwold:** I am very struck by the optimism of our first two witnesses today. As I am sure they can imagine, some of the stories and problems that we have heard in the committee so far have almost made us feel as if there were no outcome. I welcome your optimism, so I will now ask you a negative question.

What are the barriers so far that are preventing integration, or might? Personally, I think there are questions of culture. There are certainly questions of accountability, because local government

obviously has elective office and is accountable to its local voters. We have just touched on the always present issue of resources.

Could you also say something briefly about the way leadership patterns appear to be emerging in the evidence we have had so far? That may not be possible, but it would be really interesting.

Professor Sir Chris Ham: You have touched on some of the barriers. It is about the cultures and the behaviours, a legacy from that competitive era, when we want to be working in a very different way. That is why it is a bit of a struggle in some places to move in the direction that is implied by integrated care systems.

There are two other things that I would highlight. If the big prize here, as Fiona has alluded to in her responses, is refocusing on prevention, improving health outcomes and tackling health inequalities—I believe that is the big prize—what happens locally will also be shaped by what happens or does not happen nationally. We need the Government to show leadership on prevention and population health, and I would argue strongly, and I think the NAO said something similar, that we need a cross-government initiative involving as many government departments as possible to come together around some measurable health outcomes, including what that means for reducing inequalities in health. It is not just about what the health department will do but what departments like levelling-up, education and so on will contribute too.

We saw some of that in the past—not the recent past. In the 2000s, the Government had a very clear focus on tackling health inequalities. We need something similar now. Much can be achieved locally through partnership working, but if the centre does not support that and is not aligned itself, we will make only very limited progress.

Fiona Claridge: I absolutely agree with Chris. Health is everybody's business, and that direction from the top, from the centre in government, would be helpful. It cannot be just about the business of healthcare, because we know that healthcare is such a small part of people's overall health.

In terms of other barriers, I would mention some of the practical concerns. I have already mentioned things like capital. Some of the way the money comes down and flows is different for different parts of the sector: staff can be on different pay, terms and conditions; community organisations have staff who are on local authority terms; and we have primary care staff who are not on the Agenda for Change. That makes integration quite difficult. People are finding ways round that, but they are barriers. Similarly, lots of

different organisations are on different data systems, which makes sharing patient records and integration very difficult.

There are lots of practical barriers, and where people have made it work they have found ways around those, but they are still barriers and people are having to find workarounds.

Baroness Shephard of Northwold: That is very interesting. Obviously you need a very strong lead from the top down. I repeat my concern about local government, which is accountable to its own local populations. It is also a very unequal partner with the NHS as far as resources are concerned. It is potentially an almost insoluble problem to define and impose nationally, and in the end we may be obliged to fall back on useful ways of making the system work but based on local conditions. That would already be good, but the difference in accountability seems to me to be the difficulty. You need quite a lot of persuasion at national level to get that over.

Thank you so much. You have made me feel a lot better this afternoon, perhaps all of us.

Q48 **Baroness Tyler of Enfield:** I would like to pursue a bit further the issue of measurement and metrics. Obviously Fiona has already been talking about that. We all know that what gets measured gets done, and there are clearly concerns that there is a real data gap at the moment on how well integrated services are, because it is quite a hard thing to measure. How effectively does the NHS currently measure, quantify and compare levels of healthcare integration?

Fiona Claridge: I do not think we are measuring that effectively currently, partly because so much of the measurement in the healthcare sector is related particularly to the way we deliver services in the here and now rather than focusing on the future.

We also often measure the success of some services based on what they can do for other parts of the system. To give you an example, the community sector is often measured on the way it is supporting the acute sector: how is it supporting admission avoidance, how is it supporting discharge? There is a much bigger role for the community sector to play in supporting prevention and education, but we are not looking at what it is doing there and measuring some of the things that it can contribute elsewhere; we are measuring it in relation to how it supports other parts of the system. We have a long way to go on measurement.

There is a real challenge in measurement. I have already alluded to data. There is a big shift at the moment; a lot of integrated care systems are trying to ensure that they have similar systems across

their healthcare providers, but we are on different systems, and when you think about a place and about wider integration with the voluntary sector, local government and others, that becomes even more challenging. So looking at integration across multiple organisations that are all using different systems to collect data becomes a very difficult task.

Professor Sir Chris Ham: When there have been local pilot programmes in the past on integrated care, often the measures of integration used have related to the use of services. Have these pilot programmes reduced A&E attendances? Have they reduced unplanned hospital admissions for the defined population? I can understand why, but those are not the metrics that will necessarily matter most to patients and the people we are serving. It feels to me that we need to do far more to understand people's experience of care and whether it feels joined up or repetitive and fragmented. At the moment, I do not see work of that kind going on in the Department of Health and NHS England.

Secondly—full disclosure here—I am an adviser to an organisation called Carnall Farrar, which has produced an integration index as part of some joint work with the think tank IPPR. In essence, that uses about 40 metrics from routinely collected data in the NHS to produce an integration index, and it includes measures of outcomes like maternal mortality and avoidable deaths in the population. That has shown, on the one hand, a very strong correlation between the integration index and those outcomes, and, on the other hand, deprivation in the population, which is interesting but suggests caution, because if you assess the performance of integrated care system on the index and you identify some areas of poor performance, you may be identifying areas of deprivation rather than poor performance in using the resources available to those systems.

The short answer, I think, is that an awful lot needs to be done to agree on the measures, which requires what the Department of Health proposed in its White Paper, which is to develop a shared outcomes framework for assessing how well ICSs are doing and what measures should be in that framework. We still do not have that, and I am not aware that it is a high priority for the department.

Q49 **Baroness Tyler of Enfield:** You have pre-empted what was going to be my follow-up question. I have been reading a bit about the integration index, and I thought that the focus it was trying to put on patient-centred and co-ordinated care was very interesting. Do you have any knowledge about the extent to which NHS England or

the department are following this and whether they would like to adopt something like it when it is fully developed? Is it any part of their thinking, do you know?

Professor Sir Chris Ham: I do not think they are at present. I know there have been discussions. If this has been developed outside the department and NHS England, could it be used or adapted by them for other purposes? I know that some integrated care systems have decided to make use of it themselves. The real value would be if you got all the systems involved so that you could have a big dataset to compare and contrast and see, for example, how areas of similar deprivation are doing using a set of metrics. They may or may not be the ideal metrics. They are the ones that have been chosen, but at least it is a start. It raises the question: if it can be done by independent organisations, why is it taking so long for NHS England and the Department of Health to do so?

Baroness Tyler of Enfield: Fiona, are you involved at all in any of these discussions about an integration index?

Fiona Claridge: The confederation has an ICS network, so we work with all 42 ICSs. They are all memberships. We are working with all the ICSs to look at the different ways in which they are measured and to support them. Chris has already talked about how ICSs need to be learning from each other. That is definitely something that we are having conversations with them about: how can they measure against each other, how can they support each other, how can they learn from each other? Discussions that we are having with them are not specifically about the integration index, as far as I am aware.

The Chair: I am just going to ask for an impression here. This seems like such a good idea that it almost seems a no-brainer, but nobody is working on it. Would there be resistance to it and, if so, where would that resistance come from?

Professor Sir Chris Ham: Do you mean in relation to a measurement tool like an integration index?

The Chair: Yes.

Professor Sir Chris Ham: No, I do not think so. I cannot see any logical reason why there would be an objection to agreeing what measures should be used and then seeing what the results are. I just think that people have been so busy with other stuff, not least the backlogs from the pandemic and setting up integrated care systems of statutory bodies, that it has not had sufficiently high priority.

Q50 **Lord Watts:** You have probably been asked this question before, but it would be interesting for the panel to hear the answer. Could you outline just one change or recommendation that you would like to see to enable effective and efficient integration in the delivery of primary and community care services?

Fiona Claridge: I am pleased that you are focusing on community and primary care. Our members will be very pleased that it is getting some attention. We have already talked about how it does not get the same level of profile and focus. Equally, for integration to work we need to look at it in its entirety; we also need to look at the interface between primary and secondary care. It is equally important to look at the whole part of the system rather than one part of the system in isolation from another.

So while we are looking at the integration between primary and community care, I would encourage you to focus on how we think about primary and community in relation to secondary care and the wider system. You have touched on some of those elements of the wider system, but that is where some of the real challenges for us.

Lord Watts: You do not have one recommendation.

Fiona Claridge: One would be to look at primary and community in relation to secondary, and to think about that wider integration rather than one part of the system in isolation from another.

Professor Sir Chris Ham: I am afraid this will sound awfully familiar, but it all comes back to workforce and staffing. To be simplistic about it, healthcare and social care are people businesses because they deliver care and support to people through people. If we do not have enough staff to do that, people will not experience the care and the outcomes as they need to. At the moment, as the committee will well know, there is a workforce crisis, even more so in social care than in healthcare. We still have not seen the workforce plan that has been promised and delayed. Thinktanks and others have made the case strongly on that.

So if there is one thing that can make a difference to any of this it is making sure that we quickly put in place a fully funded, credible workforce plan that over time will reduce our reliance on international recruitment—sadly, we are taking staff away from countries that need them even more than we do—and give us a fighting chance of having homegrown staff who will deliver the care that people expect.

Lord Watts: Coming back to my question from a different angle, you mentioned the damage that has been caused by silo funding, and competition, which has been the main thrust over the last 10

to 15 years. Are any of those measures still in place that prevent this integration from taking place? Does that competition have any impact on the health service's and the primary care services' ability to change?

Professor Sir Chris Ham: Fiona may want to add to this. By and large, most of the barriers were removed by the Health and Care Act 2022, because that had major provisions to remove what was in place before. The caveat is how money flows within the NHS. There is a big debate going on about whether there should be a return to the payment-by-results or payment-for-activity system brought in over 20 years ago now and that underpinned the policies on choice and competition.

I would be strongly against that, even though I can understand the rationale: if you want to do something about the elective care backlog, providing financial incentives to hospitals to treat more patients has a certain logic. The problem is that also then creates further silos and tensions in the NHS family. It would not make it easy to do what Fiona was talking about, which is to put more resources and more staffing into our community services. It would help to take some of the pressure off hospitals if we had the alternatives that currently are not sufficient.

Q51 **Baroness Barker:** What chance do we have of looking meaningfully at the integration between community care and acute care when the data systems are so bad?

Fiona Claridge: There is a real lack of community data in particular and data to compare. However, I would not say that that comes down to data. You could look meaningfully at the way people work together. We have talked about some of the particular areas of focus. Often community care is looked at in relation to what it can do for acute care—whether it can avoid admissions and discharge as opposed to what it can do in its own standing on prevention, education and supporting people to stay well in their own homes. There are meaningful things that you could look at, but they may not involve looking directly at data as opposed to, more anecdotally, what happens in local areas.

We have already mentioned some great examples of where stuff is happening in community and primary care. Equally, some fantastic things are happening in relation to community, primary and acute care where people are doing some great place-based interventions. You could look at it from the angle of what things are happening at place, what is happening in neighbourhoods, and which organisations and parts of the system—the voluntary and

community sector—are coming together to do that. You will find some really interesting examples there.

The Chair: Thank you for that note of optimism, on which we bring this session to a close. On behalf of the committee, thank you both very much indeed for your answers and the way you have tackled some of the googlies that some of my colleagues have thrown to you. As ever, we would be pleased to receive any further information that you want to send to us. As ever, you will be sent a copy of the transcript for you to sign off on at some stage.