HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 15 May 2023

3.05 pm

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

Evidence Session No. 11 Heard in Public Questions 103 - 113

Witnesses

I: Daniel Hardiman-McCartney MBE, Lead Clinical Adviser, College of Optometrists; Ewan Maule, Member, English Pharmacy Board, Royal Pharmaceutical Society's, and Lead Pharmacist, North East and North Cumbria ICS; Dr Abhi Pal, President, College of General Dentistry.

Examination of witnesses

Daniel Hardiman-McCartney, Ewan Maule and Dr Abhi Pal.

Q103 **The Chair:** Good afternoon, and welcome to the Integration of Primary and Community Care Committee. We are fortunate to have three witnesses with us today from various aspects of medicine that connect with primary care. In person, we have Daniel Hardiman-McCartney, and online we have Dr Pal and Mr Maule. They are from optometry, dentistry and pharmacy respectively, and I thank them for attending. We will ask a series of questions, which I will allocate to my colleagues. Subsequently, there will be a transcript.

I will ask the first question. How well is your discipline integrated into the wider health service? We are focusing especially on community care and primary care services.

Daniel Hardiman-McCartney: Optometry is a long-standing pillar of primary care. We perform 13 million sight tests every year, 3.5% of which are performed in domiciliary settings—care homes and people's homes. There is a very big estate of 5,000 practices across the UK delivering the care, which are well distributed in local communities. However, with that comes a connectivity concern. One integration issue is that where there are lots of practices in convenient locations to deliver eye care, they are not well connected with our colleagues in primary care—be that general practice or pharmacy, or services such as fall prevention—or connected to secondary care, which we will come on to later.

Data has been a real problem in ascertaining who and where the optometry workforce is. Workforce planning has also been an issue. We know that in some rural parts of Britain the workforce distribution of optometrists is not good. However, in integration terms, we have a lot of case studies, which we have submitted, with good examples of optometry supporting general practice and helping people not to need to access care from a general setting, and supporting our secondary-care colleagues by seeing people in primary care for acute and urgent needs or for long-term conditions such as glaucoma.

The Chair: Thank you. Those examples will be of great use to us.

Dr Abhi Pal: Dentistry has some connection to the integration of the wider community at the moment, but that is only through certain pockets of innovation in one or two areas. We have examples of situations of urgent care—our pilots in the east of England, the diabetes pilot in London, and the older-people pilots in Lincolnshire—where there is some integration.

However, dental practices as a whole still work in a fairly isolated environment. The potential is huge, of course, because there is a lot of overlap between what can be provided not just by dentists. I highlight the role of dental teams—dental hygienists, therapists and nurses—who can also provide the care. The potential is huge for preventive messages in areas like diabetes, obesity and smoking to be shared. So far, that integration with the wider health service is not very great. One hopes that with the changes that can improve. National policy allowing integration has not been forthcoming so far.

The Chair: What is a specific barrier to that integration?

Dr Abhi Pal: The current NHS contract is the main barrier. It is greatly due for reform and has been for many years. The current system of units of dental activities—UDAs—which are the means by which dental services are delivered and paid for, does not lend itself to integration, in my view and that of the profession. Some efforts have been made recently on marginal changes, but more widespread work will be needed to allow full integration.

The Chair: Thank you.

Ewan Maule: Thank you for the opportunity to speak to the committee today. Pharmacy is the third-largest healthcare profession. Sometimes that gets missed. Obviously medicine and nursing are larger in terms of the volume of professionals. There is something unique about where pharmacy sits. Community pharmacy is the healthcare professional on the high street, and one of the most accessible healthcare professionals the public can reach. As a result, they have significantly more patient interactions than virtually any other healthcare professional.

There has recently been a significant expansion in pharmacy rules, not just in community pharmacy but into general practice, through primary care networks. This has meant that the input of the pharmacy professional into more aspects of the patient journey has been significantly expanded. We are starting to see good signs of integration, partly through roles working in primary care and partly because there is more of an obvious overlap between what general practice does and what community pharmacy does. That is why there has probably been more progress there than with some of the other primary care contractors.

It is really important that we use the right terminology and make sure that we understand that primary care is not just general practice but all contractor groups. The advent of integrated care boards is a really important step, because it feels like the biggest

step towards genuine integration in a very long time. I am delighted that community pharmacy, dentistry and optometry commissioning is also being taken into the integrated care boards. So we have a real opportunity. There are some really good examples.

Some barriers are probably similar to the ones my dental and optometric colleagues have referred to in contracting and perhaps some slightly outdated contracts. But there is huge potential there. What we have at the moment does not necessarily work well for citizens or the healthcare service, so we need more reform in some contracting aspects to free-up the proper integration that we all know we need.

Q104 **Baroness Barker:** We noted the Government's paper last week about recovering access to primary care. It contains the assumption that there are a sufficient number of sufficiently well-qualified pharmacists to take on the role. Is that the case, or do we need to look at changing the training for pharmacists?

Also, in order to reduce demand on GPs, will GPs and pharmacists have to work in a different way? For example, do pharmacists work to the same ethical framework as GPs? Are pharmacists required to provide a universal service, or can they refuse to serve individuals? Do we need to reframe the relationship between GPs and pharmacies, rather than assume that pharmacies can take a load of responsibilities from GPs?

Ewan Maule: These are very valid questions. On the numbers, we know that the workforce is pressured at the moment. Community pharmacies are closing at a higher rate than we have seen for a very long time. This reflects the contractual issue that I mentioned. The community pharmacy contract is still very heavily based on dispensing activity. We now know that a large part of that could be automated and centralised, and what we really need is the healthcare professional on the high street who can deliver some of these services. It is important for the contract to keep pace with the advancement of technology and the development of the health service, which would allow us to free up the staff to be able to do that. That is very important.

On ethical standards, pharmacists and pharmacy technicians are registered healthcare professionals who are held to very similar ethical standards by the General Pharmaceutical Council, so I have absolutely no concerns about the quality of the service that is being provided.

Regulation probably needs to evolve to keep up with a greater service delivery model rather than dispensing activity, so some

evolution is required there. This is not just about reducing pressure and reducing activity in general practice. Some of this is about making the best-quality care available to the patient in the right setting. There are lots of settings where a community pharmacy or a pharmacist working in the general practice is the right healthcare professional to deliver a particular aspect of care. It is not just about taking pressure from elsewhere. There are some really good examples in the north-east and north Cumbria, such as the treatment of urinary tract infections. That has just been announced as a national programme. We have been doing it for the last 12 months and it has delivered phenomenal benefits for our population.

Q105 **Baroness Armstrong of Hill Top:** Good afternoon, everyone. For each of your disciplines, can you identify for the committee what benefits better integration could bring to the wider health service, such as in patient flow and timely access to services? We are particularly interested in how integration can improve opportunities for the patient.

Daniel Hardiman-McCartney: I have two different examples, one at the front end and one at the back end of the system. During the Covid pandemic, optometry practices started delivering a lot more acute and urgent care in practices, freeing up secondary care in GP practices. In fact, they stayed open throughout the pandemic and established a number of case studies where they were able to deliver treatment for red-eye conditions, prescribe for conditions such as conjunctivitis and minor ailments, and triage more serious conditions into secondary care. That care for citizens is delivered close to where people live. It has the specialist equipment on the high street nearby. That built up a lot of trust between the primary and secondary care systems, as well as GPs.

One of the biggest barriers historically that we found was the lack of trust between the high-street professions and the secondary-care traditional medical professions. Where you break that down and have a genuine patient-centric approach around the condition, that is really good for patient outcomes. That is at the start of things.

Regarding the end of care, we know that a lot of people have lifelong eye conditions such as glaucoma and require regular reviews for a long time. High-street optometrists have the equipment in their practices to do those care assessments and reviews in conjunction with secondary care, saving people from having to travel. Where I live in East Anglia, people might have to travel to Norfolk, Norwich or Ipswich for a regular routine check-up, when in fact they could do it in their local market town instead,

using optometrists with the same level of equipment, training and expertise.

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[1] Where enhanced services are planned collaboratively, appropriately funded and with connectivity the NHS does not need to repeat the tests and measures, in the example I gave relating to glaucoma I would refer to the evidence published relating to the following shared care schemes, which confirm through audit that measures do not need to be repeated. The data provided can be trusted, used and ensure duplication is not required.

Keenan, J., Shahid, H., Bourne, R.R., White, A.J. and Martin, K.R. (2015), COGS glaucoma scheme. Clin Experiment Ophthalmol, 43: 221-227.

Cambridge community Optometry Glaucoma Scheme - Keenan - 2015 - Clinical & Experimental Ophthalmology - Wiley Online Library

Gunn PJG, Marks JR, Konstantakopoulou E, et al. Clinical effectiveness of the Manchester Glaucoma Enhanced Referral Scheme. *Br J Ophthalmol*. 2019;103(8):1066-1071.

Clinical effectiveness of the Manchester Glaucoma Enhanced Referral Scheme - PubMed (nih.gov)

Mushtaq, Y., Panchasara, B., Nassehzadehtabriz, N. *et al.* Evaluating multidisciplinary glaucoma care: visual field progression and loss of sight year analysis in the community vs hospital setting. *Eye* **36**, 555–563 (2022).

Evaluating multidisciplinary glaucoma care: visual field progression and loss of sight year analysis in the community vs hospital setting | Eye (nature.com)

Nonetheless it is a good point, as when patients are referred from a standard sight test for a vast range of conditions, there is much more variation in the types and makes of instruments used, and sometimes secondary care providers may need to repeat the assessment and tests, causing duplication. In the case of imaging and diagnostics this is because the optometrist cannot digitally send the summary image information, but also because of variation in the propriety file types used by different instrument manufactures. The optometry practice may have privately invested in one 'make' of diagnostic instrument, and the hospital another, and each party doesn't have the required software to assess the raw data within the imaging, and only a summary overview. We are tackling the compatibility issue and co-chair a working group with support from NHSE and industry to agree a universal file type and standards, specifically for eye imaging devices, in the same way they have successfully implemented image file type standardisation (DICOM) in radiography. Currently without digital connectivity practices cannot even share a single summary image/overview let alone the full raw data, which most consultants would want in order to avoid duplication.

The College and eye care organisations call for standardisation of digital imaging - College of Optometrists (college-optometrists.org)

There is huge scope to better utilise primary care clinicians for initial, acute, patient/citizen-led services and for the long-term management of eye diseases.

Baroness Barker: Would it be right to assume that the success of that is that the NHS accepts your data and information, your methodology and the robustness of your testing? Somebody comes to you, they are assessed, and the NHS does not then carry out the same examinations and test them all over again. It takes what you say.

Daniel Hardiman-McCartney: Absolutely. There needs to be trust, not duplication. There is no point duplicating things for people. You also need the connectivity to share that information, as per the review of the high street, but you are right. The reviews have been published academically in independent peer-reviewed journals and audited.[1]

Baroness Armstrong of Hill Top: Mr Maule, in a sense, you are working with the largest ICS in the country by a long way—through no competition, as it were. Therefore, you will have a broader perspective of how integration might or might not work.

Ewan Maule: That is absolutely right. We certainly have pockets where that integration is working extremely well in areas where it is sometimes a little more challenging. Across our ICS we have some very urban areas and some extremely rural areas, like the Lake District and Northumberland. We have found that integration works best where we have managed to reduce any element of competition between different contracts or groups or between general practice and community pharmacy, for example. There is traditionally a bit of competition around the annual flu vaccination programme, because it provides a reasonable source of income for whoever delivers it. Where we have managed to remove that perverse incentive in the system, that is where we have managed to get much better integration.

There are more things that we can do contractually to encourage all those contractor groups to work together in a way that is patient-centred and patient-focused and which helps to build the trust that was mentioned earlier. That is essential. The urinary tract infection programme that we put in place is a prime example. Over the first year, 15,000 patients in our integrated care board have had their UTI diagnosed and treated within a community pharmacy setting. That means that they do not have to phone up the general practice at 8 am and rearrange their day around an appointment and so on. They can walk into any community pharmacy and be diagnosed and treated immediately.

We know that that is a far better patient experience. It is far more patient-centric. We have built in the technology to allow that information to flow directly through to the general practice records, so that that is kept fully updated as well. That has helped to build the trust between the contractor groups and to develop an understanding that the service that is being delivered is of extremely high quality. We are not seeing any great increase in antibiotics prescribed—in fact, we are seeing a 40% reduction.

Sometimes it is those small steps with individual clinical conditions that, when implemented well, can deliver for the patient and develop the relationship between the different contractor groups.

Dr Abhi Pal: I alluded earlier to some of the benefits that oral healthcare can bring to wider integration. Common preventive messages on obesity, coronary heart disease and smoking are there. The concept of the dental team means that it is not just dentists; many team members can be involved in the management, care and prevention of these conditions. For conditions such as type 2 diabetes, we know that there is a bidirectional link between type 2 diabetes and gum disease, or periodontitis. Management of one can affect the other. So integration of our services can lead to better patient care in these areas.

Colocation, whereby dental practices, dental services and medical services can operate side by side—some, by choice, are located in health centres—has particular benefits in being able to transfer patients when one condition is found to be able to be cared for by the other contractors. In terms of what oral health improvement can bring, there is of course the issue of nutrition among the elderly, as the inability to eat will affect nutritional ability. Also, at the end of the day, a nice smile will not only add to social confidence but reduce social isolation. All these benefits can be enhanced by integrated services.

Baroness Redfern: You mentioned working side by side in one location. That must be really good. Does that help with better data sharing, rather than remote-working with GPs?

Dr Abhi Pal: It has the potential for better data sharing, but in reality I do not think it happens. General dental practice and general medical practice are still working in isolation. The potential is there if there can be better link-up with patient records, but the reality is that that does not happen often, because they are working independently.

Baroness Redfern: Why not? Why does it not happen?

Dr Abhi Pal: The data management and computer systems of dental practices are handled completely independently. There is no formal link-up in NHS services. With medical practices, the data is linked-up to the main NHS networks, which dental practices are not. They have not been given the facility; those link-ups have not been created. There may well be pockets of exceptions, particularly with community dental services, but, by and large, dental practices' main link-ups are the ability to have an NHS net address and the referral systems.

Q106 **The Chair:** Should we assume that a single patient record would be beneficial to patients and customers?

Dr Abhi Pal: A single patient record would be beneficial. One would know the history and could then assess the risk factors of patients, which can only enhance the care of patients.

The Chair: Do you agree, Mr Hardiman-McCartney?

Daniel Hardiman-McCartney: We need to be precise about what is meant by the single patient record. A summary care record would be helpful. A two-way electronic referral system between primary and secondary care would be helpful. As Dr Pal suggested, access to NHS.net is not widespread in primary care, which is outrageous. Electronic prescribing is another aspect. It would be advantageous, without a doubt, but lots of individual challenges of connectivity need to be solved to make that happen, as well as empowering the citizen to trust everyone who accesses that data.

The Chair: What are the barriers to getting this record, which everybody said would be helpful?

Daniel Hardiman-McCartney: In primary care for optometry, it is just straightforward connectivity—just joining up the practices given access to the summary care record. It is straightforward connectivity and information governance.

In optometry, as in dentistry, there are different patient management systems in each practice. NHS England spent quite a lot of time investigating APIs to ensure that the two systems could talk to each other, but that has not been progressed. Also, it is such a big project that it is very difficult for a small ICB to handle the huge cost involved in a national API connection between one software system and another. It is not impossible: we have case studies where it works very well.

The Chair: Mr Maule, what is your view on access to records and connectivity?

Ewan Maule: I completely concur with what the others have said. This would be enormously helpful. I do not think it is necessarily a technical challenge. It is expensive and complicated, but it is technically possible to do this.

It is also important to consider whether this is access to view a record or read-and-write access. Anyone delivering care to a patient should be able to write into that record, to document what care they have provided, wherever that setting is. It should be a single central record. Some of the difficult technical issues that have been discussed are not insurmountable. The biggest barrier is the Caldicott Guardian rules, information governance and public confidence about personal information, how it is being used and how it is being shared. That means that the GP record, which traditionally is the most complete record, is very much owned by the general practice. Therefore, there is a significant reluctance to share information on that widely and to invite input information from other areas, completely understandably. So there is a legislative element as well as a practical technical element.

The Chair: Thank you very much.

Q107 **Baroness Osamor:** Since 1 April, integrated care boards have been responsible for commissioning pharmacy, optometry and dental services. Will this change how you work with other services? How do you expect it to benefit your patients and customers?

Daniel Hardiman-McCartney: There is huge potential for ICBs and greater integration, so that is good. However, in optometry, we have seen that it is fragmented and uneven. The straightforward representation of primary care as a whole is that it is not necessarily strong in all areas. We are concerned that having just one person at the ICB who represents all primary care via the primary care network is not a very good way for us to add voice and evidence, build pathways, help saleability and share what is happening in other parts of the country to facilitate the true integration that is possible.

In Greater Manchester, Cheshire and Mersey, ICB primary care forum boards have been created, which have the broader elements of each of the pillars of primary care contributing, to feed into the ICB. Where that has happened, they can do positive things. They set up a simple system called Getting to Know Where to Go, to help people to navigate the system in their area. But we are concerned that it is very fragmented. Primary care will not be a priority for the ICBs, so although there is a lot of opportunity there, it is how we bake-in the option for primary care to be part of that and for it not to take a very traditional medical approach and outlook.

Ewan Maule: I absolutely agree. Integrated care boards, by their nature, are formed in large part from individuals and structures that were present under clinical commissioning group days, which were responsible for commissioning general practice but not the other pillars of primary care. So by default we are starting from a very primary-care, medically focused model, and a shift towards understanding and recognising the needs of the rest of primary care is significant.

We also have to understand the environment in which integrated care boards have been created. At the same time as NHS England is being reformed with significant budgetary pressure, integrated care boards have significant budgetary pressure and pressure on running costs. It makes creating those opportunities for the multi-disciplinary clinical leadership much harder to do, because we have inherited a very medically led model and now we do not necessarily have the flexibility to expand that clinical leadership.

I am optimistic about what integrated care boards can do and what they structurally can do. How that gets delivered will be challenging. Inevitably, we will see areas of really good practice and really good examples, and some areas where it is more difficult to do so.

Dr Abhi Pal: I have a similar message. What is required is good clinical leadership for each of the disciplines, including dentistry, so that decisions made by the integrated care systems can have good clinical input. Also, appropriate resourcing will allow these clinicians to give up time to be involved in the boards and to look at future leadership, ensuring that we are recruiting people with the right training to carry out these roles.

However, it is necessary to ensure that there is proper representation at the top level in these systems. I am not saying that there is no representation at all. There is some representation from primary care networks, but it must be more formalised and properly resourced.

Q108 **Baroness Osamor:** What is your discipline's experience of the new integrated care system more generally? So far, do you appear to have sufficient opportunities to participate in and influence their work?

The Chair: If you have any specific examples, they would be useful.

Daniel Hardiman-McCartney: No, is the answer. We do not have sufficient opportunities to participate broadly across ICBs. That is the challenge. The first step has to be not to take one or two

examples of good practice but to bake it in so that there is the opportunity for all of primary care to contribute to the ICBs to consider patient-centric innovative practice in the community. It is a real challenge at the moment.

Dr Abhi Pal: Likewise, there are some isolated examples of involvement, but nothing widespread. It is mainly through local dental networks being invited to take part in ICBs. There is very little involvement at the moment.

Ewan Maule: Probably by virtue of the fact that community pharmacy was working more closely with general practice prior to ICBs, pharmacy has more prominence than the other two primary care sectors.

For example, most, if not all, ICBs will have someone in a similar role to mine, at director or chief pharmacist level, but that was not mandated anywhere. It has emerged because people have recognised over time that it was essential. If pharmacy is in that position of not necessarily being recognised as essential at the outset of ICBs, I can understand why my optometry and dental colleagues, who traditionally have not been as close to general practice, have found it difficult to influence the direction of the ICB.

For most ICBs that I hear from up and down the country, it still feels medically led, but pharmacy is starting to make its voice heard in many of those ICBs.

Q109 **Baroness Wyld:** On optometry, why is that? Is it cultural? My observation as a lay person is that the tech in optometry over the last 10 years has been transformational. Are we playing catch-up in the awareness of it in the health service?

Daniel Hardiman-McCartney: That is a good point. There is a lack of understanding about what optometry can offer. There has been a lack of understanding with the investment and the diagnostics that are available in primary care optometry. It is playing catch-up, but it is policy catch-up. Often it is driven locally by people who know a secondary care ophthalmologist and an optometrist. They have done brilliant, innovative things, but because optometry is not baked-in, that expertise is not being shared within the ICBs system, and you cannot say, "Look what is happening here". All the investments have been made. All the technology is there. It is convenient, but it is not being fully utilised.

Baroness Wyld: That is helpful.

Baroness Redfern: You mentioned co-location. Are you getting

any help to achieve that co-location with GPs?

Daniel Hardiman-McCartney: I will check afterwards, but I do not believe there is any financial help.

Baroness Redfern: Are there incentives to do that?

Daniel Hardiman-McCartney: No.

Q110 **Baroness Redfern:** What roles do your disciplines play in health promotion, early intervention and the reduction of health inequalities? Also, how might the new integrated care systems make such roles easier and more effective? We have touched on that a little.

Daniel Hardiman-McCartney: The sight test itself is essential for community and for educational achievement: being able to see clearly in education, employment, even prisoner rehabilitation—the basics. We must not forget that. Beyond that, there is healthcare, and looking beyond just eye conditions to systemic health conditions. A nice case study from Dudley looked at public health—smoking cessation, cardiovascular risk factors and blood pressure—delivered in primary optometry locations. That has been so successful that it has been scaled out in other areas. It would be brilliant if we could make that a UK-wide endeavour.

On health inequalities, a very interesting paper was published only last week looking at the presentation of glaucoma, as an example.[2] They found that a lot of people from lower-income and socially deprived communities presented with glaucoma at a much later point and with much worse vision loss, because they did not routinely access preventive sight tests as frequently as people from middle-class, well-read or educational backgrounds.

So there is more to do to address eye health inequalities, particularly in communities in rural, coastal and inner-city locations, where there might be a lower number of optical practices per head of population and where public health interventions might be very helpful in going in and encouraging people to get a sight test and glaucoma check in order to pick up at earlier points. In

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[2] Rathore, M., Shweikh, Y., Kelly, S.R. *et al.* Measures of multiple deprivation and visual field loss in glaucoma clinics in England: lessons from big data. *Eye* (2023)

Measures of multiple deprivation and visual field loss in glaucoma clinics in England: lessons from big data | Eye (nature.com)

Wong, T.L., Ang, J.L., Deol, S. *et al.* The relationship between multiple deprivation and severity of glaucoma at diagnosis. *Eye* (2023).
The relationship between multiple deprivation and severity of glaucoma at diagnosis | Eye (nature.com)

practice last week, I saw someone in their fifties who had to give up their career as a lorry driver because of vision loss. They had not had a sight test for 10 years. It is an acute issue that we must do something about.

Baroness Redfern: We need to highlight more promotion as such, then.

Daniel Hardiman-McCartney: That would be very helpful. That would save sight.

Dr Abhi Pal: At the risk of repeating myself, prevention is a fundamental part of dental care that is provided up and down the practice. There are common risk factors—obesity, coronary heart disease, and diabetes in some ways, as I have said—that impact on dental disease. So preventive messages that dental teams are giving in these areas will help the wider healthcare of patients.

A fundamental problem is that the current contract does not enable or support prevention. This is one of the main reasons why we need to review this. There have been pockets of flexible conditioning, which has used a different model of resourcing. In those areas, where those projects have been undertaken, you can see real benefits. However, it is quite clear that dentists, dental practices and dental teams are used to providing prevention for patients' oral health. Those same preventive messages are important for a number of other diseases. Particularly with diabetes, again because of the bidirectional link, improving the oral health of a patient will improve the glycaemic control of diabetics. With further integration, a lot can be done to further patient care.

Baroness Redfern: With oral health, do we have nurses going into schools?

Dr Abhi Pal: We do, but by and large this is in areas where there has been some flexible commissioning, it has been done through community dental services, or dental practices do it simply for child health purposes.

Baroness Redfern: It varies from region to region.

***Dr Abhi Pal*:** Yes, very much so. It would have great impact on improving child oral health.

Ewan Maule: In community pharmacy there is a very long list of services and activities that fit into this agenda of health promotion and early intervention. Early diagnosis of hypertension is a prime example, as are weight management, smoking cessation, the urinary tract infection treatment that I mentioned. Another good

example is pain management and addressing the overuse of opioids. Lots of things can be done in that setting.

Again, the unique aspect of that setting is the access of it and how people feel about accessing care in community pharmacy; they find it much easier than lots of aspects of planned care. Some great work was done by Crisis, the homeless charity, on how people experiencing homelessness, and other health inclusion groups, interacted with the health service. All the health inclusion groups said that community pharmacy was the setting in which they got the best-quality care. They did not need to make an appointment, and it did not matter if they had no address or NHS number. They could walk in and see an NHS professional who could provide them with some care.

We know that some of those services, and some of the work that has been done on prevention and early intervention, has an impact on some of the most deprived and disenfranchised aspects of society. There is enormous value to that. But, again, as my colleagues have been saying, that is not necessarily adequately valued in the contract. So often, it is down to the good will of the people providing the service or how attached and close they feel to the community they work in, rather than because it is contractually mandated. As a result, we get significant variation from place to place and area to area. There are impressive pockets of good practice, and areas where sadly not enough is happening.

Baroness Redfern: How can you further improve health and well-being?

Ewan Maule: There is an awful lot that we can do. The single biggest thing that we can do in community pharmacy to address health and well-being is to move away from the activity-based dispensing contract, which frankly will remunerate a community pharmacy based purely on the volume of medicines that it dispenses. A national overprescribing review not long ago said that we overprescribe medicines for patients. Very often, medicines are not the right answer, but they are the easy answer—a pill for every ill.

If community pharmacies were renumerated in a way that allowed them to provide services that meant that taking someone off a medicine was as valuable to them as starting someone on medicine, we would start to see that more holistic patient care coming through. That is the single biggest change that we could make. That is probably reflective of the fact that the community pharmacy contract has essentially been the same for a decade or more.

Q111 **Baroness Shephard of Northwold:** In the order of optometry, dentistry, then pharmacy, what one change could the Government make to enable better integration of your discipline with the wider health service?

Daniel Hardiman-McCartney: Our one change would be digital connectivity. That is the key enabler of greater integration with other pillars of primary care and with secondary care colleagues. That digital connectivity in an optometry context would be a two-way electronic record service. We could refer people into secondary care or primary care, or even fall services or social care, where people need support putting their eye drops in.

Secondly, it would be the summary care record. Thirdly, it would be NHS.net access and electronic prescribing. There is a growing number of independent prescribing optometrists with the skills and expertise to prescribe but not the access to the NHS prescription or electronic prescription system. The best way to do that would be through better integration with ICBs. Being a bit cheeky, our one change would be digital connectivity, but really through greater involvement with the ICBs, so that we can set out our stall on the case for that.

Baroness Shephard of Northwold: That would come first.

Dr Abhi Pal: Mainly, I would look at contract reform. At the moment, it does not lend itself to prevention or integration with the other services. By reforming it, one could unleash the potential of dental teams to work with the other services and provide further integrated care. I agree that better integration and sharing of data would be the next one.

Ewan Maule: At the risk of repeating ourselves, I would say exactly the same as my two colleagues. It is digital connectivity and read-and-write access to records, some fundamentals in the contracts, and removing competition between pillars of primary care, ensuring that contracts are complementary and synergistic.

Q112 **Baroness Shephard of Northwold:** My supplementary is probably impossible to answer. How difficult would a change of contract be in professions where it would be the first step?

Daniel Hardiman-McCartney: There are two parts to the contracting situation in optometry in England. There is a national template of contract for sight testing, which works well. People can go into any practice in the country and get a sight test. If you are under 16, over 60, or receive support such as universal credit, you can access that. It is working well. It is about building on that. Local areas then add-in enhanced contracts. That is where there is

scope to scale, assisting good practice. It is not difficult. It is perfectly achievable, because it has been done, but it is on local contracting, with ICBs having the will and desire to make the effort in the area.[3]

Baroness Shephard of Northwold: Thank you.

Dr Abhi Pal: In dentistry, the current contract started in April 2006. Pilots for amending and changing the contract started in 2010-11. They have been piloted for 10 years, yet we have still not seen a new contract.

Baroness Shephard of Northwold: Where is the reluctance?

Dr Abhi Pal: A mutually agreeable model is yet to emerge.

Baroness Shephard of Northwold: It is on both sides, you mean?

Dr Abhi Pal: Yes. Having said that, some changes that could have come about earlier were made in 2022. Using the current contract, marginal changes have been made to facilitate more care and can facilitate more periodontal treatment, which again will have an

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[3] I saw you have previously heard from experts in artificial intelligence and regarding the potential benefits of machine learning, deep learning and artificial intelligence (AI) in supporting greater innovation in primary and community care settings. I thought it may be helpful to note that the UK is one of the leading centres for the use of these novel techniques in ophthalmology, and in creating a relatively new field called oculomics. This is where ocular biomarkers, in particular ocular imaging, as described by Baroness Wyld in our hearing, can be used to assess cardiovascular and neurological risk factors. This means an image of the eye can be graded using this novel method and people risk stratified, with good concordance for a wide range of systemic health conditions. Once identified preventative treatments could be prescribed, or targeted education provided to improve modifiable risk factors. Although there is much hype around AI, there is growing academic and professional consensus that this could be transformative in improving patient outcomes, using the existing infrastructure of primary care optometry. (With the connectivity that we discussed during the session). Here are a couple of papers on the topic, if this is in scope and helpful to the committee.

Poplin R, Varadarajan AV, Blumer K, et al. Prediction of cardiovascular risk factors from retinal fundus photographs via deep learning. *Nat Biomed Eng*. 2018;2(3):158-164.

Prediction of cardiovascular risk factors from retinal fundus photographs via deep learning - PubMed (nih.gov)

Denniston, A, Keane, P, et al. Building trust in real-world data: lessons from INSIGHT, the UK's health data research. Current Opinion UCL Discovery

Thomson (ucl.ac.uk)

impact on the care of diabetes. However, as yet we do not have any forthcoming substantive change to the national contract.

Baroness Shephard of Northwold: Thank you.

Ewan Maule: Community pharmacy is a sector made up of everything from very small independent one-store pharmacies to very large international conglomerates owned by hedge funds. It is not a homogenous sector. That presents one of the challenges. Lots of businesses have business models based on the current contract, so any transition from that would be difficult for all. A transitionary contract would help. It is not impossible, but it is very difficult. Anybody involved in the world of medicines, in prescribing and pharmacy, could tell you what the new contract needs to look like, and it is quite different from what we have, but there are lots of vested interests in how it is just now.

The problem is that any transitionary contract must not lose the value of what we have; it must not lose in particular the bricks and mortar pharmacies that we have on the high streets, in the rural communities, in the deprived areas. They must be retained, because if they are lost, the impact on the rest of the health service will be enormous. How we do that without breaking too many eggs in the meantime is the difficult thing. That is why we have never done it until now.

Q113 **Baroness Tyler of Enfield:** My question straddles primary health services and community health services. There was a brief reference earlier to optometry services being available in community settings, care homes and the like. Dr Pal, could you tell us what you feel about the sufficiency or otherwise of dental services in care homes and other settings? I ask, because in my experience it is often very difficult to get dental services for elderly people in care homes, particularly if they are quite immobile.

Dr Abhi Pal: The care in these environments is provided partly by community dental services that are able to provide it, and partly by general practice environments. Community dental services are already very stretched, and with the number of care homes they do not have the capacity to provide care, so it is left to general practices.

There have been some pockets of innovation, such as in Yorkshire, where there has been some degree of flexible commissioning to allow care in residential and care homes. That would be a really good model when further-integrated services are there, but that is in very isolated areas. The contract does not allow for going into care homes unless it was in place pre 2006, in which case the

practice will carry on providing domiciliary services. By and large, it is an overlooked area.

In the new world, there is the potential to provide care through special integrated services and flexible commissioning, and practices would like to do it. This is not just about providing dental care and invasive treatments. That is part of the problem with the current contract: it largely promotes only treatments. Prevention will play a huge part in areas like this, as will promoting prevention to populations that cannot access dental care regularly.

So, yes, there is huge potential, but a lot of work is still needed.

The Chair: On behalf of the whole committee, I thank all three witnesses in the room and online. You have given us a great deal to think about. As you know, this was a public session. There will be a transcript, and you will be able to look at it. As always, if there is anything that you have not been able to say which you think would be helpful to us, please do not hesitate to get in touch. In the meantime, thank you very much for your attendance.