



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 15 May 2023

3.55 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. 12

Heard in Public

Questions 114 - 122

Witnesses

I: Dr Lindsey Cherry, Associate Professor and Podiatrist, University of Southampton; Sallyann Sutton, Professional Officer, School and Public Health Nurses Association; Genevieve Smyth, Professional Adviser on Primary Care, Royal College of Occupational Therapists.

Examination of witnesses

Dr Lindsey Cherry, Sallyann Sutton and Genevieve Smyth.

Q114 The Chair: Welcome to the second witness session this afternoon of the Integration of Primary and Community Care Committee. We are very pleased to welcome in person Dr Lindsey Cherry, associate professor of podiatry at the University of Southampton, and Ms Genevieve Smyth, professional adviser on primary care at the Royal College of Occupational Therapists. Joining us online is Sallyann Sutton, professional officer at the School and Public Health Nurses Association. Welcome to you all. We will take it in turn to ask you questions.

Starting with Dr Cherry, how well is your discipline currently integrated into wider health services and especially, as it is our focus, into primary and community services? In answering that question, please talk about the barriers that you can identify.

Dr Lindsey Cherry: On balance, in some areas our profession is quite well integrated. In key areas—for example, looking after people with high-risk feet who are at risk of amputation, particularly particular people with diabetes—there is quite good integration. In some areas, particularly in primary care, we have seen slower workforce transition and movement to integration. At the moment, our workforce is around 12,000 podiatrists, just under 60 of whom are working in primary care, so a tiny proportion have moved into primary care. One of the biggest barriers is the overall lack of workforce available to develop and transition into primary care roles.

Genevieve Smyth: In 2022, the Royal College of Occupational Therapists carried out three surveys of our members across the whole workforce, looking specifically at our rehabilitation workforce and children's community services. All told us the same story. About 86% of respondents have seen significant increases in demand over the past 12 months, alongside record levels of occupational therapy vacancies. These two factors are challenging occupational therapists' capacity to deliver even basic services.

In that context, integration has become the icing on the cake rather than core business. NHS England has identified that occupational therapy is undersupplied across the whole of health and social care in all regions of England. In many places, we are undersupplied by 15% when it would normally be about 4%.

To overcome this, RCOT is writing our very first workforce strategy, which will address the whole workforce pipeline. However, to amplify this, we need government to do its part in the promised

NHS workforce plan, so that it is seen through the lens of a multidisciplinary team which includes occupational therapists. It is only by doing this that we can ensure the delivery of integrated rehabilitation, reablement and recovery in primary and community care.

The Chair: Thank you very much.

Sallyann Sutton: It is fair to say that the integration is variable across areas. Where school nursing services are provided by NHS trusts and are perhaps part of an acute community provision, integration is much easier because they sit within the same provider.

Then we have areas where school nursing services are provided by non-NHS organisations, and it is not naturally joined-up, as well as areas where school nursing services no longer exist. We have a similar problem with capacity in the workforce. There is a diminishing amount of school nursing. There has been a downward trajectory since around 2015, impacted by cuts to public health grants. This limits the ability to support integration.

There are examples of integration working well, such as GP surgeries, particularly on safeguarding, where conversations go on about the most vulnerable children and families and where there are links into community nursing teams for children with long-term conditions. There may be an asthma pathway in place, for example. A lot of integration is by means of good relationships rather than a robust infrastructure that supports integration.

I reinforce that the main challenge is in workforce capacity. It is also other professionals understanding the role of the school nurse and the contribution that school nursing can make.

The Chair: Thank you very much.

Q115 **Baroness Tyler of Enfield:** Thank you very much. My question is specifically for Ms Smyth. Bearing in mind what you have just said, very forcibly, about the workforce constraints that you are operating under, what benefits could be available from the integration of your discipline with the wider health service, particularly in patient flow and accessing the right care at the right time?

Genevieve Smyth: Better integration of occupational therapists would maximise our skillset, allowing us to focus on everyday occupations and activities, so that people, families and carers can remain active and well for as long as possible. Occupational therapists told us in the surveys that they are often forced to

practice as generic community clinicians due to staff shortages. More integrated approaches would prevent this.

We also believe that shifting and realigning our workforce towards primary care would help to create system capacity, so that people could get advice and help early on, rather than when they have acute and increasingly complex sets of needs.

However, as my colleague has already mentioned, there are 6,500 GP surgeries in England and only 200 occupational therapists working across them. We estimate that we need another 1,400 occupational therapists to drive early intervention and prevention services, as part of the primary care multidisciplinary team.

Finally, better integration would allow occupational therapists to expand their skills where appropriate. For example, we have consultant-level occupational therapists who are nationally recognised leaders. They regularly teach junior doctors in their speciality area, yet they cannot prescribe medicines that would improve people's ability to get on and live their ordinary lives. We urge the Government to include us by changing the medicines legislation to ensure that expert occupational therapists with the right skillset and in the right clinical context can prescribe medicine.

Q116 Baroness Tyler of Enfield: Thank you. My follow-up question is rather different but just occurred to me. In terms of the benefit that your profession can bring, to what extent is the name of your discipline, occupational therapy, a barrier, in that some people might not understand that it is not just about occupational issues for people of working age and at work but very much relates to people's activities in their home—older people, for example? Does that act as a bit of a barrier at the moment?

Genevieve Smyth: It is true that there is a lack of understanding about our profession. When we move into primary care, one of the biggest barriers we face is that GPs do not understand the full set of skills that we can bring to primary care. However, generally we find that once they have worked with us, they love us and cannot see how they have coped without us. So I do not think it is the name that is the barrier. We are in the wrong parts of the system. If we were in the right parts, we could explain and show our value and what we do.

Baroness Redfern: What is the position for OTs working in residential care?

Genevieve Smyth: We do work in residential care. Some of the earliest sites where we have moved into GP surgeries have been in

supporting residents in care homes. We have an increasing complexity of people in care homes. Occupational therapists have been doing sterling work as part of the primary care team, going into care homes and supporting the paid carers to better understand how they can facilitate everyday activity and occupation, working closely with our physiotherapy and pharmacy colleagues, for example, to deprescribe, because it is not always about giving people medicine: it is sometimes about deprescribing in care homes so that people can engage more in their everyday occupations and activities. I can provide examples.

Baroness Redfern: That is working well, then.

Genevieve Smyth: It is working very well.

Q117 **Lord Watts:** My question is for Sallyann Sutton. Can you give an example of how community nursing in specialised settings—for example, in school and residential services—can reduce pressures on other parts of the health service?

Sallyann Sutton: School nurses are specialist community public health nurses. We are qualified to postgraduate level and have a specific skillset in identifying the needs of individuals and population.

Our work focuses on promotion, prevention, early intervention and protection. When we work in schools—with all children; we are a universal offer—we also provide additional help to children where they might have long-term conditions. We contribute to disease prevention and to the support and management of long-term conditions.

We also promote the appropriate use of health services, perhaps helping with admission reduction or ensuring that families take their children to appropriate services, using pharmacies rather than an ED. Also, because we work across health as a whole—mental health and physical health—we can sometimes join up the services so that the young people get thought of as a whole person.

We have a key role in reducing pressures on other parts of the health service. Again, some of the challenges are that we are a very small workforce and increasingly have challenges with capacity. Again, the starting point is not always understood by other professionals. Our role is sometimes unclear to GPs. However, similar to what my colleague from occupational therapy said, when a GP works with us and realises how we can contribute to the management of the child—say, on an asthma or epilepsy pathway—and how we can play a pivotal role between home health services and school, our role is then seen as critical.

Lord Watts: What is the important link between you and GPs? What makes that relationship successful and what makes it difficult? Is there a common pattern?

Sallyann Sutton: I hate to say this again about capacity, but what makes links work is the ability and time to build relationships—having a named school nurse or team with a named GP surgery, so that they can build up that relationship and trust, which allows better sharing of information about children and families so that those children and families only tell their story once. However, you need the reliance of a school nurse being able to have regular contact with a GP surgery. Again, there are far more GP surgeries than there are school nurses. That is key.

The other thing is good digital infrastructure—the ability to send or access information on IT systems, negating the need sometimes for telephone or face-to-face conversations. As a school nurse, I could then go on to an IT system, see the history of a child, understand what the GP has done, what referrals might have been made, what treatment has been offered, so that I can take that information back and work with the family and perhaps the school. However, IT digital systems do not promote that seamless information sharing. Often, the IT systems do not even speak to each other.

Q118 **Baroness Wyld:** My questions are for Dr Cherry. The first is about socioeconomic factors and how much they influence the types of conditions that you see. Secondly, we touched on your view on integration and how well integrated you are, but if you had that integration in an ideal world, how far would that help to address the myriad conditions that you can identify and deal with?

Dr Lindsey Cherry: On the connection to socioeconomic standing, it is hugely impactful. As podiatrists, we are specialists in all things foot and ankle, but fundamentally we are keeping people mobile, walking, and physically active. With a decline in physical activity, you get a worsening of many other health-related comorbidities, in mental health as well as physical health. We are pretty pivotal to keeping people healthy and more mobile.

In terms of integration, it is really hard with a small workforce, because the workforce we have has a vital role. We know that if you deplete the workforce, health outcomes decline. We have lots of examples of that. One is Covid, where we had restrictions on what were considered lower-risk services, which might be your prevention-type agenda, and our workforce focused only on high risk, such as people at risk of amputation. We found that, ultimately, everyone deteriorated. When they then presented as

high risk, they were in a poorer state of health. So we know that prevention is critical.

However, to have change and integration, you have to shift a limited resource, so investment in the pipeline of our workforce is also critical. We have a widening foot-health workforce, but because of the stresses and strains that people are under, we are also seeing stagnation and fewer opportunities for people to develop in their career and become the more senior, advanced-level clinicians.

We know that what works well in relation to integrating into primary care is the transition of our advanced, very well-rounded clinicians who have independent prescribing, because then they can provide exactly what is needed at that first point of contact. They can do the diagnostics. They can provide prescribing requests to the various tests and then interpret them. However, moving those senior clinicians from one place to the other creates a detriment.

Baroness Wyld: You said that 60 had gone into primary care from your entire workforce. What is the impact of that on diabetes management, for example? How could you transform that if you could have anything?

Dr Lindsey Cherry: It is a good question. In my region, we have put consultant-level practitioners into that integrated system. They have the rapid access to the right things at the right time, so it expedites treatment, reducing the healthcare burden as a consequence. So reorganising our resource can create efficiencies.

Q119 **Lord Altrincham:** I have the digital question. What practical benefits would better data sharing and a single patient record provide to your patients and customers, and how might they be achieved? Perhaps you could also comment on barriers to doing this.

Sallyann Sutton: I touched on this in response to earlier questions. Access to one system would avoid duplication in care. We often see children who have been referred to numerous different professionals because they have had assessments by numerous different professionals, so you get a crossover of referrals, ending up with multiple or repeated referrals, meaning that children and young people do not always have access to the appropriate treatment at the appropriate time and in a timely way.

Also, having a one-patient record would be a step further towards a goal that all children, young people and families want, which is sharing their story once. They tell us time and time again that they go from one professional to another and have to repeat their whole

story, which can be distressing and frustrating, and wastes a lot of time. Having a single patient record would prevent that. It would also allow us to target resource and avoid that overlap and duplication. We would start to understand what each service is doing and able to offer. Again, that would improve timely access to the right care for children and young people at the right time.

On the second question, from my experience, cost and time become an obstruction. There is the cost of developing a new system, and the time that it takes to scope, procure and implement a system and agree which one meets everybody's needs. It is that whole process of getting to the point where all professionals are happy that the chosen system will do what it needs to do for everyone. Often, information sharing gets in the way. Who should have access to which part of the system? We seem to get stuck. As much as information sharing and data protection should be helping children and families, it often gets in the way. Also, who owns a record? Who has ultimate responsibility for the governance structure? Those can be barriers. We hear time and time again in practice that three, four, five or 10 years on we still have not got anywhere near to any kind of robust system, let alone a single patient record.

Genevieve Smyth: Having a single patient record will be a cornerstone of being able to deliver truly integrated care across health and social care. With 20% of the occupational therapy workforce in local authorities in the community, they cannot routinely or easily share information with their health colleagues, or vice versa, so connectivity between different types of electronic care records is extremely difficult.

We must address connectivity and content of the single patient care record at the same time. Currently, many systems do not routinely record anything about the social determinants of health, such as housing, education and employment, despite these being the biggest predictors of quality of life and life expectancy. Additionally, they often compartmentalise people, rather than being framed around person-centred practice, shared vision-making and what matters most to the person and their family and carers. The impact of illness, injury and disability on a person's everyday life and their rehabilitation goals is usually the very last question that gets asked rather than the central question that is recorded and shared.

Dr Lindsey Cherry: My answer is similar to those of my colleagues. Additionally, however, the podiatry workforce is shifting and working increasingly in the private sector, with only 40% of

podiatrists working in NHS practices. Our colleagues in the private sector are providing a vital role to supplement NHS services. At the moment, there is no way of us sharing and integrating the information that we are collecting about people and for people. Similarly, we are also seeing the growth of foot-health services in charity and voluntary sectors. Again, this is vital in supplementing the work of podiatrists in the NHS, but with no shared records at the moment.

Additionally, partly from my academic side, there is something very important about how data is recorded and used. We know that there are data coding errors. In primary care records, for example, you can find over 100 different data codes that might relate to foot pain and foot health. It means that the data is just not usable in any kind of public health setting.

We also know, in relation to this and building on what Genevieve was saying, that there are perhaps two different ways of looking at the records that we take. One is about recording a log of things that have happened or that need to happen. The alternate way of viewing records is that it is a person's own record of their health and healthcare plan, and it should be owned by them and travel with them to whichever healthcare professional they choose to access, whichever setting they want to access that in.

Lord Altrincham: That is helpful.

Q120 **Baroness Armstrong of Hill Top:** Good afternoon. I want to ask about your professions' experience of working with the new integrated care systems. Do you feel that you have the right opportunity in that new structure to participate in and influence the work of the people you represent, and for their work to be recognised? If not, what should be done?

Genevieve Smyth: Occupational therapists' current experience of ICSs is one of competing demands. This means that primary community social care and rehabilitation is, frankly, not at the forefront of consideration and planning. When other areas have stronger, clearer and more detailed plans, those are prioritised. The Government lack a detailed integration plan with the necessary funding.

Additionally, occupational therapists are far from being able to influence the integrated care boards, so an essential component of more integrated approaches will be occupational therapy and allied health professional leadership. RCOT wants occupational therapists to be supported in their leadership ambitions. A contribution to

system transformation could go a long way towards solving the integration challenges across health and social care.

Finally, we believe that all integrated care systems should have a rehabilitation lead, either an occupational therapist or another allied health professional. That would help to ensure that everyone who would benefit from rehabilitation receives it and that occupational therapy in rehabilitation is fully staffed and resourced.

Dr Lindsey Cherry: It is fair to say that we see a regional variation. In some areas, it comes down to personal relationships, and having a good advocate for the profession who can explain the potential benefits that podiatry can bring to the communities and how those roles might be integrated and clinically supervised, and what agenda they can contribute to. Sometimes a barrier is people not understanding the full scope of podiatry and how they can contribute to some of the wider agendas beyond the narrow view of foot health.

Podiatrists contribute to foot health and to physical activity in reducing the risk of cardiovascular disease, diabetes et cetera. Therefore, having good advocates for what the profession can bring and contribute is vital. In areas where we have those connections, we see incredible gains and good benefits. That is where we have seen those uptakes in posts and have started to see the workforce transformation happening.

Baroness Armstrong of Hill Top: We would appreciate examples of what you all think are good practice. If you want to give us examples of where it is not working too, that would be useful.

Sallyann Sutton: Again, it is variable across regions. Generally, at a local level it relies on relationships and connections to have any level of influence on ICSs or ICBs. Locally, decisions are made at a much higher strategic level. There is often little understanding of the role of the school nurse.

When there are any changes in policy, children and young people often come second to adults. This is where the role of professional organisations such as SAPHNA come in. We work with a range of charities and organisations that focus on the health and well-being of children and young people in order to influence more strategically as a collective. We have had some good results, not necessarily with ICBs but with other conversations, such as those on Core20PLUS5 and ensuring that children are accounted for in that policy area.

There are lots of missed opportunities for school nursing to voice how it contributes to the children and young people's agenda.

- Q121 **Baroness Barker:** Yours are all professions that people should be able to contact before they are ill and need to contact the NHS. Does that really happen and, when it does, how do you enable that contact to turn into something that leads to prevention, health promotion and so on? Can you give examples of that and of where you and your professional leads have been able to take the lead away from the NHS?

Dr Lindsey Cherry: I can give an example from our area. I am from the Hampshire and Isle of Wight region, Southampton. When we implemented podiatrists in primary care, initially we said, "Below the knee comes to me", because it had to be simple and understandable. We recognised early on that the scope of the podiatrist was poorly understood. Initially, we had a slow uptake. Now, we routinely see between 10% and 20% of all GP e-consults being triaged into podiatry FCP clinics. We are now significantly reducing the workload that is going directly to the GP.

We can also evidence that when those folk come through the door, we can get them expedited into the right services at the right time because the podiatrists are known to the secondary care community care teams. We have the connections and the points of contact. It is far easier to refer through pathways when you understand how they work and who is at the end of them. Personal relationships and clear pathways have made a difference to us in setting up and delivering this pathway.

However, we have also worked closely with our ICB to launch public health awareness. We have the "Ready Step Go" campaign, which is about upskilling the non-registered healthcare workforce in the early identification of foot health problems. We may be working with friends, family members, carers in a care home setting, where we are providing training and education to champions who then go on to provide training and education, so we are also supporting general awareness of the foot health prevention agenda, by not creating barriers.

One of the biggest changes that our profession has faced with that small number who have moved to primary care is that instead of working in secondary care, where we are specialists in a particular condition, in primary care you become specialists in people and the person. Community and secondary care models work on a referral and discharge basis. Primary care works on an open-door basis. That change in being able to welcome people back as and when they need us has also led to people who in other scenarios

frequently fail to attend appointments engaging with our services in primary care. We can demonstrate how, through our primary care service, we have prevented visits to A&E and unplanned surgery.

Genevieve Smyth: We have many examples of occupational therapists contributing to health promotion, early intervention and reduction of health inequalities, particularly, as my colleague has already mentioned, as part of the primary care MDT. For example, there are services in Sheffield that are using frailty indexes to identify people who are at risk of developing more serious frailty and offering home visits by occupational therapists to intervene early and to promote safety in the home and healthy ageing.

We have occupational therapists running vocational clinics in GPs' surgeries in Hackney, London, to stop people from falling out of work. When someone becomes unemployed, generally their use of healthcare increases. In Leeds, we have mental health occupational therapists in GPs' surgeries, supporting university students with mental health problems and ADHD to help them to stay on their courses and complete their education.

We have more mental health occupational therapists in youth centres in the north of England, teaching young people self-management techniques for mental distress, because the young people will not get help, even from a GP's surgery, because they do not trust them. Finally, we have social care occupational therapists in Kent running services via GPs' surgeries, to identify and address people's housing needs at an earlier stage. ICSs could scale-up these small pockets of local intervention and could help us to join the dots across these systems. However, to my knowledge, all these examples are happening without any intervention from ICSs at the moment.

Sallyann Sutton: School nursing delivers the healthy child programme. At its core, that is about universal reach, so that all children and young people have access to a school nursing service and are entitled to health reviews or contact with a health professional to discuss problems early.

We provide health education on a wide scale. We are an open access service, so no referral is needed. School nurses have been very good at embracing digital technology to increase accessibility and reach. Lots of school nursing services will use traditional methods, such as telephone calls and face-to-face contact, but they have also embraced text services, where a young person can text a school nurse.

We have parent text services, where a parent can have a text conversation with us, which can be anonymous if there is some level of fear about contacting a health professional. This allows us to build a relationship with them and gain their confidence. They will then usually disclose their name, which might lead to a face-to-face contact. We use a lot of websites, so we can direct parents to web services for information, as well as using a range of social media to access the various age groups. A lot of school nursing services embrace digital technology. This has definitely increased accessibility.

School nurses are also excellent and expert at building partnership relationships with schools, their partners in early health, social care, and with GPs. If a family approaches another professional with a health or well-being issue, they will direct those parents, or the children or young people themselves, to single points of access. Most school nursing services will have single points of access, so one front door. Once they have contacted us at the front door, we can often offer one-off advice. That can lead to a health review and a series of health interventions, or it can lead to signposting or referral to more specialist services. School nurses will be available at open days and parents' evenings to promote the role and increase the access to services, as well as being seen in school delivering drop-in and health education sessions to children and young people.

Children and young people tell us that it is about having that familiarity with the professional, getting to know and trust them and to know what they can do that promotes access to the service.

Q122 Lord Watts: This is probably an unfair question, and it is a difficult one, but I will ask it. What one change could the Government make to enable better integration of your discipline with the wider health service?

Genevieve Smyth: In addition to increasing the size of our workforce to address vacancy rates, we must make the most of the existing workforce. To do this, occupational therapists must be located where they can have the most impact and deliver earlier interventions in primary care and GP surgeries. Current examples of innovation are from Suffolk and Wales, which have developed more integrated approaches between primary and community care by realignment of the community occupational therapists to the GP surgeries. Although 90% of the public's contact with the NHS is via GPs' surgeries, 90% of the health workforce and funding is not there.

Additionally, where occupational therapists have been able to move directly into GPs' surgeries, fragile funding slows and destabilises progress. The contracting decisions for GP surgery funding exclude allied health professionals and, as far as I can tell, my nursing colleagues. We are not given the chance to influence the funding of our own services in primary care.

Lastly, pay, terms and conditions between primary and community care are different. Agenda for Change is not recognised in GP surgeries, which puts therapists off taking risks to innovate integration in primary care.

Dr Lindsey Cherry: We are a very small but mighty and vital profession. Our challenges are no different from the ones you have already heard. It is crucial that there is a clear strategic voice on the value and role of podiatry in an integrated service. The current workforce is working hard under a very narrow set of commissioning. This leads to a narrowing of our skill mix, a limiting of our professional scope of practice, and an attrition of our workforce into a private sector that is separated from our NHS health sector. Having that clear strategic voice underpinning the value and vision of how podiatry can contribute would be vital moving forward.

Sallyann Sutton: Again, we are a very small workforce. Our motto is "small and mighty". We are a local authority public health commissioned workforce that works with our colleagues in local authority social care and education, but equally with our colleagues in NHS-commissioned services. Looking at commissioning in a more robust way that seeks to commission one integrated system that can consider all factors governing local authorities and the NHS would be a good starting point. It would allow consideration of budgets and how they are spent, together with an appropriately funded workforce plan that considers training, recruitment, retention and pay.

The Chair: I thank you all very much for what you have told us. "Small but mighty" is how we might describe all the professions that we have heard from this afternoon. As you know, this is a public session. There will be a transcript which you can comment on. I urge you, if you have any further information or examples that would be useful to the committee, to share them with us. We would be anxious to read them and to feed them into our report, which is due by the end of the year. In the meantime, on behalf of the committee, I thank you all very much for your evidence today.