



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 5 June 2023

3.05 pm

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

Evidence Session No. 15

Heard in Public

Questions 142 – 155

Witnesses

I: Dr Edward Scully, Director, Primary and Community Health, Department for Health and Social Care; Mark Joannides, Deputy Director, General Practice, Department for Health and Social Care; Jason Yiannikkou, Director, Systems, Integration and Reform at Department for Health and Social Care; Helen Causley, Deputy Director, Community Health Care, Department for Health and Social Care.

Examination of witnesses

Dr Edward Scully, Mark Joannides, Jason Yiannikkou and Helen Causley.

Q142 The Chair: Good afternoon and welcome to the Integration of Primary and Community Care Committee. Most of the members are here in the room with us, as are our witnesses. Lady Tyler is online. We have apologies from Lady Finlay, and Lord Kakkar will join us shortly.

Our witnesses are all Department of Health and Social Care officials. Dr Edward Scully is a director, as is Jason Yiannikkou. Mark Joannides and Helen Causley are not the subject of questions but will be there, we hope, to provide answers. As you know, this session is being recorded and we will take it in turns to ask you questions. I have asked the panel to make their questions precise, and we would very much appreciate precise answers from you.

Mr Yiannikkou, could you please describe your remit in the DHSC, especially how it relates to integration and the policy framework for integration? We are particularly interested in where responsibility lies for integration policy between your department and the National Health Service.

Jason Yiannikkou: I am the director for systems integration and reform in the department. My team covers quite a few things. With regard to integration, we, with NHS England colleagues, helped to develop the legal framework that was taken through the Health and Social Care Act last year. We, alongside others, also work to support systems to develop and improve over time. There is a lot to unpack there, but I am sure we will come on to some of it later.

I will have a go at describing the policy framework. Perhaps the place to start is demography, and I know that previous witnesses have given evidence on this too. In many ways, the policy framework is perhaps best seen as a response to the challenges of demography that we have experienced for a number of years, are living through now and will face as we go into the future.

I will not say a huge amount about all that, except to say that, as you will know, our population, which is living longer, is increasingly experiencing multimorbidity, throughout the life course but particularly in later life. Our services are adapting in response, and part of the point of the framework that we set up through the Health and Care Act was to support organisations in the health and care system to collaborate more closely. That, if you like, is what lies behind it. I can say a bit more about ICBs and ICPs, if that is helpful.

The Chair: We will come on to that.

Jason Yiannikou: I will say a bit about us and NHS England. We work closely with NHS England and have done so from the inception of the policy framework, and we both work closely with the systems themselves. We have distinct responsibilities. NHS England is perhaps more focused on integrated care boards. On the NHS side, the money and accountability flow down through NHS England to ICBs. We, as the department, are focused on health and care but also on wider government, so we tend to focus a bit more on the integrated care partnerships, the ICPs. We produce the guidance for ICPs, and NHS England produces the guidance for ICBs. We make sure that we are consistent with each other and check with each other as we develop our work.

Q143 The Chair: The committee has found a bit of vagueness about accountability for integration between departments. Could you say a bit more about where the accountability for integration is between your department and the NHS, and the voluntary sector, which provides a lot of community services?

Jason Yiannikou: It might be worth going back to the legislation to sketch out some of this for you. When we reframed the legislation we were mindful of the interdependence between health and social care and of the need for organisations locally to work together. We got the message loud and clear from many quarters that a massive structural upheaval, a top-down reorganisation on a grand scale, was not what people were looking for.

In effect, we tried to construct an accountability framework that worked within some of the formal accountabilities for local government and for the NHS nationally but which also brought partners together to work together.

Within that framework I would draw attention to the planning requirements on systems. There is the integrated care strategy which the ICP is asked to pull together and which over time becomes a big focal point for accountability in the round. There is also the joint forward plan that ICBs pull together, which is more of an in-year plan on the NHS side but which also links to other things. On the NHS side in particular, the day-to-day accountability is discharged through the NHS oversight framework, which NHS England produces. It is structured around a series of metrics, and each ICB, and indeed each provider organisation, is segmented against those measurements in a one-to-four category.

So there is a mixture of vertical accountability up to NHS England on the NHS side, and accountability between partners in localities and systems. Those two things complement each other but cannot be expressed in terms of each other directly.

Q144 **The Chair:** If I were to ask you who was personally responsible in central government for integration between the service, which person would that be?

Jason Yiannikou: On the ministerial side, the Minister for Integration is Helen Whately. The senior official responsible is me.

Q145 **Baroness Osamor:** The Hewitt review was published two months ago. Will a government response be published before the committee finalises its report in November?

Jason Yiannikou: That is ultimately a matter for Ministers to decide, but I am reasonably confident that we will be able to publish a response before then.

Q146 **Baroness Osamor:** How would you describe the current balance between autonomy and accountability within ICS structures?

Jason Yiannikou: This is one of the perennial issues that we face in the system and have faced for some years. The review talked about the importance of recognising that you can have high autonomy and high accountability. Those two things are not necessarily at odds with each other.

The interdependence between the different parts of the system is a stronger feature of the challenge we now face, particularly with regard to the demography, as I emphasised earlier. Organisational autonomy is perhaps less important than organisational collaboration and interdependence than it was.

There is also an issue, which I think you were getting at, between the centre, or the national part, of the system, the systems themselves and localities, and the extent to which we constrain what can be done at system and local level by the things we ask of them. Again, that is a long-standing debate.

We have tried, and NHS England has tried, to be focused in the things we ask of systems. The planning guidance issued by NHS England in December was a conscious attempt—it said as much at the time—to be focused and clear about what it was asking for from the centre, precisely because, as someone from one of the systems once said, if you have seen one integrated care system, you have seen one integrated care system. They are all different—they have different populations, needs and strategies—so giving them some room is an important imperative in the way we work now.

Baroness Armstrong of Hill Top: Primary care networks were meant to be a developmental means of working towards integration. What have you learned from primary care networks?

Do you feel that they have been successful or not successful, given that the public feel that access to primary care is worse now than they have known?

The Chair: Can we also take a question from Baroness Tyler?

Baroness Tyler of Enfield: I want to pursue the question of accountability. I was intrigued by your explanation that, in accountability terms, the department was looking at the work of the ICPs while NHS England was looking at ICBs. I had thought that the integrated care systems, with their two component parts—the board and the partnerships—were one entity. Does this split accountability that you describe coming down from the department and then NHS England make accountability more diffuse, particularly when you have a plethora of other bodies as part of the overall architecture?

The Chair: We have lots of alphabets here—PCNs, ICBs and ICSs.

Jason Yiannikou: We always have three-letter acronyms. I might come to the second question first and then turn to Ed on PCNs.

I am glad you asked me this, because it would probably not be helpful if I implied that we are interested only in ICPs from where we sit. We are very much interested in ICBs as well. Ministers have been meeting ICB chief executives and chairs in recent months and are just now embarking on a second round of conversations with them. It is more about where formal accountabilities tend to flow, but of course NHS England is accountable to the department. In that sense, all those accountabilities converge on the department and then on into Parliament.

The Chair: And what about the PCN question?

Dr Edward Scully: On PCNs, you are right. Almost the first line of the long-term plan in 2019 talks about PCNs. One of the big upticks is that we can finally break the divide between primary and community healthcare. Multidisciplinary working has been happening in general practice for years. There are all sorts of different kinds of staff. We have funded additional staff to go in, and we have just hit the figure of 29,000. We have probably learned that we may need to invest more in some of the organisational development to help to bring primary and community healthcare together.

The Claire Fuller stocktake builds on the primary care network footprint and suggests that that is the basis from which teams should emerge. When I go around the country and speak to teams

about how they are building their local integrated neighbourhood teams, I find that they are doing it on a primary care network footprint. So I think the basis is there for them and the staff are there, but honestly we could have done more. We should have thought more about the organisational development and how to bring all the different sectors together in doing it. We need to learn about that for the future.

Baroness Armstrong of Hill Top: And when do you expect everywhere in the country to be covered?

Dr Edward Scully: By a primary care network?

The Chair: By an integrated neighbourhood approach, given that PCNs are meant to be merging into that next year.

Dr Edward Scully: Analysis done by NHS England, which is still being validated—we will write to you when we have the results—suggests that it is virtually there. All the areas I have spoken to all over the country say that they are developing it on the basis of integrated network teams. My take on all the visits I have done is that it is pretty much universally there, but I can't say categorically about the numbers for a couple of weeks. It is pretty close, judging by all the areas I have spoken to.

The Chair: The committee would be very glad to have any further information that you have on that.

Dr Edward Scully: As soon as we have it, we will write to you.

Q147 **Baroness Wyld:** This question is for Mr Yiannikou. I return to the Hewitt review of funding and what she says about prevention. You will be well aware that she says in the report that funding to ICSs with regard to prevention should increase by 1% over the next five years. I appreciate that the response is yet to be published and you may want to dismiss the recommendation, but, assuming that the principle were accepted, have you thought about how you might mandate that? We have touched on the tension between the centre and localities, but you may want to reflect on that as well.

Jason Yiannikou: As you rightly say, the response is currently with Ministers for consideration. Stepping back a bit and looking at the issue more generally, I can say a couple of things. The first is that the bringing together of partners to think about things up stream is central to the policy intent behind integrated care systems, not least because even in the most acute bits of the system there is a recognition that, unless some of that is tackled, some of the problems, issues and pressures being faced at the moment will continue. So that is definitely designed in, as it were.

Secondly, on the particular question of prevention, percentages and so on, there is a further question about how you define prevention. Work that we have done recently on the major conditions strategy—with prevention colleagues in OHID, as it happens—brought that home to me. Once you start looking for prevention, you can see it everywhere. It is often about building resilience through life as much as it is about some of the things that are often labelled as primary prevention.

So there is probably some analytical thinking to be done on that issue, irrespective of where we get to on that recommendation. That is certainly something that we want to see systems pursuing in relation to our population need and demographic position, and in the overall policy intent and design.

Baroness Wyld: I will allow you your caveat about the response, because I know it is tricky. Where you have seen good practice—you have just cited some—is there a case to mandate those increases?

Jason Yiannikou: Where we have seen good practice, it will have been in cases where we have not mandated it. Again, the guiding thought behind a lot of what we are trying to do is about getting to a learning system made up of learning systems where some of that is transferred laterally.

There is always a balance between the things we standardise and mandate centrally and the things we leave open for others to find their way towards. Sometimes we try to mandate the outcome but allow people to find their own way of getting there and then share how they got there.

That is probably where we would be inclined to go, but of course there is then the question of how quickly you can get there. One of the medium-term challenges that we need to think about, along with NHS England colleagues and others—the NHS Confederation is looking at this as well—is how we can transmit some of that good practice between partners. One of the advantages of ICSs, even if this sounds odd, is that there are 42 of them, rather than 100 or 200 as we had with CCGs. That makes it slightly easier, because you can get people together in a smaller space to do some of that.

Lord Watts: The NHS and local government are under tremendous pressure on their budgets. Unless you mandate, is there not the possibility that bigger animals will just grab every bit of resource that is available in the NHS? Will you not need to have a mandate if you are going to transfer money from one section to another?

Jason Yiannikou: That is one perspective. I suppose the issue is that if you start mandating on one front and then mandate on another, you end up with a lot of competing mandates and effectively transmit the difficulty out into the system in a different way. Some of this might be about trying to make the cost-effectiveness case based on lived examples as well as the health-outcomes case.

Q148 **Baroness Redfern:** For the first part of my question, I would like to ask Dr Scully about the physical co-location of primary and community services. How has it improved patient access? Could you give examples?

Dr Edward Scully: Yes, I can. The first thing to say about co-location is that it is not always entirely necessary. When I go to areas and ask, "Do you find it helpful to be together?", some areas have said, "We don't think so". Manchester sticks out in my head. I remember them saying to me, "We developed lots of ways of working together virtually through really good tech during Covid and we have built on that, so we do not think we need to co-locate any more". Virtual wards are a very good example of that. They emerged during Covid, and if you watch them in action you see that they are brilliant things. People attend them using tablets with all the different services going on, and it is a great way of integrating.

Baroness Redfern: Has that been extended?

Dr Edward Scully: Some areas have said to me, "We don't need to be co-located. We think we can do well without it". My personal take is that when you are co-located, it really adds value.

Baroness Redfern: Who says not?

Dr Edward Scully: I was talking to some GPs and community health nurses in Manchester about this. Those are the ones that I can remember off the top of my head. I remember that, because it was quite a surprise.

Baroness Redfern: It would be interesting to know who.¹

¹ This visit to Trafford Local Care Organisation and Manchester Local Care Organisation happened on 14th April 2023 and Ed met with Rob Bellingham, Director of Primary Care and Strategic Commissioning, NHS Greater Manchester and Dr Sohail Munshi B.E.M CMO, Director of Clinical Integration, NHS England. Discussions on the day included GP Access, how Integrated Neighbourhood Teams and Health Development Coordinators support GP practices and population health, examples of collaboration in past year and the Additional Roles Reimbursement Scheme.

Dr Edward Scully: As I say, my personal take is that it really adds something when you are co-located. Literally the best example I have ever seen of the integration of primary and community healthcare is in Hull. The Hull community health partnership became a community interest company, which means that it can hold the contract. It runs eight GP practices and has four pharmacies and four care homes, all under the chief exec in Hull.

The best example I have seen of an actual centre is the Jean Bishop Integrated Care Centre up there. It is a really nice building—it was built only in 2018—and it targets care at the 12,000 frail and elderly people who they think are most vulnerable to going into hospital. Because they are under the same physical roof and one organisational roof, they work together seamlessly. There are all sorts of different professionals there who you do not normally get in the same building: geriatricians, advanced nurse practitioners, community and district nurses, GPs and pharmacies. It has got really good results and has the best evidence I have heard on reducing admissions. For that cohort of 12,000 elderly people, they have reduced hospital admissions by 15%. That is a really good example of when you are one organisation and under one roof you get a team ethos. You can feel that as you go in. I thought it made a bit of a difference. As I say, though, in Manchester they told me that they did not think you needed to co-locate and that you could do it with technology.

Baroness Redfern: So some GPs are against integration and some are for it. That is what you are saying, is it not?

Dr Edward Scully: I am not sure about that. I think that is more specifically about co-location. I cannot remember any GPs saying to me specifically, “We don’t want to work with community health services”.

The Chair: They would hardly say that to you, would they?

Dr Edward Scully: Probably not, no.

Baroness Armstrong of Hill Top: That is not an NHS building, is it?

Dr Edward Scully: It was funded by the CCG in 2018.

Baroness Armstrong of Hill Top: I thought it was more independent than that.

Dr Edward Scully: No, it was funded by the CCG. The Hull community health partnership spun out of the NHS in 2018.

Baroness Armstrong of Hill Top: I have seen it.

Dr Edward Scully: Have you seen it? It is really good. The health partnership spun out and became a community interest company.

Q149 **Baroness Redfern:** The second part of my question is to Mr Yiannikkou. When did you recognise the problem of the primary care estate as a limiting issue on integration, and what is the department going to do to address it? Is there an annual update of the estate?

Jason Yiannikkou: I might turn to Ed on estates.

Dr Edward Scully: I understand that there is an annual update to NHS England from every ICB on estates.

On the first part of your question, we recognise that there is a huge variety in GP premises because there is such a range of different ownership models. Some 50% are owned by GPs, 25% are third party-owned, and 20% or so are owned by the department, community health partnerships and other organisations². So there is a variety of different state premises, and we recognise that.

There have been four changes in what has been done recently on estates.

Baroness Redfern: Who makes that decision about the estate?

Dr Edward Scully: Those decisions have now all been delegated to ICBs.

Baroness Redfern: And the ICBs report to whom?

Dr Edward Scully: NHS England.

The Chair: You said that you have four points.

Dr Edward Scully: I will go through them quickly. First, you talked about strategic estates planning. That has all been delegated to ICSs. Secondly, there used to be different flows of money for hospitals, community health and GPs. That has all been brought together in one pot in that delegation process. Thirdly, with regard to the £4 billion³, ICSs now have to come up with capital and estates priorities and send them up to NHS England, saying what they want to spend their money on. Lastly, we talked about the

² 49% of general practice premises in England are owned by GPs, 35% owned by a third party, and 14% owned by NHS Property Services.

³ Around £4bn per annum capital funding has been delegated to ICSs to support their capital priorities from estate maintenance and new build, purchase of clinical equipment through to investment in digital technology.

one-year reports, but they have now been asked to do long-term plans over this year. So, all ICSs are now required to have a five-year plan on what they will do with their capital and estates.

Q150 Baroness Shephard of Northwold: My question is for Dr Scully and is about digital integration. We have had a lot of evidence from a number of witnesses in earlier sessions about a lack of what they call interoperability and digital integration, and how difficult that makes it for different services to work together. This is at a time when you are trying to reintroduce things anyway, service by service, so we have a lot of sympathy for the difficulties that might be being experienced.

I am sure you recognise the problem, but we would like to know how important a constraint it is. If it is a constraint, what is being done by the department to try to address it? We understand sensibilities about sharing information, confidentiality and all that stuff, and it is highly difficult, but clearly some places are doing better than others. Could you fill us in on all that?

Dr Edward Scully: Effective interoperability is without doubt a key foundation for integrated working and doing it differently. There are three or four things that I would like to say. The key strategy for the Government and NHS England is shared care records. That is a programme that has been running for a couple of years. The Government's data strategy last year, *Data Saves Lives*, set out the ambition that all areas will be able to have full access to everyone's records via shared care records by March 2025.⁴

Baroness Shephard of Northwold: When you say shared care records, what is the span of that, or will you come to that?

Dr Edward Scully: It is the lot. Shared care records are a secure way of bringing all the separate health records together in one place. It joins up patient-based information around the patient rather than around the organisation. It is a hub record that all the other records can dock into. All ICSs were required to have a basic shared care record by last year.⁵ As I say, the Government's commitment is that everywhere will have a shared care record fully that brings all those records in by 2025.⁶

Baroness Shephard of Northwold: Is this for the care sector as

⁴ Commitment set out in *A Plan for Digital Health and Social Care* (June 2022) is to "roll out integrated health and care records to all people, providing a functionally single health and care record that people, their carers, and care teams can all safely access, enabled by a combination of nationally held summary data and links to locally held records, including shared care records (by 2024)"

⁵ As of March 2022, 100% of ICSs had a Shared Care Record in place.

⁶ See footnote 4.

well as the NHS?

Dr Edward Scully: Yes. Off the top of my head, 60% of local authorities that provide social care use them at the moment.⁷

Baroness Shephard of Northwold: Did I break your flow?

Dr Edward Scully: You did, but it is all right; I will carry on. I have read the transcripts of some of the previous sessions and you are right: the picture is mixed across the country. Some areas are really good when it comes to doing this. On the shared care record programme, there are a number of exemplars that are the real frontrunners. Leeds was a really good one, and that has now been spread out to the rest of Yorkshire and the Humber. London is the same across all the ICBs.

It is not a one-size-fits-all solution for all the ICBs. They were given funding to develop their own shared care records, but some of them have done it collaboratively with other ICBs, while others have done it on their own.

We talked about Hull. Hull is probably the best place I have seen for interoperability, not because they are using shared care records but because they all come in under one organisation and all use the same system—I think it is SystmOne. They all share records. When I went around Hull, the palliative care nurses and the district nurses had access to each other's records, so they had full interoperability without shared care records.

Baroness Shephard of Northwold: All the examples you have given us have been urban ones.

Dr Edward Scully: Okay.

Baroness Shephard of Northwold: Have you any comment to make on that?

Dr Edward Scully: The examples I have given off the top of my head are the best ones, but I have been to rural places as well. I suspect that is a reflection of how it can be more difficult in rural areas. Having said that, one of the best modern GP practices I have seen is a really rural one in Stow, Suffolk, which has a brilliantly modern GP approach and work well with other bits of the service. So there are rural ones too, but the urban ones happen to be the best ones I have seen and know about.

Q151 **Baroness Shephard of Northwold:** Colleagues in all the services

⁷ More than 50% of care providers currently have a digital social care record. To note, these are distinct from Shared Care Records.

are terrifically cautious about what they would perceive as risks about data sharing. Is that one of the constraints? I think we would all understand that.

Dr Edward Scully: That is a good point. There is a bit of a culture of that. Everyone is cognisant of the Data Protection Act. Rightly, data privacy and protection are important to the Government—I know it is important to everyone. The 2022 Act,⁸ which Jason led on, tried to bring a bit of parity with the importance of sharing. Under the previous legislation, health bodies had to consider sharing records and information. That moved up to become a requirement in the 2022 Act, but culture and behaviour take a bit of time to follow on from legal changes. I know the joint digital policy unit has been doing lots of engagement across the department and NHS England. It has produced an information governance toolkit for primary and community care and is doing a lot of work with the sector, but I think you are right: culture probably lags behind legal changes.

Q152 **Baroness Tyler of Enfield:** The committee is aware of the department's primary care recovery plan, which is obviously trying to make it easier for people to access GP appointments. In that plan, there is a noticeably bigger role for pharmacies in primary care pathways. First, how do you intend to ensure that pharmacies have sufficient staff with the right skills and the financial resources to take on this increased responsibility?

Dr Edward Scully: Again, I think that is for me to answer. For a bit of context, as you know, community pharmacies are private businesses that provide pharmaceutical services. As private businesses, they are the ones responsible for staffing their business.

I have three or four points to make about how we will support them, if that is okay. First, as part of the primary care recovery plan, £645 million was announced as new money for pharmacies and for primary care in order to pay for it. Under those plans, pharmacies will be able to supply medicines that previously only GPs could prescribe, for seven different services: sore throats, ear pain, sinusitis, shingles, impetigo, insect bites and urinary tract infections. These are brand-new services. Currently, I think, only two bits of the country do it, Liverpool and bits of Cornwall, so for the rest of the country this is brand new.

⁸ The duty to share information to support the provision of care to individuals (section 251B of the Health and Social Care Act 2012) was in fact introduced by the Health and Social Care (Quality and Safety) Act 2015

We have just started negotiations with the pharmacy sector, part of which are about how we can ensure that the majority of that £645 million goes to help them to get the staff and people they need. When I went to Liverpool and talked to them about what they had done and how they had done it, they said, “We need more money to pay for people to be able to do this”, so that is what we have done. So that £645 million covers an 18-month period from the end of this year.

Secondly, a number of investments and changes to training have been made to help pharmacy staff to do this. From 2026, all pharmacy graduates will have prescribing powers. Only about 10% of pharmacists have prescribing powers at the moment, so that will be quite a big change. We are also training about 3,000 pharmacists this year to become independent prescribers, so that will have more skills around it. NHS England has recently announced a new clinical examination skills training, so pharmacists who have not done all this examination stuff in the past few years will get refreshers. That is a £16 million programme.

Lastly, we are changing some legislation to enable pharmacy technicians to do more. We are changing the supervision legislation and other legislation on the automation of dispensing processes so that we can free staff up to focus on this new approach.

Baroness Tyler of Enfield: I recently had occasion to go into a pharmacy and ask for advice on a specific issue. I was not speaking to the pharmacist; it was someone at the counter. To my surprise—I was very pleased—she took me into a side room, took my blood pressure, gave me some advice on medication and then said that she had been on a training course to diagnose skin cancer. Given that she was not the pharmacist, that quite surprised me. Who is paying for all this training of existing staff?

The Chair: Just before you answer that, Baroness Barker would also like to ask a question.

Baroness Barker: Something that surprised me was that in the recovery for general practice plan there seems to be little acknowledgment of duplication. Audiologists and opticians are also private practitioners, but they work to specific service specifications and so on. If you have a test at Boots for your hearing or something, you are referred via your GP to the NHS, which conducts exactly the same tests all over again. Just as you went through a process of trying to work out how pharmacists could do this by tackling the fundamental problem of data sharing, why is that not being done—or is all this skating around the central problem of data sharing that continues to exist?

Dr Edward Scully: I will go to that question first. On audiology, another part of the primary care recovery plan says that we will introduce a new approach where you can self-refer and will not need to go to your GP to go to NHS audiology services.

I do not think it is about skating around the interoperability issues. Everyone knows that it is a serious issue and that we are not quite there on it yet. Lots of investment is going into trying to overcome that. There is another commitment that every trust will have electronic patient records as well as everyone having access to shared care records. There is a real push on that. So I do not think we are skirting around the issue.

The Chair: What about the question about who is paying for the training?

Dr Edward Scully: NHS England is putting £15.9 million into the skills training. I had not heard about the training for skin cancer, but it is my understanding that it is all from NHS England.

Baroness Tyler of Enfield: And that is directed not just at the actual pharmacists but at technicians and other staff.

Dr Edward Scully: Yes, and part of the legislation that is going through will enable those pharmacy technicians to supply prescription-only medicines for the conditions that I talked about earlier. We are not there yet with that; we have to make legislative changes in order for that to happen.

Q153 **Lord Watts:** First, many of our witnesses have expressed concern about the shortage of staff and the impact that has on limiting integration between primary and community health services and social services. What is the department doing to address that problem? Secondly, we have heard that integration is being limited by the fact that clinicians are often not aware of what other NHS staff do. What is the department doing to address that shortfall too?

Dr Edward Scully: I will answer both of those. I will break my answer down into the GP bit and the nurse bit. GP workforce shortages are recognised by the Government. Various bits of action have been tried to be taken over the last few years.

We talked earlier about primary care networks. One key thing to talk about is the additional roles reimbursement scheme, which pays for additional staff to work with GPs. We have just hit 29,000 of those. The percentage of appointments that are not being done by GPs is gradually increasing. Only 47% of appointments in general practice are done by GPs at the moment; the rest are done

by the wider multidisciplinary team. So there is starting to be a bit of an impact from that.

We are trying to do a lot on retention and training. The number one thing that GPs have told us would improve retention is changes to the pension rules, which the Chancellor did earlier this year. Whenever we spoke to them, they always said that the annual allowance was the biggest factor. The very early average retirement age for a GP has gone down from 58 to 57⁹, and it is at that point that the annual allowance starts to kick in.

We have done a big thing on training. The number of GP training places has gone up from 2,671 in 2016 to 4,032 this year¹⁰. Those are the kinds of things we have tried to do on GPs, but we know that we have to go further. In the primary care recovery plan we tried to reduce the amount of bureaucracy that GPs have, because they tell us that they just have too much of it. That is one of the things that we really want to do.

Lord Watts: How much of a problem has been created by the lack of progress on coming forward with an NHS workforce plan?

Dr Edward Scully: I can talk a bit about that afterwards, if that is helpful.

Lord Watts: Some of my colleagues might want to talk about that later, but it would be helpful at some stage.

Dr Edward Scully: I can talk about that, for sure.

The Chair: When will we see it?

Dr Edward Scully: Shortly.

Baroness Armstrong of Hill Top: We have been hearing that for two years.

Dr Edward Scully: It will be shortly.

Lord Watts: And will all your systems be fed into that staffing? It is all right having these ambitions but, unless you have the staff to deliver, it will be a problem.

Dr Edward Scully: Agreed. The long-term workforce plan will look at five years, 10 years and 15 years, and it will have the anticipated requirements for expanding education and training for GPs, district and community nurses, and pharmacists.

⁹ The very early average retirement age for a GP is around **58**.

¹⁰ **Last year**, we saw the highest ever number of doctors accepting a place on GP training - a record 4,032 trainees, up from 2,671 in **2014**.

The Chair: We shall look forward to that with great eagerness.

Baroness Redfern: I see there has been a drop of 500 in the number of full-time GPs. Has there been an increase in the number of part-time GPs?

Dr Edward Scully: Since March 2019 there has been an increase of 1,903 in the number of GPs.

Baroness Redfern: So there has been an increase in the number of part-time GPs.

Dr Edward Scully: Between March 2022 and March 2023 there were 503 more doctors in general practice¹¹, and from the baseline, which I think is March 2019, there are now 1,903 more doctors in general practice.

Baroness Redfern: So that has been increasing. Okay, thank you.

Q154 **Lord Kakkar:** The purpose of this committee, as you will be aware, is to consider questions of integration of primary and community care. How does the department identify potential barriers to proper integration, and how does it mitigate against them?

Dr Edward Scully: It is through constant dialogue with the systems. You have hit the nail on the head.

Jason Yiannikou: Ed is right. One of the things we are trying to do in the way we operate now is to speak much more with systems rather than to them, if you like. I have gleaned from looking at the transcripts of some of your previous hearings that one of the biggest barriers to integration, some of which you have touched on today, is trust and relationships between different organisations, different professions and different people who we need to work together more closely. That might sound a bit soft, but it is really important.

We as a team had an interesting session with someone from the West Yorkshire and Harrogate Partnership, which is one of the leading ICSs, who told us many things, one of which really stuck. A watchword of theirs is that real change comes through doing real work. Getting partners and members of multidisciplinary teams to do things together is often the best way of making change happen, rather than thinking about governance and other abstract things, important though that is.

¹¹ Between March 2022 and March 2023 there were **440 more full time equivalent doctors in general practice.**

There are also practical barriers to integration, as we have touched on today. Data is one; we have been through that a fair bit. Workforce is another; again, we have touched on that. The numbers are another, of course, but there is also the design of roles and the development of career structures that allow people to move into different settings over the whole of their career and not just to be siloed where they started. Then there is money and how that works, such as budget pooling and whether we can support that to be done better.

There are practical things that we can help with a bit in government, but, to go back to where Ed helpfully started, we need to be in constant dialogue with the systems to understand not just where we think the barriers are but where they are finding them.

Lord Kakkar: You mentioned, quite rightly, three principal areas: data, individual careers over a lifetime of contribution and service, and financial flows and money. Do you have a systematic way in the department of identifying issues in those areas, and potentially in others, and how is that then shared more broadly with the system?

Jason Yiannikou: It is a combination of things, really. You can apply different lenses to get to some of these problems. I would make a big plea for talking to people. That is an underestimated technology that stands us in good stead. We can also look at data and work back from that. Some of the forensic work that our analytical colleagues do to support some of our policy work will help us to come to answers. We will obviously look at reports such as the one this committee, think tanks and others will produce to tee up some of those questions for us. I would not want to confine it to one particular lens or methodology.

Q155 **Lord Kakkar:** I turn to the question of data, which has been covered extensively. Do you think that the legislation as it exists—we heard mention of the Health and Care Act 2022, and we have the data protection regulations and Acts—sit well with each other in such a way that we can ensure that there is proper data sharing for the benefits of our citizens when it comes to integration of primary and community care services?

Jason Yiannikou: That is a good question. We want to affirm the importance and relevance of both. In effect, they embody a tension that has to be lived with in the system between protecting individual data and ensuring that the data flows into the right places to improve care outcomes. To return to a phrase that we have used before, the importance of maintaining public trust on these issues has been at the top of the minds of people who work

on this more directly. We have to live with both those aims rather than necessarily trying to tilt towards one at the expense of the other.

The Chair: There are three questions that we will take together.

Lord Altrincham: Following Lord Kakkar's question, does the department specifically track areas that are not integrated, or do you find that everything, from your seat, is somewhat integrated and you are trying to improve them? Do you see complete blackspots, like the ones we have heard about through our hearings, or do you not see that on the whole? Do you tend to see everything more or less working on PCNs and more or less integrated?

Baroness Armstrong of Hill Top: What levers do you now have to enable and encourage change? People have said that all they have left now is shouting at people.

Lord Watts: I am confused about what you say about it being ideal if all these services are located in one place. At the moment, GPs, for example, can buy a place and locate a pharmacy and other health services on it, and they can pay for that with the money they get from the NHS. After 20 years, the GP owns that building. How does the NHS continue its progress if it does not own the building? Does it need to refinance the same £1 million building that it has already financed, or is there another plan?

The Chair: There are three questions there. I would be grateful for your answers.

Jason Yiannikou: I will just remind you that the third one is for Ed. I hope Ed agrees. I will take the first two.

On the question of tracking what is not integrated, it is perhaps not as systematic as your question implies, but there are a couple of things to mention. We have not yet mentioned today the work that the CQC will do to review systems, which perhaps will give the most comprehensive sense of how well integration is proceeding in a given area.

We know that integration is most difficult and, in some ways, most needed in areas of transition where people can fall between two services. The physical needs of people with learning disabilities, for example, often involve quite a lot of services working together, and a lot of conscious thought and effort is needed to make that work well. There are well-known areas of vulnerability within systems that we can focus on and will look at.

On the question of levers, in some ways one purpose of the legislative framework is to bring people together—a bit like us in this room—to confront difficult issues. Bringing them together will not, in and of itself, solve those issues, but it puts them in the position of having at least to come up with a shared plan and to say how well it is delivering against the framework. There are more direct regulatory forms of intervention that apply to particular organisations. Duties to co-operate have been put into the legislation. I wouldn't want to **overegg** how important the duty to cooperate is when things are difficult. There is a combination of hard and soft levers.

So there is a combination of hard and soft levers. In many ways, we have constructed the system in a way that asks those within systems to take responsibility and to have—to use a term that some of your previous witnesses have used—mutual accountability. I know that can sound a bit soft, but, as has been described back to me by people, including acute chief executives, working in systems, it can feel very real. Some of the national accountability can feel more distant than your partners looking you in the eye and saying, “You haven’t delivered on the thing you said you’d deliver on”. I am not saying it is easy, but it can be quite powerful.

Dr Edward Scully: The GP ownership of premises is tied up with the partnership model. A review of premises a couple of years ago asked whether we should be looking at models that separate out premises. We are now in the last year of a five-year GP contract, so we will consult over the summer on possible changes to the contract—Scotland, for example, has a different system for property—and gather views on the next contract.

Lord Watts: If the GP does not want to sell that property back to the NHS because he owns it, you will have to find another location and start building your services again, will you not?

Dr Edward Scully: The valuation of the property owned by GPs is in the region of £6 billion. It is quite a hefty property portfolio. I would say that 50% of all 6,500¹² practices are owned by GPs. Mark, do you have any thoughts on this?

Mr Mark Joannides: I think there are 8,900 buildings across 6,500 practices¹³, and it is very much a mixed economy. Some of those are purpose-built facilities, and some are converted houses.

¹² It is difficult to get an accurate picture of how many practices are currently active in the UK. From the appointments in general practice data, the number is 6,440. Meanwhile, the latest GP workforce data says there are 6,376. Therefore, we would stick with there being around 6,400 practices.

¹³ See above.

As Ed said, we have come to the end of the five-year deal and are looking at the next five-year deal. Consideration of what the future estate looks like and how it is comprised has to be a priority. It is clear that there is no silver bullet for that, and I think we will continue with some form of mixed economy, because, as you rightly say, there is already significant investment there by GP partners.

The Chair: Thank you very much to our witnesses and members of the committee. We have been seeking to have you before us for some time, as you know, and we are very grateful for your time. Of great concern to this committee is the whole area of accountability for integration, and I hope we feel somewhat clearer about that from your evidence this afternoon. As you know, this was a public session and there will be a transcript, which you will be able to correct for transcript errors only. If there is anything further that you think would be of benefit to the committee—you have mentioned a couple of things—we would be very pleased to receive them.