



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 5 June 2023

4.05 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. 16

Heard in Public

Questions 156 – 164

Witnesses

I: Professor Kath Checkland, Professor of Health Policy and Primary Care Health Organisation, Policy and Economics Research Group, Centre for Primary Care & HSR Division of Population Health, HSR and Primary Care, University of Manchester; Dr Jane Harvey, Clinical Director, Hyde Primary Care Network, and General Practitioner Principal and Partner, Dukinfield Medical Practice; Sian Thomas, Deputy COO, Division 3, Royal Wolverhampton NHS Trust and Partnership Director at OneWolverhampton,.

Examination of witnesses

Professor Kath Checkland, Dr Jane Harvey and Sian Thomas.

Q156 The Chair: Good afternoon and welcome to this session of the Integration of Primary and Community Care Committee. We are very pleased to have with us in the room as witnesses Professor Kath Checkland, professor of health policy and primary care at the University of Manchester, and Dr Jane Harvey, clinical director of the Hyde Primary Care Network. Online, we have Sian Thomas, chief operating officer at the Royal Wolverhampton NHS Trust. As you know, this session will be recorded and all my colleagues will take it in turn to ask you questions. One of our members, Baroness Tyler, is online.

Professor Checkland, what is the evidential basis for the efficacy of multidisciplinary working, which this committee is very much concerned with, in particular the effect it has on the outcomes of both health and care?

Professor Kath Checkland: That is an interesting question. It depends on what you want multidisciplinary team working to achieve. There is fairly good evidence that it improves patients' experience of services but very little evidence that it does one of the things people often want it to do—keep them out of hospital. There have been quite extensive meta-analyses of very large studies looking at whether bringing teams of district nurses and other staff together to manage people out of hospital will reduce admissions to hospital.

Although it sounds like it should, often it does not. One reason is that it tends to uncover unmet need, so the evidence is that you sometimes end up with more hospital care because people's needs have been better assessed and the hospital treatment they need then gets provided. However, patients like it and feel that they are better cared for; people's experience of care improves.

The Chair: Presumably it could also uncover other unmet care needs that do not require hospital treatment and could be treated at a much earlier stage, thus preventing hospital admission, or is that too wide an assumption?

Professor Kath Checkland: There is no evidence that that is the case in the UK system. There is some evidence of it in other systems like that of the United States, which has less well-developed primary care. Where we have well-developed primary care, there is not a lot of evidence that multidisciplinary team working reduces later use of services.

The Chair: How do you define “multidisciplinary”? Are there lots of different kinds?

Professor Kath Checkland: There are lots of different models. There is some evidence that multidisciplinary teams that are wider than just healthcare and include social care professionals have a better chance of supporting people well at home.

The Chair: Thank you. Perhaps we will come back to that.

Q157 **Lord Altrincham:** What is your experience of the new primary care network structures? How far do they facilitate increased integration in the NHS and between the NHS and other partners?

Dr Jane Harvey: From my personal experience, I feel that PCN structures are fantastic at encouraging integration. At the heart of it is a huge strength of primary care—going back to the old-fashioned idea that you have your trusted local GP who will stand alongside patients from the cradle to the grave and know the longitudinal information and social context, maybe over generations. In our area, we have eight practices. They all have their individual characteristics, but our patients are ours; there are no exclusion criteria and we do not discharge people from general practice.

As a PCN, working together and having our own staff, we feel that we can mitigate against crises in different practices and help people to work together. Our PCN staff can provide services that GPs may find it difficult to provide, especially large-scale, low-risk things like vaccinations and proactive care. It also allows the headspace—we know that general practice is 150% full—to look at our whole population. We have 75,000 patients across eight practices and can look at unmet needs, other needs, things we are doing well and things we are not doing well that a jobbing general practitioner will not have time to do in their 11-hour day. We have a collective, positive voice and collaborate with other providers, which I think we do well, and we work quickly and innovatively and really respond from the bottom up to what our patient population needs.

Professor Kath Checkland: If it is okay, I will answer your question from my research perspective, because we recently completed a large-scale evaluation of primary care networks for the Department of Health as part of our funded research for the NIHR. I agree with Jane that PCNs have great potential. However, they were established with multiple objectives. Not only were they established to improve local integration but they had other associated policy objectives. The three we identified in our research were to support integration with other services, to support general

practice—we call it “rescuing” it—and to be a voice in the wider system of ICSs.

Those three objectives are quite different from one another. If you were designing PCNs to do each thing, you would design them slightly differently. A very large proportion of the funding into primary care networks has been to finance additional roles—extra staff—which are not completely but very largely focused on supporting general practices to keep going and manage to provide services.

Our research found that PCNs are very variable across the country. Some are very well-established and doing marvellous things. Very often, the most well-established are those with a history of collaborating and which have been doing this stuff for quite a while. Others are finding it more difficult, such as if they have not worked together before or there is a history of poor relationships, which is true in some areas.

We found that they need quite a few things around them to have the energy and enthusiasm to integrate with other services. They need good managerial support. As Jane said, GPs are really overcommitted and have lots of things on their plate, so you need good managerial support in a PCN if they are going to be able to liaise with community services, talking to them about how they establish those collaborations.

Finally, to be able to do this really good integration work, we think they need a slightly firmer structure around them. CCGs were established at what we now call place level. In Greater Manchester, for example, that would be Bolton, Bury or Stockport, and in my area it would be Derbyshire Dales. In the initial phases of PCNs, CCGs were able to provide background support so that PCNs that were struggling could have input and those that were doing really well could be supported to help their colleagues. In the current structure, as described by previous witnesses, that middle layer at place level is missing—some kind of firm commissioning and planning support to work with local PCNs and community service providers and be that commissioning and planning voice to help the two groups to work together. That is what came out of our research.

Sian Thomas: For a bit of context, I am operationally responsible for one primary care network. There are six in the city of Wolverhampton. I am also operationally responsible for all our community services, and I am the director of the place partnership in Wolverhampton, so a number of things that my colleague referred to fall within my remit in Wolverhampton.

I completely agree that the strategy around primary care networks to increase the resilience of primary care has been incredibly helpful. It supports and enables them to work together in a way that was perhaps not as facilitated or mandated before primary care networks. It helps to get the balance right between having primary care at scale and maintaining the localism that is so important to people when accessing primary care. It also gives them a more co-ordinated voice in the system when primary care may be trying to deal with quite large-scale organisations, such as the acute community trust that I sit in.

However, I agree that there are challenges in their formation. Although there was a suggested scale to their size of population of 50,000, that is as far as describing what they should look like went. The variation in the way practices have identified that they want to work together is huge—some are geographically coterminous and some are not, and some cross local authority boundaries—and that can make planning and delivering services incredibly difficult. I am responsible for community services, so the one PCN that I am responsible for has access to some of that infrastructure that some of our other PCNs may not have. However, we have tried to commit to other PCNs in the city not being disadvantaged, and that if we try something with our PCN that works, we will make it available to the other PCNs in the city.

Our PCN has nine practices and a population of just over 55,000. We are not geographically coterminous; we operate from one side of the city, which borders Staffordshire, which is quite wealthy and white British, all the way to the centre of the city where we have our student population and our highest rates of ethnic diversity and deprivation. We cover quite a broad population, and we are trying to deliver a range of services that meet their needs.

Lord Altrincham: To pick up Professor Checkland's comment about the different objectives put on PCNs, has increasing resources to PCNs tended somewhat to reduce integration with other services?

Professor Kath Checkland: I would not say that it was about an increase in resources per se. There are mismatched incentives in the system. Community services do not necessarily have the incentives to integrate with primary care, because they operate largely on block contracts. Primary care networks have increased funding—some of the funding is tied up in staff and some of it is not—so they have incentives to integrate, but sometimes they are a bit mismatched with community services. The geographical point is really important. PCNs and community services operate on

different geographical footprints. If you want them to collaborate, you need to think about how you draw those boundaries.

The Chair: We have another question about PCNs from Baroness Armstrong.

Q158 **Baroness Armstrong of Hill Top:** One of the things put to us at virtually every session is that access to records and the way digital information, and information generally, is handled is a problem for integration at a local level. How do you think PCNs can or do facilitate and encourage greater digital interoperability at local level? What do you think could happen to enhance and improve that?

Dr Jane Harvey: We feel that PCN structures are great for digital interoperability because there are eight practices and we share records and are all on the same system. This means that wherever the patient comes from, we will know about them and our GPs trust each other and us to have care for those primary care records.

We are also very keen, as are Dr Amir Hannan and his friends, on patients owning their own records. We have a very high percentage of patients with access to their records, which is their property to do what they want with. We also feel that we are quite light-footed and have good purchasing power, so we have been doing lots of innovative software solutions and bought population health searches, long-term condition follow-ups, ways of booking and messaging patients, and total triage. From the PCN point of view, we feel that we are working well with digital interoperability; if we have a problem, someone helps us to find a digital solution to it. We have been using all the solutions in trying to find really good ways forward.

Professor Kath Checkland: More generally, it can be difficult because in a primary care network you do not necessarily have all GP practices on the same system. Two or three systems are in use, so you might have a primary care network in which the GP practices are on different systems, which can be complicated.

There is a broader issue. We heard in the previous session about summary care records and shared care records in Greater Manchester; they are working very hard to develop a shared care record. We need to have a big public campaign on this. I once gave evidence at a citizens' jury on the interoperability of records. I was astonished by how little members of the public were happy for other people to access their records. People were telling us they did not even want the practice's administrative staff accessing their GP record. It is quite an education to tell patients, "Actually, the

district nurse, the GP, the podiatrist and someone else will be able to look at your record". Patients can be quite iffy about that. We need to be careful to bring the public with us. I was really surprised at the citizens' jury by how conservative people were about who could look at their record. It requires significant public education.

Sian Thomas: I think about digital across probably four tiers. In terms of an electronic patient record, the whole of the city of Wolverhampton is on one system, so our PCN is on that system and we can share records and make sure that there is a single narrative for the patient. That is incredibly helpful, but one of the gaps is how that record is shared, particularly with community services, where some of the strongest links are. We can share information that allows us to risk-stratify patients so that we can identify people on a performance-metric level who might need additional support, but being able to read across the actual record for the granular, person-centric information is lacking.

There are a series of digital support tools that sit on top of the electronic patient record and are incredibly important in doing searches, supporting automation and potentially taking the first steps in artificial intelligence. Purchasing at scale is very important and the PCN footprint is probably too small; at the moment, we are very much being allowed to find our own way and a thousand flowers are blooming. There is a real risk that we will end up with system disparity, and at some point we may all have to change direction to align. We have an opportunity now to try to standardise that into a larger-scale footprint.

There is also telephony, which is hugely important in making sure that patients can access primary care appropriately. We are on cloud-based telephony as a primary care network, which means that all our calls can be shared across practices, so if there are redundancies where any one system is failing or the queue is too long, we can move it around our PCN. However, we cannot share between PCNs; digital interoperability ends at the door of the PCN itself.

As my colleague referred to earlier, patient tools are also incredibly important, but until we have a much better communication and education campaign, the uptake will be quite challenging. I am thinking particularly of a city like Wolverhampton, where we have very high rates of ethnic diversity and deprivation. We need to think about how we build trust with our communities on the use of their information.

Q159 Baroness Barker: My question is again to Sian Thomas and is about the advantages of vertical models of integration in the NHS.

In your experience, how possible is it to balance those arrangements with horizontal models of local place-based partnerships? Again, we are going back to the fundamental question about data sharing.

Sian Thomas: There is no one size fits all, and I would not advocate that a single model is right for the nation. Localism really is important. The vertical integration journey in Wolverhampton started before primary care networks were an organising principle and a structure. One challenge was that we were so focused on the vertical integration that we probably did not spend enough time thinking about the horizontal relationships between practices, which are equally if not more important.

When it comes to the support around primary care networks, vertical integration has lots of advantages in supporting things like planning, procurement, infrastructure, strategic developments and some risk management.

On data sharing, we had to go through a full GDPR-compliant process to make sure that all the patients at our practices were satisfied with how their information would be shared, but it has allowed us to undertake a population health analysis at a scale that is not possible elsewhere due to the information that we have, and it is very easy to identify patients between our community services and primary care services. That has meant that some of the models that have been supported in the primary care network through additional roles such as home visiting by paramedics or advanced nurse practitioners' support to care homes have been able to be far more integrated into our community service. When the GP surgeries close, for example, the out-of-hours offer is continuous because it is viewed as a whole, as part of our community service. Does that answer your question?

Baroness Barker: Yes, it does, but I think I am right that again you are restricted by keeping the information in the NHS.

Sian Thomas: Yes.

The Chair: To be clear, it is not shared with the local authority or with social services. You are not able to do that.

Sian Thomas: No, not without specific agreement for a specific piece of work or at specific individual level.

Lord Kakkar: Would it be useful to be able to share data more freely?

Sian Thomas: Absolutely. Look at the example that was set during Covid, where a level of permission was given. We are trying to work in the best interests of people, and we were able to innovate in a very different way. It is burdensome and time-consuming to work through these processes, and, as I think someone said earlier, once you put a multidisciplinary team around an individual you undoubtedly identify unmet need. If we shared information earlier, perhaps that unmet need would have been identified two steps before.

Lord Kakkar: Beyond the potential anxiety of patients and service users regarding the sharing of data that we have heard about, what is the other principal impediment to making this happen.

Sian Thomas: The number of different systems that are in operation mean that technically it can be difficult—I am not a technical person—for the back-ends of the systems to talk to one another, and for the information to be housed in a warehouse that allows it to be tied together there is a lot of architecture that would need to be supported, but work on that architecture is probably not happening while we do not have the permission at the data-sharing GDPR end.

Q160 **Baroness Barker:** Confining this question simply to the NHS at the moment, do you have evidence, data, from your work so far that shows that there are better outcomes for example for patients with complex needs who have to interact with different parts of the NHS?

Sian Thomas: We have just participated in an NIHR BRACE study that looked at different models of primary care around the country and is currently going through peer review. It has highlighted a number of statistically significant differences, particularly with emergency admission rates and outpatient attendance rates, but it has not shown that we have been able to make a difference in outcomes for a particular cohort of patients. Our model came to fruition only six months before Covid happened, so if we participated in that study again in 18 months we would hope to show something different. At the moment, they are the only two areas where the study seems to have shown that statistically significant difference.

Professor Kath Checkland: I was also going to mention the BRACE report. There is a report currently in the public domain, and another one is coming out. Professor Judith Smith's team at Birmingham led that report, and I can share it with you. It looked at vertical integration and international models, and at some of the models in the UK. There is not vast evidence, either internationally

or in the UK, that outcomes are particularly better. Some things work well and some things are not quite so good. It is not barn-door evidence.

Lord Watts: I do not expect you to tell us now, but I would be interested to see how the selection was made for the public juries that you talked about earlier—the questions that were asked, the answers that came back, the proportion of people and the main concerns. You must have that, so it would be useful to see it.

Professor Kath Checkland: A colleague of mine at Manchester ran the citizens' juries. It was a couple of years ago, but I could share that with you.

Lord Kakkar: If I am understanding correctly, it is being suggested that integration does not make that much difference to demand for secondary care services and hospital services. Is that correct?

Professor Kath Checkland: There is not good evidence at the moment that it does. It feels instinctively that it should, but there is that unmet needs question—there is a lot of unmet need out there—and, with older people, even if we intervene early and treat people well and they live a long life, they often have multiple health needs in their 90s. Good prevention means that you live into your 90s, but you will still have illnesses; you will still get ill in your 90s and you will still need care.

Lord Kakkar: Does that mean that we might be putting emphasis on integration for the wrong reasons? There is a very good reason for integration, if I have understood you: you can drive at a quality of life and better intermediate-life health outcomes in the community through effective integration, but it will not have the impact of being able to remove resource from the secondary care system and put it into the primary and community care systems.

Professor Kath Checkland: That is probably true. We certainly do not have any evidence at the moment that it is possible to save money. There was a study a few years that looked at things like virtual wards and caring for people in the community not to see whether it produced better care or allowed people to stay at home but to see whether it saved money. That study found that you needed to provide the care in the community for a bit longer. Providing care in the community is quite labour-intensive. You need lots of staff to go about; they have to travel between homes and so on. So it is not necessarily cheaper.

Q161 **Baroness Redfern:** Following on from the previous question, can I

address my question to Dr Harvey? You mentioned integration working well. How can you bring local authorities into that as well as the private sector? What are the barriers to being able to have a full envelope of everybody?

Dr Jane Harvey: Our position in primary care is that it is really important to start with the patient in mind. In what we have discussed so far, vertical integration might or might not happen, but it is really important that it happens for patients' experience.

When people are happy at work and well supported, that integration happens. In that situation, the power of primary care and PCNs is that this is not someone who might have a social worker some of the time but not always—they will always have a GP and will always be on our books. They will never be discharged and there are no exclusion criteria. If we put the patient in the centre, they have the most amazing care and support workers whom we have employed through the additional role scheme—we are not allowed to employ nurses or doctors on that scheme—who advocate for someone who might need housing or food rather than a vaccine or having a long-term condition sorted out. People all want to do the best for that person in social care and the local authority. We can bring people together. It is a different way of looking at it, as opposed to through structures that all have their own criteria and are all working to their own KPIs, which are complex for many of the groups.

The one thing I really want to get across as a strength of primary care is that you are ours and we will work with you whatever. That is the emphasis that we have been trying to put forward: if we have integration from the bottom up, hopefully it will come vertically down too. As Kath has explained, it was easier when the CCGs were around; that support has disappeared and we are now trying to work—

Baroness Redfern: That is because CCGs had a lot of input with local authorities.

Dr Jane Harvey: Exactly.

Baroness Redfern: Do you think that is failing now?

Dr Jane Harvey: It feels very unstructured and people are still scrabbling around trying to work out what to do.

Baroness Redfern: Is it treading water and not improving?

Professor Kath Checkland: Absolutely. Because we have lost that place-based structure—

Baroness Redfern: Everyone was at the table.

Professor Kath Checkland: Everyone was at the table, and CCGs had good relationships with local authorities. The role of local authorities in integrated care systems and integrated care partnerships has not yet really been worked out.

Baroness Redfern: And you also had the private sector there.

Professor Kath Checkland: Those kinds of relationships are not quite worked out. At ICS level, multiple local authorities are involved, as each ICS covers more than one local authority. The one-to-one relationship that we used to have between CCGs and local authorities, largely, has gone.

The Chair: You talked about a patient centre. Does that include after-hours services? What happens on a Friday night at 9 pm?

Dr Jane Harvey: Our PCN runs extended access from 8 am until 6.30 pm, and GoToDoc covers the evenings and weekends, working with 111. We put on extra clinics when we had the respiratory problems before Christmas, when we managed to get some extra funding. As a PCN we can respond to that quite quickly and put on extra clinics. We had a phone number that people could ring and get seen on a Saturday or Sunday, but that funding has now disappeared. We hope to get funding next winter and to be able to do the same again. I read all the reports from the 111s and the GoToDocs on the Monday morning—that is what I should have been doing this morning—and make sure that everyone who has had a crisis outside that time gets a response from us in primary care.

Lord Kakkar: How common is your model in its application across the country? Are there other primary care models that are less intensely connected with their patient lists?

Dr Jane Harvey: A lot of GPs and primary care workers would love to be that intensely connected, because that is why they are in the job; they are local people providing a local service to their friends and people they know on their street. That model is incredibly important, taking strength from the communities and working with our health champions and patient participation groups. When talking about ICBs and structures, it sometimes feels that they are a million miles away from what is happening on the ground.

Lord Kakkar: When it does not happen in the way you have described, which is the ideal model, what is stopping it?

Professor Kath Checkland: I can probably answer that from our research. There are a number of things. We looked at PCNs across the country and found that the biggest difference between those working well and those not working well was in their historical relationships. That is difficult, because you cannot fix it. However, you can be aware of where those issues are.

Groups that have worked together for a long time—GPs have been collaborating for decades in different types of structure—often get on very well and have trusting relationships. Where they do not have those is where you need to put in the support. That is where you need a body at a slightly higher level that can look across their patch, say, “We have six or eight PCNs here. Those two PCNs are working really well, but those are struggling a bit more and need more support”, and then put that support in.

ICBs are too big to do that, because each ICB will have 50 or more PCNs, so you need something at place level. Basically, you need to delegate from ICB level down to place level to be able to oversee the primary care networks in the area and give them support if they are struggling. There are a number of management issues. They need good management to be able to do this and to work closely together. Funding has been introduced for that, which is very welcome. Funding to provide management support is really important.

It is hard to emphasise enough how different PCNs are from one another. Some PCNs have one huge practice and lots of little ones, others have practices of very similar sizes, and some PCNs have a single practice. They are hugely different from one another and so need different levels of support. You need a mechanism to provide them with that support.

Lord Kakkar: Does that exist across the country?

Professor Kath Checkland: At the moment, the commissioning of primary care—the level of support—has been delegated to integrated care boards, but they are very large and it is difficult for them to give local support to PCNs. You need something at place level to provide commissioning and planning support for primary care networks to bring community services together at place level.

The Chair: Perhaps a CCG.

Professor Kath Checkland: You could say that.

The Chair: I will not say it.

Q162 **Lord Kakkar:** Turning to the primary care estate, how, as

currently disposed, does it either facilitate integrated working with broader community services or hamper it?

Professor Kath Checkland: My colleagues will probably have something to say on this too, but our study found that the main problem with the estates was housing the new staff. The additional roles scheme, as Dr Scully said earlier, has brought a lot of new staff into primary care and quite a lot of practices do not have room for them. On the collocation or otherwise of district nurse teams, community service teams and primary care, some areas have nice big shiny new buildings where they can be collocated. I do not think collocation is the be-all and end-all, but where you can manage it it can be really helpful, because you can have those conversations in the corridor, meet people and get to know each other.

However, the estate is what it is. Building a health centre in every town or whatever would be vastly expensive, so we have to work with what we have. That means knowing what estate you have and then working out the best ways to use it, and upgrading it where there is a problem with it, as there is in quite a lot of places.

Dr Jane Harvey: We are trying to do something a bit more community-based in Hyde. We have been lucky in that our local GPs want to invest in a collocation area. We were visited by Jonathan Reynolds, who had spoken to owners of our local shopping centre, which had an empty supermarket. We are currently refurbishing that and trying to look beyond the medical model. We will have 11 clinical rooms, but mainly we will have a large, accessible common space.

One big feature is a large kitchen, because, as we know through tackling health inequalities and from our refugees and asylum seekers, food brings people together. We can then start doing a lot more proactive work on longer-term conditions. We will make sure that the people in those rooms are mental health charities, citizens advice, health visitors, welfare rights and drug and alcohol teams.

There is virtue in having something that is very much in the middle of the community and has input from it, and where services outside the medical model can happen. Presumably that is partly what we are talking about when we talk about integration. There is a lot of power to that model.

Greater Manchester is doing a big estates consultation at the moment that started with data and clinical need. In Hyde, we have already done that. We have looked at our data, our clinical need,

our health inequalities, health promotion and population health, which is why we want to do that. I imagine that it can be different in different areas and that it is a bit of a mishmash. It is tricky and complicated.

Sian Thomas: Estates are quite a limiting factor. The size of primary care practices has been mentioned. That is a real challenge, but so is the quality of those buildings. A number of our practices are essentially in converted houses, and there comes a point where you find yourself questioning how much money you want to invest in a building that might not have an appropriately long life span. Should we be putting lifts into houses so that the first floor can be accessed? How can we make them more disability and infection-prevention compliant with modern standards?

There is a large capital challenge in the primary care estate and ownership models, and potential conflicts of interest where the ownership model is linked to GP landlords. I agree with colleagues that co-locating people is not necessarily the be-all and end-all. Working on the relationships is far more important.

Lord Kakkar: Are there are specific government initiatives that would help? What else could central government—DHSC and so on—be doing?

Professor Kath Checkland: As colleagues said earlier, there needs to be a general think about primary care estates. There will need to be investment, but where that will come from I do not know.

Q163 **Baroness Barker:** At one of our earlier sessions, Andy Burnham talked about the fact that two of the 10 local authorities in Greater Manchester are not improving—not yours. Given that you have emphasised the importance of long-term relationships, are we missing something here? Is there something here about areas of greatest deprivation—the two boroughs that are not improving are the ones with the greatest deprivation in Greater Manchester—staffing levels and continuity? If there is, is that an issue of inequality that we should focus on, and is that more important than premises, or do the two things go hand in hand?

Professor Kath Checkland: I think they go hand in hand. It is definitely harder to staff GP practices in very deprived areas. Historically, practices in deprived areas have much larger list sizes per GP and retention is harder.

One of the strengths of the primary care network model is that it has the potential for differential investment or support. If you have a group of practices working together and one practice is

struggling, the other practices can differentially invest and support it. So there is a strength in the primary care network model in supporting practices in deprived areas and in the funding and financing of primary care networks.

We found evidence that the formula for funding the additional roles is working well and that there is more investment going into more deprived areas. There is definitely the potential for using the primary care network model to try to equalise and differentially invest in deprived areas.

Q164 Baroness Osamor: What one change would you like to see the Government implement to make it easier to integrate care at PCN level?

The Chair: We would like one thing only from each of you.

Professor Kath Checkland: For me, it is the thing I have already mentioned. Primary care and community service commissioning needs to be established on a firmer footing at place level. As was said earlier, the current legislation is very permissive—I would say too permissive. If I was in charge, I would tell ICBs that they need to establish a committee or a body to do primary care and community service commissioning at place level.

Dr Jane Harvey: I would ask for some stability. A lot of our energy is consumed by constant reorganisation. A pandemic and everything being completely reorganised has taken masses of resources out of the system. I would ask that we pass on some of the nurse and paramedic pay resolutions, because I am now scrabbling around trying to match for our nurses, who are not on Agenda for Change because they are part of primary care. It will only increase health inequalities if I cannot retain staff and they go back to the big organisations because that is where they get Agenda for Change.

The Chair: I am afraid that may be beyond the pay grade of this committee.

Sian Thomas: I would say longevity of funding. Many of the pots of money that are made available to primary care are short-term and chop and change with remarkable frequency. Depending on the bidding process required, primary care does not always have the infrastructure to access those pots, and if we really want population health to be managed through primary care, we need to manage the population over the long term. Primary care, which is largely a business model—we have to recognise that—needs continuity of income in order to make those long-term investments and not put the model at financial risk.

The Chair: Thank you very much. On behalf of the committee, I thank our three witnesses—two in the room and one online—for your excellent answers and for the time you have given us today. We have mentioned extra things that we want from you, and we would be very pleased to have those. If there is anything that you would like to have said but did not have the opportunity to do so, please feel free to contact the committee clerks. In bringing this session to a close, I thank you very much for your evidence to us this afternoon.