HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 19 June 2023

3.05 pm

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

Evidence Session No. 19 Heard in Public Questions 184 - 197

Witnesses

I: Dr Amanda Doyle OBE, National Director of Primary and Community Care Services, NHS England; Dr Tim Ferris, Director of NHS Transformation, NHS England.

Examination of witnesses

Dr Amanda Doyle and Dr Tim Ferris.

Q184 **The Chair:** Good afternoon and welcome to this Integration of Primary and Community Care Committee. We have one member online with us today—that is Baroness Tyler—and a couple of members have not yet joined us, but will do so. We are delighted to welcome as witnesses today Dr Amanda Doyle, who is the national director of primary and community care services at NHS England, and Dr Tim Ferris, who is director of transformation at NHS England.

As you know, we will take it in turns to ask you questions. We have specific questions for you both, but if you want to pile in on the other one's question, please feel free to do so. My colleagues will, of course, also come in with supplementaries if they feel so moved.

Perhaps I will come to you first, Dr Doyle. I know that you have had a very difficult day today, so we particularly appreciate you taking the time to be with us. Could you please describe your remit with the NHS and explain how it relates to integration, which is the subject of this committee's inquiry, and perhaps outline the policy framework? Then I will come to you with the same question, Dr Ferris.

Dr Amanda Doyle: I am national director for primary care and community services. That means that I am responsible overall for primary care services, general practice, pharmacy, dentistry and optometry, but also community services across the NHS. That includes generic community services, but also things like urgent community response, end of life care and elective community services, so a range of services that sit largely outside of hospitals. I am a GP. I was a GP in Blackpool for about 23 years, in a very deprived area. I also led the Lancashire and South Cumbria Integrated Care System for five years, which was the one of the first waves of the integrated care system, so I have a background in doing the integrating as well as the responsibilities I have now in the national team.

From our point of view, there are two things. There is the environment that we create through our commissioning and statutory framework, creating ICBs, delegating responsibility for commissioning of primary care services and enabling the development of integration. From a purely primary and community care front-line service point of view, it is very much about driving a policy that enables integration to happen on the front line, because that is where it will be seen and where we will get rid of some of the service gaps that are apparent to patients every day. So it is

very much from a "What's our policy for front-line services?" point of view, as well as the wider framework point of view.

Dr Tim Ferris: Good afternoon. Digital technology, data and data policy is within my remit as the national director of transformation. You may be aware that it used to be under several different organisations, and over the past year and a half we have merged NHSX and NHSD into NHSE, and they are all now part of the transformation directorate. My own background is the US equivalent of a GP. I practised in an inner city health clinic for 30 years in Boston. I am also a professor of medicine at Harvard Medical School. That is enough about my background.

In the specific context of the transformation directorate and the integration of community and primary care services, I will speak mostly to GP services. Information, and the flow of information, is a very important part of that integration, so it falls within my remit. I will wait for further questions on what we do there.

My own integration framework is from the patient's perspective when they are receiving services. Patients want three things in the continuity of care. They want continuity of information; all the people who are serving them should have the same fact base on which they are operating. They want continuity of management plans—what is the plan based on that fact base, and what is the plan for the service delivery? They want continuity of relationships; they know the people caring for them or they know them through someone else, that there is some web of relationships, because normal trust in human interaction is having continuity of relationships.

It is those three aspects of continuity that I think about enhancing through whatever technology or data policy we are trying to promulgate.

Q185 **The Chair:** Indeed, those will find an echo in the witnesses who have appeared before us so far. I want to ask about the policy of integration between NHSE and the department, DHSE. There seems to have been a bit of confusion about that—or a lack of clarity, let me put it that way. Could you help us with that?

Dr Amanda Doyle: NHS England is an arm's-length body. It is a statutory organisation. We work in partnership with the Department of Health and Social Care, but we are not formally integrated with the Department of Health and Social Care.

The Chair: And that applies to all policy development?

Dr Amanda Doyle: In my experience, policy development is very much an officer level, and at more senior level people are working very closely as we develop policy and proposals, but we are not formally integrated as organisations. Separately from the more formal integration through integrated care partnerships are the things for which we are separately responsible, so health services for NHS England and social care services for the Department of Health and Social Care.

Dr Tim Ferris: There is one exception to that broadly true description. There is a joint DHSC and NHSE digital and data policy unit in the transformation directorate that generally focuses on two areas. First, it is responsible for the capital spend on technology. Capital spend on technology in the NHS, to the extent that it is not devolved, is a DHSC responsibility, not an NHSE responsibility. The other is data healthcare data policy, which is jointly created in this unit. So we have a joint unit where it is formally joined.

The Chair: Thank you very much for that clarification.

Q186 **Baroness Finlay of Llandaff:** Dr Doyle, some witnesses have expressed concern that staff shortages are the key limiting factor for integrated working in primary care, community health services and social care. What is NHSE doing to address that? I should declare that I am a fellow of the Royal College of General Practitioners. I also have a chair and an interest in palliative medicine, and I will ask you a question about that afterwards.

Dr Amanda Doyle: There is no doubt that demand is currently outstripping capacity, particularly in general practice, but widely across the health service there are challenges in the size of our workforce, retaining our workforce and having a workforce that is sufficient for the capacity we need. As you know, we are about to publish the long-term workforce plan, which is designed to address these issues, although I am not a position to talk about that yet prior to its publication.

In general practice, we have recently published the general practice access recovery plan. That has a section on workforce, how we expand capacity in the workforce and how we move to a greater skill mix. We have been successful; we have recruited more than 26,000 extra clinical staff to enhance our skill mix a year earlier than the target that we had set ourselves and, therefore, introduced quite a successful opportunity for multidisciplinary teams across primary care networks.

There is no doubt that we need to do more. We have increased the number of trainee general practitioners for the last two years; this

year, we had the largest number ever, 4,032 trainees entered. However, we need to do more to retain more experienced clinicians and try to make changes to enhance the way primary care, community services and social care services work in an integrated way across a neighbourhood. Obviously, challenges with recruiting to the workforce will make those changes more difficult to do.

Q187 **Baroness Finlay of Llandaff:** What training infrastructure are you putting in to ensure that all these new recruits coming in have a different approach and are working in a much more multidisciplinary way? My interest is also with the voluntary sector, and we have heard evidence that a very disappointing number of integrated care boards, and commissioners in particular, have not adequately commissioned the palliative care services that they should, as designated in the recent Act. We know that good care is cheaper than bad care, and there is very strong evidence now from the King's review that providing really high-quality care saves money; it does not cost more money. What training are you putting in to support a change in work patterns? Otherwise we will just get the same silos.

Dr Amanda Doyle: There are two aspects to integrating care at a neighbourhood or place level, which is where we are really going to see the front-line benefits for patients. What I just described about recruiting a wider skill mix in a multidisciplinary team supports primary networks. That has been part of additional-roles funding that has gone into general practice specifically through primary care networks.

Claire Fuller's stocktake, which looks at a vision for the future of primary care, talks very much about integrated neighbourhood teams. Those integrated neighbourhood teams form the primary care network team and, equally, a range of other teams, services and organisations that support people at home in their neighbourhood. Palliative care services, community nursing services and social care services are a great example of that.

You are absolutely right that unless we develop teams working together with a range of enablers that help them to learn, develop and offer seamless care to patients, we are not going to get very far. Key among those is shared clinical data—Tim has talked about data—to allow seamless care. That is vital, particularly with palliative care services; if members of a hospice team, for example, are seeing a patient, it is immediately apparent to the GP, who might also be seeing the patient, what has happened. Also key is the seamless transfer of information about things like medicines, so that medicines can be ready before they are needed—community nursing teams are often very involved in that care—and working in

an integrated way so that the patient notices seamless delivery and not a series of hand-offs between services.

You are absolutely right about the value that the voluntary sector and community organisations offer to patients, particularly in supporting patients with the bits of care that are more about care and less about the purely medical interventions. For palliative care, it is things like respite and night-sitting services, but also services to support people who are newly discharged from hospital. Almost 1 million people have now been referred to social-prescribing link workers, offering a range of non-medical interventions that support improvements in independence, improvements in confidence or improvements in making changes to lifestyle, all of which contribute to health and independence. As the population ages and suffers from more long-term conditions, we need a reset away from purely diagnosing, treating and curing people to supporting people to stay healthy as long as possible, despite long-term conditions, and independent in their own home.

Q188 **Baroness Shephard of Northwold:** Is there is a problem because of the number of GPs choosing not to work full-time? We have been told that, in August 2022, 23.2% of doctors in general practice worked full-time, which is a staggering statistic. We have asked this question before. It must hide a multiplicity of different things that they are doing when they are not working full-time as GPs. I would find it very comforting if you were able to say, "It's not what it looks like", because we all know that it is very expensive to train a GP, and it is very expensive for people to embark on training as GPs. This raw statistic looks a bit depressing. Can you enlighten us?

Dr Amanda Doyle: You are right. As you say, it is for a multiplicity of reasons. The most obvious perhaps is that most GPs are now women, which is a big change from when I first became a GP. Lots of women work part-time for part of their career and then go on to work full-time for many years, like I did. Equally, these days, lots of men, and women, prefer to have portfolio careers, and so work part-time in general practice but work the rest of the time in other roles that are contributing to healthcare planning, to delivery, or to teaching and training and a whole range of supervision of other staff. Those are all medical leadership roles, but in that data they will look as though they are working part-time.

There are people who have come further in their career and who reduce their hours and work part-time for a number of years before they retire. We cannot ignore the fact that, alongside all that, there are people who are finding that the job, the workload, the demand

is overwhelming, and they are choosing to adjust to that by working less than full-time.

All the other explanations are perfectly reasonable and we support people having those flexibilities in their career, but it is really important that when we are implementing things like the primary care recovery plan it is very much about creating a future where general practice is a job where people can manage the workload, can do what they were trained to do, it is a satisfying job and they want to stay doing it for 30 years.

Dr Tim Ferris: I have an international comparison point. Just to be clear, I employed over 1,000 primary care doctors in the Boston area, and less than 10% of them worked full-time for exactly the same reasons, including, very importantly, the last reason: that it is an exhausting job and working essentially 10 sessions a week is very difficult.

Q189 **Baroness Shephard of Northwold:** My question is about digital integration, and it contains a difficult word, which is interoperability, a lack of digital same. Is this limiting integration between primary and community care? We had such an interesting answer from a witness at another meeting of this committee, who said that they had set up citizens' juries on whether sharing data would be a good idea in the primary care sector, which is very wide and includes pharmacies, dentists and all the rest. The particular citizens they chose were not very keen on the idea. That was the finding of that particular look at it all. It seems hard to understand why that would be, but I think it is about trust and all that. What can be done to enable more integration if that is really helpful? Is it really helpful? If it is considered to be helpful by NHSE, what are you doing about improving it?

Dr Tim Ferris: The answer to the middle piece of that triple-barrelled question is unequivocally yes. It is always better to have more information; you just make better decisions. As a clinician, the more information I had, the better I was able to make decisions that were in the best interest of the patient. You will not get equivocation from me on that point.

On the challenges associated with the integration of information, I will go back to what I said before about information continuity. Remember that there are three pieces of integration; I said information continuity. One thing that is important for me in thinking about this is that although interoperability—that big word, which I will explain in a second—has distinct advantages, we could go a long way just by having the information available to the

clinician without interoperability. You just need to know the information. You do not need your systems to talk to each other.

Interoperability is the idea that different groups of clinicians who use different software can both read each other's data and write to each other's data. That is done through APIs, which are basically the plugs that connect different kinds of systems. It is a great thing to have, but it is not necessary to provide clinicians with the information they need to make decisions. I just want to be clear about my position on this. The most important thing for direct care, the care of patients, is to have the information available, and technologically that is not complicated. Technologically, interoperability is considerably more complicated. I am a big fan of not letting the perfect be the enemy of the good. Let us make sure that clinicians have the information they need to make decisions.

First, though—I will speak very specifically about social care and primary care—in order for social care and primary care to be connected, even just to have visible data you have to digitise. Just a couple of years ago, only about 30% of social care was digitised. Now we are closer to 60%. It is growing very quickly now; I can get you the exact numbers. This is very important. It is a fundamental enabler—you cannot share the data if it is not digitised—and we have a way to go in digitising social care. By the way, we are also not completely digitised on secondary care, but we have a path to get there and we are at very close to 90% now.

I will give an example of the way this works. When I visited St Helen's, the A&E physician told me that he had recently received social care information that he had never had available to him before. This completely changed the way he was able to manage the patients in A&E. He was able to call the social worker, for example, and construct a plan together. I then walked across the street to the social worker, who was able to see the A&E information and to intervene: "Oh, I know that patient. They've had this problem for a long time. You don't need to admit that patient". This is the kind of example where social care information and secondary or GP information dramatically changes the process and makes it more efficient. To the point made earlier, high-quality care is less expensive care. It is very important to ensure that the social care providers and the GP and secondary care have access to that information.

It is also very important to maintain trust. That means that the people who have access to that information must be vetted and employ two-factor identification. They must meet all the rules for secure access, because that is the only way to build trust. We also

have privacy-enhancing technology, which we are deploying throughout the NHS to make sure that there is a complete audit trail of who accesses what information at what time. All of this is in the interests of making sure that we build and maintain the necessary trust, because without that trust we will not be able to make sure that the information is used to optimise the care of patients.

Q190 **Lord Kakkar:** We have heard in previous evidence sessions that there may be an impediment to data sharing in primary care and beyond primary care as a result of current legislation, where the primary care physicians, the GPs, are the data controllers and have those obligations placed upon them. Do you think that is the case, and that there is some need to revisit the legislation to ensure that that is not an impediment to the proper mobilisation and application of those data to drive not only improvements in individual patient care but, more broadly, system-wide improvements and the substantial research opportunity? I should declare that I have an interest as chair of the UK Biobank.

Dr Tim Ferris: There are four important uses of healthcare data: direct care; population health, such as all the vaccine information during Covid; planning—it is very important to have the information in order to plan the delivery of services and improve performance of services; and for UK Biobank research. Those are the four uses of healthcare data. It is essentially the same data, but the people who are using them, the purposes to which they are putting them and the legal environment are different for all four ways of using data. That is the complexity here: that the same data, depending on its use, falls under different legal environments or rules.

With respect to the data controller issue, it is my opinion that it is a challenge. You had to have an individual physician or a group practice. It made a lot of sense 30 years ago when the law was created. It might no longer be fit for purpose. I say that based on a few different things. Scotland has resolved this problem by making NHS Scotland a co-data controller, so there is co-joint ownership of the data. Honestly, if I were a GP in this country—to put my hat on back in Boston, where I am from—if I had legal liability for the exchange of data, I would be worried about that. I did not have any legal liability. My employer was liable for the uses of the data. I just used the data to deliver patient care. Scotland overcame this problem just recently by making NHS Scotland the co-data controller. That removes from the individual physician the liability associated with the use of the data. There are other ways of approaching this problem, but that is one way of approaching it.

Dr Amanda Doyle: As Tim has described, this is really complex. It is very difficult for GPs to understand what they are responsible for and what happens to data once it leaves their systems. So we are getting a completely natural reaction, which is sometimes a nervousness about opening up data sharing. It is vital. We laughed while we were waiting outside the committee room because we were discussing this very point. We need to find a solution that clarifies it.

There is some resistance to a GP sharing clinical record data with patients themselves. That is absolutely different. That is completely straightforward from our point of view, and we very much support patients having access to their own clinical data and owning that data. That goes some way to giving people confidence in that data then being shared with other providers of care, because they can see what the information is.

Lord Kakkar: If I have understood correctly, there may be merit in this committee recommending that an approach is taken, not necessarily the approach in Scotland but an approach to relieve GPs of the sole responsibility for data protection and data controller status. One route forward may be for that responsibility to be shared with NHS England to drive forward the multiple uses of data that you describe.

Dr Tim Ferris: I completely endorse that position.

Baroness Finlay of Llandaff: Do you see that also extending to the voluntary sector? In Wales, the hospices all went on to the unified Welsh record. That meant that we took the responsibility off individual hospices' shoulders and they had to go through all those checks, including recording who had accessed which bit of data at which time. It was useful. I recall one occasion when we detected somebody who had accessed data that they should not have accessed, so we also know that the safety net was working. Wales with a population of 3 million can do that, but is England too big? Should that go down to regional level or could it be England-wide, given that people move between different areas and different sectors and may go for tertiary care in one area while getting primary and secondary in another area.

Dr Tim Ferris: The point you make illustrates to me the notion that there are potentially multiple different ways through this problem, but that, none the less, it is a problem that needs to be solved.

Baroness Shephard of Northwold: My question is particularly about the understandable nervousness of GPs about their liability

with regard to data. Dr Doyle, is there any gleam in department's eye on some kind of legislative solution easing the passage to what you have said—and we all agree—would enormously improve integration and be in patients' and practitioners' interests?

Dr Amanda Doyle: Do you mean with regard to patient access to their own data or to the wider data sharing?

Baroness Shephard of Northwold: I mean what Dr Ferris has outlined on GP liability. He said that there could be a legislative solution, perhaps, which I assume would mean in our case doing something about a GP contract. In order to solve this, would there be a gleam in the department's eye to look to legislation to ease it along?

Dr Amanda Doyle: Making a change of that nature would need legislation, but it is not part of the GP contract, so discussions about change to data access rules would fall to Tim.

Dr Tim Ferris: I think it is well appreciated in the department that this is a significant challenge that needs to be overcome. I would represent the position as: let us look at all the options, legislative being one of them, and make a decision that expedites the enactment of the advantages that we all hope for.

The Chair: Thank you very much. We will take that. We will not misquote you about gleams.

Q191 **Baroness Tyler of Enfield:** My question is primarily for Dr Doyle. You have already referred to the Fuller stocktake. We have focused on that as a committee. In that report, Claire Fuller identified estates as a key area in improving primary care and stated that the NHS should move towards a model where estates are a catalyst for integration rather than a barrier to it. With that context, to what extent is physical collocation of primary and other community services necessary to enable full integration and get better patient access? If that is the case, is this a priority at the moment for the NHS?

Dr Amanda Doyle: We could do lots of things by building relationships and organisations, aligning some of the incentives and aligning the ways in which teams are trained and work, but there is absolutely no doubt that physical collocation makes that easier to do. It makes teamworking easier if you see people, talk to them day to day, have conversations about patients and their care in the building face to face. That makes it quicker and easier. It makes teams feel more like teams and makes them work more quickly together.

Importantly, if we expand our estates' capacity to enable collocation, we have effectively expanded our estates' capacity to enable more delivery of services outside of hospitals, so it enables us to work more closely with secondary care. In lots of places now, specialists in secondary care may deliver services out in primary and community centres or work closely with primary care networks on care for their patients; I am thinking particularly of frailty care, diabetic care—those sorts of things. It also enables the development of a hub approach for the community. It enables us to locate diagnostic services and urgent treatment services out in the community, so that primary care has a greater opportunity to work not only in an integrated way with other services but at scale for things like urgent same-day activity or out-of-hours care, and so on.

We have a diverse and complex primary care NHS estate. Arguably, we need to think much more broadly about the whole public sector estate and how we use it. One challenge is that traditionally we have not done that very well. It should be a benefit of integrated care systems and integrated care partnerships that the health and local authority estate in particular is looked at as an entity in which we can all deliver services. There are some great examples. When I worked in Blackpool, we had three primary care centre hubs, one of which was joint health and local authority. It had a swimming pool, a gym and a library, but also health services—GPs and a community pharmacy. The gym was used for reablement services. The opening of that centre increased footfall in the library, which had all sorts of other benefits. There are lots of great examples around the country of how this works. Absolutely it is conducive to integration.

Q192 **Baroness Tyler of Enfield:** Thank you. Could I follow up on a couple of the points that you raised? I am sure the committee would welcome any of the specific examples of fully joined-up facilities that you referred to.

You talked about secondary care. I know the Fuller report pointed out the fact that capital investment has been directed very much at secondary care at the expense of primary care. For full integration, that capital investment would need to be directed in a separate way. Finally, in the context of estates, do you think that current GP ownership models are barriers to integration? One of our previous witnesses identified that.

Dr Amanda Doyle: There is no doubt that, as we expand our thinking about the capacity needed in primary care and community services to serve a population who in the future will be much more reliant on preventive care, and care for long-term conditions such

as increasing frailty, out of hospital in their own homes, as well as our thinking about the expansion of things like virtual wards, where we deliver care in the community rather than in a traditional hospital bed, that will drive us to greater consideration of what the estates and IT infrastructure need to be out of hospital, both in primary care and in community services. We absolutely need to rebalance that.

One challenge that the current predominant ownership model in general practice gives us is that both investment and revenue flows that support that model sustain a model that is an individual practice-sized building. Lots of what that we want to do as we move forward into collocated primary and community services and a scaled-up primary care delivery drives the need for bigger premises with a wider range of capacity. Those two models do not sit comfortably together.

There is also an argument that a younger generation of GPs is less keen to jump straight into partnership, including building ownership and all the risk that that brings. A rethink is required about how we approach the issue of the estate in primary care. Lots of the estate is modern, high-quality and fit for purpose, but, equally, lots of the estate is still converted houses or other buildings that predate the NHS and which therefore have been adapted for their current use rather than designed for it.

Q193 **Lord Watts:** How does NHSE identify and mitigate barriers to integration in the NHS and between the other local partners? What are the most effective levers that you have at your disposal to bring about that integration?

Dr Amanda Doyle: There is no doubt that the most effective way to bring about integration in a local system or place is to build strong relationships between the key organisations in that place. That is between the integrated care board and wider system partners up to local authorities and others, but also between the integrated care board and the range of NHS providers in that system.

Creation on a statutory basis of integrated care boards has created an environment and a set of responsibilities for ICBs that should drive the local planning, strategy development and joint collaborative commissioning approaches that foster integration. Approaches such as single financial control totals for integrated care systems make a huge difference when it comes to facilitating investment decisions and looking across the whole totality of health and care rather than it being up to each organisation to make decisions solely for that organisation.

We are giving integrated care boards and local authorities a range of opportunities to work in a collaborative way and have joint commissioning arrangements and common aligned incentives arrangements such as working with the care sector and with other providers in the voluntary and faith sectors. The Health and Care Act, which created ICBs, has provided enablers for that to happen. But the top and bottom of it is building strong relationships locally to develop a strategy tailored to that local system and that local geography.

Lord Watts: Do you think that bringing all those parties together with each of them having a say in budget setting for the local area is important? Bear in mind that we have heard that people are trying to do things in different ways. When the health service is under such stress, is there a tendency for each one of those to do their own thing and protect their own budgets? Is there not a case for bringing together, through the budget processes of those local partners, an understanding of each other's problems and how best to deal with them?

Dr Amanda Doyle: Absolutely, bringing a range of perspectives into the budget-setting process is more likely to achieve a balanced position as well as to invest in the things that make a difference. We have already heard that good care is more cost-effective than disjointed, chaotic care. Well-established evidence shows that investing in robust preventive services and supported-discharge services reduces spend in hospital and in clinical services. It is absolutely important that all those perspectives are brought into a budget-setting process. However, this is not easy stuff. For a challenged position, it is very difficult.

Dr Tim Ferris: On the data side, in a data-rich environment there are ways of demonstrating more or less integration. Of all the different metrics associated with measuring the degree of integration, my personal favourite is asking the patient from the perspective of the patient, "Did your care feel joined up?" There are multiple survey mechanisms for achieving that. Looking at that type of data, as well as all the other data that we have at our disposal, is a very important part of the process of making sure that we identify areas where we have opportunities for improving our integration.

The Chair: Baroness Redfern and Baroness Finlay will ask questions one after the other.

Q194 **Baroness Redfern:** Can I go back to the NHS estate and the local government estate? It is 2023. Is a framework being developed to link or to work together, or is it just a hopeful wish?

Q195 **Baroness Finlay of Llandaff:** Has the time come to formally abandon the gatekeeper role of the GP? In your large number of teams, how does the patient know who is currently in charge of their care and carries responsibility for their care?

Dr Amanda Doyle: They are two completely different things. There is no formal national framework for how we approach a formal bringing together the public estate. A lot of work is being done on strategies for estates and each ICB is producing a strategy for its own estate. Although we can treat the NHS as one entity to some extent, local authorities are very much separate entities.

Baroness Redfern: When will the outcome of the strategy be?

Dr Amanda Doyle: Each ICB is delivering its own estate strategy.

Baroness Redfern: Does each ICB report this year?

Dr Amanda Doyle: They are in the process of delivering that now.

The Chair: I am well aware that we could debate Baroness Finlay's question for three hours.

Dr Amanda Doyle: We could debate for three hours. Could you repeat it please?

Baroness Finlay of Llandaff: I am asking you whether the time has come to abandon having the GP as the gatekeeper. In this large hub of people, how does the patient know who currently has responsibility for their care rather than there being gaps and everyone saying, "I thought somebody else was doing it"?

Dr Amanda Doyle: It is really important that the patient knows where to go, who to contact and who they can go to for help. I do not like the gatekeeper role quite so much now. GPs are expert generalists. They are the best people to deal with complex multimorbidity in people in primary care, and we should use them in that way. Part of that role will be a gatekeeping role, particularly for specialist hospital services, but we should absolutely not use GPs as the funnel through which we access every other service.

We need to empower people to access services more directly themselves. We have done that. We have asked community service providers to make a list of community services directly accessible by patients by September this year. We are expanding the range of services that people can directly access from pharmacies as part of the primary care recovery plan. There is a big piece of work in letting patients know that, not only giving them the information they need on which to base their decision—some of that is quite

straightforward and some of it is more complicated—but communicating that to them.

Currently, there are seven conditions that you need to see a GP for because you need a prescription-only medicine for them. We are in consultation about rolling out a pharmacy-first approach so that people can receive those prescription-only medicines from pharmacies. We expect that to be rolled out towards the end of this calendar year and we will very much communicate that to the public. We will not be using general practice as the gatekeeper to everything. We will be using the specialist skills of GPs in knowing what secondary care services and diagnostics might be needed to access, but not where it is obvious to people what they need—elderly people who might need a test and a hearing aid—giving the people the ability to book themselves in for that sort of stuff.

Q196 **Lord Kakkar:** We have received previous witness evidence that suggests that there is no evidence at the moment that integrated care will drive a reduction in demand and resource utilisation in secondary care. How much would it be a barrier to promoting effective integrated care if resources could not be released from secondary care in the future?

Q197 **Baroness Barker:** My question is for Dr Ferris. We have heard a lot for several months about the need for greater information sharing, but every time we have dug down into projects that people have brought to us, the answer to mitigating the barrier is for the NHS to take over everything so that they keep the data in an NHS-approved system. You cannot take over the whole of social care. That is the first point.

Secondly, there are still some conditions where it is very important to patients to know that their data is held securely. For example, people with HIV do not wish their status to be broadcast around. Is there now a case for an additional role, a personal patient data officer? How do you think that responsibility should be made known to patients?

Dr Amanda Doyle: Integrated care systems are just less than a year old—they came into force formally on 1 July last year—so it is too soon to have any real evidence about the impact of that driving things in that direction. However, the premise on which the thought that it will is built is the fact that we have lots of established evidence about greater use of prevention, greater focus on population health management, more proactive risk stratification and more proactive care of people at highest risk who are most likely to be admitted to hospital.

We have not yet seen an effective implementation of all those things in a way that lets us not only demonstrate that they work at scale but start to reduce the impact of demand on secondary care services. Some of it is counterbalanced by the demographic change, increasing long-term conditions, increased life expectancy, increased length of time living in poor health or with frailty. To some extent, all those things will drive demand for services overall. We have to invest proactively in the things we know will make a difference and hope that that stops the ever-rising demand for secondary care investment, which is what we see at the moment.

Dr Tim Ferris: Because of modern data and modern technology, it is not necessary to move data all to one place. It is unnecessary now with the processing speeds and memory capabilities. You leave the data in its secure and local location and use only the parts of it that are important for their intended use, along the four uses that I mentioned earlier. I think it is a red herring to say that the only way to do this is to move all the data centrally. We can accomplish everything we need by leaving the data more or less locally. There are a few caveats to that, but it is important that the people who have access to that data fulfil all the rules that I laid out earlier.

You asked whether there was potentially a new role. I think the national data guardian is the role that you described. I work with Nicola Byrne all the time in her role as the national data guardian, and there are Caldicott guardians. Maybe I am misunderstanding, but I am not sure there is the need for a new role.

We need to be more explicit about the use that we are putting any particular piece of data to. Who has access to that data? Does it fulfil their needs? What audit trails and security technology do we have around that data environment to ensure, as I said earlier, that we build and maintain trust that we manage the data appropriately?

The Chair: Thank you both very much indeed for an excellent session. We appreciate your time. We have already suggested to you other things that we might want from you. If there is anything else that you think would be useful to the committee in its deliberations, feel free to get in touch with us. As you know, this is a recorded session and you will be sent a transcript to look at for transcription errors. In the meantime, on behalf of the committee, thank you very much for your time this afternoon.