



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 16 October 2023

3 pm

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

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Questions 237 - 254

Witnesses

I: Hon Helen Whately MP, Minister for Social Care, Department for Health and Social Care; Hon Neil O'Brien MP, Minister for Primary Care and Public Health, Department for Health and Social Care.

Examination of witnesses

Helen Whately and Neil O'Brien.

Q237 **The Chair:** Good afternoon, and welcome to this meeting of the Integration of Primary and Community Care Committee. We are very pleased to have here with us this afternoon two Ministers, Minister Whately and Minister O'Brien, who have separate and overlapping responsibilities in the department for this topic.

We have questions for you in the usual way. My committee is never backward in coming forward to ask supplementaries, but we want to give you the opportunity to talk to us as fully as possible in the hour and a half that we have with you. I will keep an eye on the time.

As you will know, we have been hoping to have you and your officials here for a while now. It is a pity that it has had to be postponed, but we very much hope that you are feeling better, Minister Whately, and are still valiantly getting round on your crutches. As you have both come to us rather late in our process, there will be a limit, as I am sure you understand, to how much can be incorporated into our report, which is already well in progress. We will put our questions to you both, and you can choose which to answer as and when. Do feel free to box and cox between the two of you.

I will ask the first question. Could each of you describe your ministerial remit, with particular reference to how it relates to integration, how that responsibility is shared, and who in particular is personally responsible in central government for the overall success of integration across the NHS, including local government and the voluntary and community sectors?

Helen Whately: Thank you for your welcome, and my apologies that you have had to wait so long for me to come before the committee, along with my colleague Neil. Thank you for your patience in my getting to the point where I no longer have to sit with my leg elevated, which would make this more challenging.

My ministerial brief includes social care, and I am sometimes known as a Care Minister. I also have responsibility for the urgent and emergency care pathway, so a lot of my time is spent on social care and discharge, and for the front end of the system, which is avoiding admissions to hospital in the first place. That involves social care, but community healthcare is also within my ministerial brief, along with 999, 111, ambulances and emergency departments, and the flow from end to end. I also have oversight of dementia, end-of-life and palliative care.

Specifically on integration, I am the Minister with oversight of integration of health and social care and the structures that we have put in place to support integration—integrated systems¹ which includes integrated care boards and integrated care partnerships.

Neil O'Brien: I am the Minister for Primary Care, so the Minister for GPs, dentists, ophthalmologists and pharmacists. I am also a Minister for Public Health, so the Minister for everything we are doing on obesity, smoking and the like.

In terms of what I have been doing, a lot is happening on the integration front, in primary care in particular, be it the growth of PCNs or the measures that we are taking as part of the primary care recovery plan to improve the interface between primary and secondary care and the rest of the system. Both those things have in common a focus on prevention, in a sense: we are trying to do more to make the national illness service a national health service and to keep people from needing expensive hospital care in the first place.

The Chair: Thank you. I also asked who was personally responsible in central government to see that integration is happening. Would that be you, Minister Whately?

Helen Whately: Yes, in the sense that I have oversight of integrated care systems and that infrastructure. Clearly, you will see integration happening in many areas. There will be things that Neil will be doing where, from the primary care point of view, he is seeing integration happen. A lot of the work I have been doing on urgent and emergency care and on discharges is about building integrated teams, such as care transfer hubs, which will bring together people from different parts of the system—acute, community, mental health, social care, and voluntary organisations. They are coming together, so I particularly look at what is happening in care transfer hubs under my remit as Minister for Urgent and Emergency Care, albeit that it is being delivered very much through integration services.

The Chair: Thank you.

Q238 **Baroness Finlay of Llandaff:** Thank you both for coming. Over the past 25 years or so, we have seen lots of initiatives to improve integration, or even to bring it about where it did not exist. Yet

¹ The Health and Care Act 2022 established statutory integrated care boards and integrated care partnership which alongside other partners such as local authorities, partner NHS trusts, provider collaboratives, VCSE organisations etc. form an integrated care system.

they are often still needed. The question, therefore, is why they do not really work. What do you feel are the root causes of the problems that have made these repeated interventions necessary? We have heard quite a lot of evidence from different people about lots of different parts of the system, so we would be interested to hear about it from your perspective as Ministers.

Helen Whately: As you say, people have talked about integration for many years in many ways. Sometimes it becomes an overused word, in fact. I look at it very practically; I look at what is happening, what it is actually about. It is about people from different organisations within the NHS but also linking the NHS and social care, and social care to local authorities but also to providers, and the diversity of that part of the system and the extent to which they are coming together and working together.

In the structure that we have at the moment, which we introduced and legislated for with the Health and Care Act 2022², there is an integrated care system which includes integrated care partnerships and integrated care boards. I spend a significant amount of time talking to the people leading those organisations, and I have heard many times that this feels like the best shot at it. People have talked about integration a lot over the years, but this is the best effort that the system has made and the best structure that has been put in place to date to achieve it in practice.

I am hearing that partly because the structure that we have legislated for was bottom-up; it came from the system, and as we move from CCGs into the current landscape, that is what people across the NHS were asking for. So to some extent the legislation formalised what was already happening in some areas. It was a kind of bottom-up drive for this approach to integration.

Although there is a common structure with our 42 ICBs, ICPs and the footprint, there is also a recognition of diversity. We do not expect each area to do it in exactly the same way. We want every area to work out its own way of integrating. Yes, there is support—there are frameworks, guidance and common reporting structures—but the way it is happening at the moment reflects that diversity, with different areas being able to do the right thing for their population by using the relationships, organisations and interactions that already exist.

Neil O'Brien: That is right. It is a bottom-up reform that came from the system and was then formalised in the 2022 Act. There is much greater clarity about the direction of travel. If you compare it

² It is Health and Care Act 2022 - [Health and Care Act 2022 \(legislation.gov.uk\)](https://www.legislation.gov.uk).

to, say, the early 1990s when the emphasis would have been on competition and choice, the focus on integrated systems working together is much clearer.

In terms of what is underneath that, it is partly about the formal structures—the ICBs and so on—but there are also the structures of what goes on in each different part of the system. In general practice, for example, you see the move towards PCNs and things like the Additional Role Reimbursement Scheme³ and towards a much more multidisciplinary team. So there is a structural element to it that is partly borne out in the way the workforce is changing.

There is also a technology aspect to it. Many practical obstacles have been encountered over the years when people have wanted to do this locally. One of the primary issues has been flows of patient data and the management of information to different challenges. In pretty much every part of the system, those are things that we are now well on the way to addressing. Work is not complete, but it is making terrific progress compared to where we were even a few short years ago. So structural change, workforce change and technology change are all supporting something that itself has come from the system and from local leaders.

The Chair: In terms of root causes, would you say that the reasons why we have struggled with integration were structural before the new systems?

Helen Whately: Some of them are historical in the way our healthcare system has evolved over the years with separate organisations. Going back, you have acute hospitals doing their thing and primary care and GPs doing theirs, while the social care side has a different flow of funding and accountability, and community care trusts are separate again. That is a simplistic way of describing the starting point.

We are building something that makes those organisations overlap much more. Often there will still be separate identities, although you will see models where you will get, for instance, an organisation that includes secondary care, community care and some primary care, so there will be an actual change in the organisation, but in other cases it is about creating joint teams where people are still employed by different organisations but work in the same place and feel part of the same team, or even where they work together without necessarily being in the same place.

³ It is Additional Roles Reimbursement scheme - small factual correction rather than transcription error.

As Neil mentioned, some of the enablers are really coming together. On the data side, for instance, it is about improving data sharing between organisations and moving towards having the single patient shared care record, which clinicians from different organisations can look at and have a common information source. That is an example of one of the bits of infrastructure that is helping this integration to work in practice.

The Chair: Indeed. We will ask you a bit more about that later.

Q239 **Lord Kakkar:** I want to turn to what was a very thoughtful White Paper published in February 2022, *Joining Up Care for People, Places and Populations*, and explore what progress has been made with regard to the implementation of some of the impressive proposals that were suggested might have happened by now and through the rest of this year. I will then turn to the question of the better care fund. First, though, I want to ask about the implementation of some of the wish list of activities in that White Paper.

Helen Whately: Is that the White Paper that I would know as the Fuller stocktake, or a different one?

Lord Kakkar: No, it is the White Paper on integration.

Neil O'Brien: A lot of the big building blocks of that vision are now in place or well under way. Through the Act, we formalised the creation of ICBs and ICPs. All the ICPs have set out their integrated care strategies, which is the five-year horizon view, while the ICBs have now set out their joint forward plans and are producing annual reports and the like. There are a lot of other big building blocks of the system. At the GP level, PCNs are well established and have a large number of people working towards them.

In terms of building on that vision—of course, a few things have happened since then—we have doubled down on that, with everything that was in the Hewitt review, the Fuller stocktake and what we put in the GP recovery plan. So quite a lot of the vision is now well on the way to happening, and there have been significant investments in the digital enablers and the workforce enablers of it. Whether everything in it has happened I do not know, but the big structural changes are well under way.

Q240 **Lord Kakkar:** There was some interesting discussion in that White Paper of the need to align regulation more effectively to ensure that, for instance, the inspection and regulation of care environments could be done in a joined-up way; that the budgets for the delivery of that integrated joined-up care could be mobilised in a fashion that made them truly meaningful for application to

individual patients; and that there was a system of accountability that that would ultimately give you as Ministers the confidence that, through the system, this integration was delivering for individual patients and populations.

The most important aspect was that there would be clarity of what outcomes would be measured to provide reassurance that all this was moving in a direction that could ultimately deal with the important questions that the White Paper and all the other reforms that you have introduced are intended to answer. In those broad areas, within the structure that you have described, are you content that sufficient progress is being made?

Helen Whately: I am happy to pick up on those three areas. First, on the point about accountability, there are multiple ways in which ICBs and ICPs are accountable. One is that there is an NHS England oversight framework of ICBs and their performance. It groups ICBs into four different categories. Those at one end of that get more support and focus, while those at the other end are seen as more mature and further progressed in what they need to do as integrated care systems. Clearly, there is also an element of local accountability that ICBs need to have in relationships with local authorities and their local communities.

Related to that, on the one hand, yes, there is accountability through the system, but we also designed the system to be particularly accountable to its local community, to be able to understand the population needs of that community, and therefore, to a significant extent, to be able to identify what outcomes are most important for that population. That is quite important in giving local systems some flexibility to determine what are the right outcomes for their own population; it is an important part of their autonomy, hand in hand with them obviously needing to reflect some of our priorities both as a Government and nationally.

On your point about funding, one thing that is going on is the Section 75 review, which is looking at exactly that area and whether more needs to be done to give the flexibility for funding and pool budgets. There is a call for evidence open at the moment, which will close at the end of this month. Then, we will look at what comes out of that and whether more needs to be done at the national level to give greater flexibility on the funding side, approving budgets and things like that.

On regulation, a very important area of progress is the introduction of CQC—Care Quality Commission—oversight of integrated care systems. To me, that is a really important step in this. To date, the CQC has looked specifically at specific providers and assessed them

on what they do. This is a novel, and I think important, bit of progress, with the CQC now looking at systems and how those providers work together. That will give an important lens not just on whether the provider is doing its job within its own silo but on whether it is playing its part in the system so that the system functions. I am looking forward to that CQC process giving some real insights and helping integrated care systems to learn from each other. We will no doubt have some variation there, with some doing it better than others.

Lord Kakkar: In the White Paper, there was a suggestion that you might designate front-runner areas where all the reforms in those four areas that you kindly described might be applied in a system, with the benefits determined and shared more broadly with systems that are less advanced. Is that still your intention?

Helen Whately: We have a programme at the moment of six discharge front-runners that are doing some really interesting things and really driving integration, with different kinds of focus. There are examples in Sussex. There is an example in Leeds where they are doing exactly that by being at the vanguard and being more innovative. Part of the investment in them is for them to be able to test the model and for others to learn from what they are doing.

Q241 **Lord Kakkar:** If I may turn to the second question, what are the strengths and weaknesses of the better care fund? How might it mature and be developed in future? Where do you think its priorities will lie with regard to integration?

Helen Whately: I think the better care fund is proving very valuable in the way it is bringing together local authorities and NHS organisations in working out how best to spend a budget on intermediate care and areas such as rehabilitation and reablement, for example, where there is not necessarily a clear dividing line between social care and NHS services. It is therefore helping to get rid of some of that boundary between the different bits of the system.

Over the past few months, there has been a particular bit of work on intermediate care, looking ahead at this winter and the months ahead to identify likely demand and to plan for how the system will meet that demand across the breadth of services and for how best to use the better care fund pot to meet that need. I think that is a very good sign.

I would like to see areas putting more than the minimum into the better care fund pot. I know that some areas are doing that. In

some areas, you see systems and organisations leaning in and putting extra money into that pot. It is a good sign when we see that.

Lord Kakkar: How might that be encouraged? Do you think it is sufficiently flexible now to give those putting money in the confidence to achieve what they want, or might other reforms and incentives be required for it to achieve that objective?

Helen Whately: I do not think I can pre-empt the Section 75 review; you may well give us some helpful insights into what more we could do to help that pooling go further.

With regard to all the work to get systems to look ahead and plan for what they will need in order to be in the best possible shape to get through the winter—this has been done to a significant extent under the umbrella of planning for this winter; from my point of view, it started many months ago back in the spring with the urgent emergency care recovery plan—I have been told that, because of some of the questions that we asked from the centre as part of the planning process, organisations have come together to answer those questions in a way that has been helpful to them.

Q242 **Baroness Armstrong of Hill Top:** Good afternoon. It is good to see you. When do you think the Government will be able to take a view on what is working and where? Given what you have already told us, there are huge differences. In my region—the north-east—the ICB covers the whole of the north-east and Cumbria. It is certainly not place-based; it is very much based on the old region from the regional health strategies of 20 years ago. Then you have other ICBS that cover one borough and so deal with only one authority. When will you at the centre take a view on what is working so that everyone, wherever they live, can expect integrated care to deliver?

Secondly, in the next year, how are you going to tackle the pressure that we are already hearing about, with ICBs having to think much more about acute care and being driven by the acute sector because of the huge waiting lists? When are you going to get through that to make sure that the integration of primary and community care that we are talking about, which may well affect hospital entry in the medium term—and will certainly help with hospital exit, which you are looking at—gets looked at?

Q243 **The Chair:** While you are answering those questions, let me add another. Can you tell us about the progress being made on the feasibility of having a single person accountable for shared outcomes, which is mentioned in the White Paper? You have quite a lot of questions to answer there.

Baroness Armstrong of Hill Top: Sorry about that.

Helen Whately: I will do my best. No doubt you will pick up on what I say as well.

On the first question about how we know what is working and where, I see it like this. It is early days for integrated care systems and ICBs. There are varying levels of maturity; we know that. NHS England has done reviews of maturity and knows which ones are further ahead than others. Extra support is giving to those that are less mature, so to speak. There is an element of giving these systems time, both for relationships to form and for infrastructure to come together. I genuinely think that the CQC assessments will be helpful. In essence, it is about an organisation taking a step back and taking an impartial view on how well this or that system is doing.

I also think that, in the shorter term, we can do a good job of knowing what works if you look at the more service-level element—that is, what kinds of integrated teams delivering stuff work well. I have been doing quite a lot of work with NHS England on the development of proactive care for people who are frail or elderly—and, broadly, proactive care models, because they are a very good thing—rather than people going in and out of hospital when we know that they are at risk of multiple attendances and long stays in hospital that will not be to their benefit.

We know that it is much better if, in any neighbourhood or community, you can identify the people who are at most risk of that and put things in place that proactively maintain independence and avoid those frequent visits to hospitals. There are examples, such as the Jean Bishop centre in Hull, where the data is clear that that kind of integrated multidisciplinary model, involving primary care, geriatricians, community nursing and therapy, all comes together and reduces A&E attendances.

Baroness Armstrong of Hill Top: We have known that for quite a while.

Helen Whately: Yes, but you then say, “Well, how come we don’t have that going on in every area?”

Baroness Armstrong of Hill Top: Exactly.

Helen Whately: The reality is that you can find many examples where there is a similar theme, but things are done slightly differently. The job at the centre is to try to be a catalyst for it to happen more substantially across the whole country. NHS England will shortly publish a proactive care framework for people living

with frailty, as this is a model that really works, and to support systems in doing this.

I know from my conversations with ICB chief executives that they really want to do this stuff. They are excited by the opportunity that the ICB structure gives them to look at the population's needs and to think much more in a population health management way. It is therefore a good environment for commissioning more of those kinds of services in. When the Jean Bishop centre was first set up, it was almost against the odds. Now, the system is more geared towards encouraging and enabling that. That is where we will be able to see more quickly, "Okay, here are some specific benefits and outcomes", while over a longer timeframe we will be able to see what real difference that the ICSs⁴ are making to whole-population health outcomes.

Related to that, there was your question about how we make sure that care happens against the pressure of delivering on acute, and that we see the shift that we want to see in out-of-hospital care, for instance. For me, those are not in competition. Look at what we are doing across urgent and emergency care: yes, part of what we are doing is investing in acute services, and, yes, there are 5,000 more beds in the acute sector as part of the winter plan, but a substantial part of the UC recovery plan is on out-of-hospital care. It is about urgent community response services—multidisciplinary teams working with the ambulance service and community staff going to someone's home, rather than them being conveyed into an emergency department. That is an out-of-hospital response, which is good for the patient but also takes some of the pressure off the acute sector.

Similarly, the care transfer hubs that I talked about a moment ago, which support discharge and help people to discharge earlier, are a lot about more resources outside hospital to support people rather than acute, supported by significant extra amounts of funding under the discharge fund of £600 million in extra funds this year and £1 billion next year, to support discharge and admissions avoidance. So I do not think it is either/or; those things are complementary.

On the single person question, it is a work in progress. It is not as simple as, "There is that person who's going to have accountability across the whole lot". What I see from my position of having oversight is that these are evolving models. It is not a one-size-fits-all solution as simple as, "There's a person".

⁴ ICS - Integrated care system includes ICBs, ICPs, LAs, and other partners within their boundary.

Q244 **Baroness Osamor:** How will the White Paper be more successful at addressing barriers to integration than previous initiatives?

Helen Whately: I will try not to repeat myself on this, but a crucial part of the drive to create a more integrated system is the way that it has come from the bottom up rather than being top-down. We are supporting systems where local areas do what people want to do, rather than imposing on them a way of doing it while going with the grain of what the system wants to do in the partnerships that people want to have and the relationships that they have established in enabling those green shoots to thrive.

Another part of it, which Neil referred to a moment ago, is on the infrastructure side, driving, supporting and using the opportunity we have with technology to make sure that some of the building blocks are in place, such as data sharing and shared records so that people in different organisations as appropriate have access to the right information that they need to see and can contribute to it.

On the estate side, integrated care systems can do their estate strategy where they look at who should be coming together in one place and where it makes sense to have people with the same roof over their head. On the workforce side, ICBs are playing a role in looking at what workforce is needed across the area, building joint teams and looking at how to train people to come together as a single workforce. Those are the enablers to help this ambition to succeed.

The Chair: We will come back to more of those questions.

Neil O'Brien: Each of those different enablers we have produced through consensus with the system, with, effectively, checklists of series of actions that you should be doing as a system. For example, the Fuller review had about 15 different things that we hoped local areas would do to create integrated neighbourhood teams, alongside the primary care recovery plan. We published a whole other report by the Academy of Medical Royal Colleges that was all about a big list of things that we wanted everyone to do to produce less bureaucracy between primary and secondary care and a better and smoother interface there. In the technology space—on the technology enabler side—we have done a maturity assessment of how they are all doing on producing shared care records and things like that.

It is about having clarity about what is expected—not so much from the centre as developed with everyone in the NHS as an agreed set of actions that we should be doing and that we can measure against. For some of these things, it is about putting deadlines on

them and funding them in the technology space. For example, we are putting something like £1.9 billion into electronic patient records in hospitals to complete that project and get 100% coverage. Similarly, huge investment is being made in other parts of the digital infrastructure that will underpin a properly integrated approach. So it is a combination of clarity about what systems need to do and, in some cases, funding and deadlines to drive all this forward.

We are not trying to go against the grain here. This is what everyone in the system agrees that we should do and what people have been talking about for 25 years, as has been said already in this session. Everyone now has a different spirit. Naturally, every organisation will try to think about its own budget. That has always gone on, but having more of a sense of fellow feeling and having everyone as same part of the same committee, formally making them all on the same team, starts to challenge the long-standing problem that has been there for ever.

The only other way around that problem was yet another top-down reorganisation where we would impose some cookie-cutter vision and made everyone into a single organisation. No one in any significant numbers in the Commons or the Lords as we were passing the 2022 Act wanted that, so we have to go with making the system work, and I think we are doing everything we can to enable that.

Baroness Armstrong of Hill Top: Why, then, has productivity slumped? Everyone wants the system to work, but—

Neil O'Brien: I disagree that productivity has slumped. In general practice, they are doing something like 15% more appointments every month than they were before the pandemic. They are seeing a huge number of more people.

Baroness Armstrong of Hill Top: Not in hospitals.

Neil O'Brien: Obviously demand is ever going up because we are an ageing society, but the amount of stuff being done is increasing, so I slightly take issue with that. The integration agenda unlocks huge efficiencies in patients having a hassle-free NHS where you are not constantly giving people the same information again and again, and clinicians do not have to chase each other around because they have access to each other's records and can get hold of the right information at the right time. If we get it right, potentially there will be more preventive activity and more upstream activity, and more people being in better health for

longer and not needing treatment, or, if they do need it, getting it at a better and earlier stage. It is central to our efficiency drive.

Q245 **Baroness Redfern:** Thank you very much for coming this afternoon. In our committee meetings, we have heard from many witnesses from the primary and community care sectors. They have told us that it is not always easy to begin to engage with ICSs, in particular to be treated as equal partners. How important do you consider such barriers to entry to be? How should they be addressed? In the same phase, we have also been told by our witnesses that there is a definite cultural clash between the decision-makers in the NHS and those in local government.

Neil O'Brien: On your first question, again, this is a long-standing issue. If you read Nick Timmins' book on the history of the NHS, you will see that it goes right back to the start and shows that parity of esteem has always been an issue. As one of the players, secondary care is financially much bigger than primary care. By consciously investing in rural primary care, in growing the workforce by a bit more than a quarter since 2019, and making the workforce much more multidisciplinary—the growth that we have put in has been through the ARRS in particular—primary care is spreading its wings. It can do more and give people more direct access to a specialist in primary care, be they a pharmacist or a physio, without necessarily having to refer on.

It is a bit about genuinely empowering primary care and a bit about the creation of ICBs, which is about trying to put some of the long-term concerns to bed. One reason why we produced the report with the Academy of Medical Royal Colleges, as part of the primary care recovery plan, was to address some of the everyday frustrations of clinicians, particularly in primary care. They may, for example, turn up and find 20 completely unformatted letters on their desk. They may find, when they are trying to get hold of someone in secondary care to find something out, that they cannot get hold of them and there is no private phone number. They may find that they do not have read/write access to a shared record, so they cannot just look up what has happened to their patient—and so on and so forth. There are all these causes of friction and waste in the system.

We have come at them trying not to boss one side around. By having a report produced that is the result of a consensus between primary and secondary clinicians—because both sides suffer when there is this unnecessary friction—and generating a consensual vision of the practical problems that we need to address, we can start to make that relationship work a bit better. We are very much gripping that. Every ICB in the country will have to report later this

year on the progress that it has made against that report. We will give them all a clear framework saying, for example, "This is how we're measuring your progress. Are you creating a single phone number for your patients to ring up so that they do not have to ring their GP? Are you creating a private phone number for a GP so that people can always get through and don't have to go through the public system?" We are conscious of that long-standing issue, through what we are doing in the primary care recovery plan and more.

Baroness Redfern: Do you think that there is a cultural clash?

Neil O'Brien: It is a really long-standing issue. I cannot remember whose ladder it was that famously showed, in the 1940s or 1950s, the parity of esteem issue between general practice and secondary medicine, but this is not a new thing. I do not think there is a cultural clash, but I do think that there are often practical frustrations. It is our job to try to reduce them, partly through the investments that we are making in technology and partly through having a clear action plan and then driving it through in order to stop people wasting their time.

Helen Whately: On the joining up of the NHS and social care, in talking about social care, I think about both local authorities and care providers. I might talk about that slightly separately. What I see and hear is that the integrated care systems, the ICBs and ICPs are giving local authorities a voice. That is what I hear from local authorities and what I see when I have meetings that bring ICBs together, whether through board members or through chairs who have a local authority background. We are hearing the voices of local authorities in integrated care systems. You get differences in different areas, of course, but what I am hearing from them, with them very much being in the room and in the conversation, is positive. The feedback is that it is happening more than in the past.

I will not say that the job is done; clearly, the reality is that there are different accountabilities and different funding flows, as we said earlier. But real progress has been made on that. We will only see that get better as we get more joining up of the data and better-quality data for social care, with better insights into patients' individual pathways through social care and healthcare and what we call client-level data, which goes down to individual records. That will help, too.

Other things that are helping are the questions that are coming from the top and the much more joined-up way in which we are looking at the system as we tackle the challenges, such as flow through hospitals. We are really looking at the system in a joined-

up way in government; it helps from the top as well as from the bottom when we see these structures coming together.

As I mentioned on care providers, the next thing to look at is where we see variation. In some integrated care systems, care providers feel that they have a strong voice—that it is not just local authorities but commissioners and the providers themselves in the room. In other systems, I hear providers say, “We feel like we’re not being listened to, but we have the answers to some of these problems, because we’re the ones providing the care. Find a way for us to get in the room”. There is much for us to do to see how providers can be supported.

Some of it is because in some areas there is a clear geographic footprint and a legacy of providers coming together; they have an organisation and an individual whom they have agreed represents them in these kinds of forums. In other areas, there is a more fragmented care sector and there is no agreed person who goes along and represents, so it is harder. The ICB says, “Who do we talk to from social care other than the local authority?”

Baroness Redfern: In rural areas, care is more fragmented than in, say, urban settings.

Helen Whately: Actually, I have not seen that particularly. I know from conversations that I have had with Lincolnshire, for example, that it is a good example of the strong care provider voice, and it is a pretty rural part of the country. I do not see it so much as an urban/rural divide. When there is clear geographic coterminosity of the boundaries for the NHS and local authorities, that is helpful. It is also more likely that they have a longer history of working together there. It is easier if the boundaries are the same for local authorities and NHS organisations as they are often further ahead in those places. To me, this is the next push on the social care side.

Q246 **Lord Watts:** Do you think the Government have missed a trick in not having a work plan for the care sector in the way we have one for the NHS? Is it not likely that, at some stage, that will—or could—lead to a shortage in one sector that has an impact across both sides of the care service?

Helen Whately: I would like some of the conversation on this to take into account more of what we have been and are doing in social care for the workforce. There is a substantial vision being set out; we set it out in a White Paper, *People at the Heart of Care*, a couple of years ago. It was substantially about social care workforce reform, and we are making steady progress on implementing it. We have been working on our care workforce

career pathway, recognising one of the things that I hear many times from care providers when they are recruiting, the DWP, jobcentres or people thinking about going into social care: that there needs to be more of a career path. So we are developing that career path.

The social care sector is not a blank slate. In fact, many large organisations already have some kind of career path, so we are working with them. It has to be something the sector buys into. That is one thing we are doing, one of the steps—I will put it in the picture—to really recognising the skills of the social care workforce and seeing social care and work in care as a profession. I do not mean that everyone working in the profession should have a degree. Clearly, we have those in social care who have a degree and, clearly, social work is a profession—social care nursing, for instance. Clearly, you need a lot of skills as a registered manager, but we also recognise the skills that care workers have and want to make sure that there is greater recognition and structure around that.

Lord Watts: I take the point you are making. However, we know that there is a shortage of GPs, doctors, dentists, chiropractors. The workforce plan is intended to try to look to the future and identify the sorts of training we will need. Is not including the social sector in that leaving it at a disadvantage to the NHS?

Helen Whately: There are clearly differences between social care and the NHS. One clear one is the length of time you train to work in social care compared to the length of time it takes to train a doctor. The NHS long-term workforce plan was a big piece of work that involved a lot of getting together of the NHS. Social care is a different thing. Just because the NHS has done a thing, it does not necessarily mean that we should try to do the same for social care. Social care is different.

We already have in place, and are already working on, a 10-year vision for the social care workforce, where we are already seeing progress. We had a very recent report from Skills for Care that showed that we have 20,000 more people working in social care now than a year ago, so we are making progress. I would not want to detract from some of the progress we are making with these big reforms to say, "Let's stop and start again with doing a whole new care workforce". We are already well on the way with substantial reforms to the care workforce.

Lord Watts: That is not the evidence we have had. Our evidence suggested that that is a weakness.

Helen Whately: Some of it, and the reason I point to some of the work that we are doing on reform, is that not everybody knows about it. The more we can shine a light on what we are actually doing for the care workforce—it takes time and cannot be done overnight, because we need to do it well—that will build confidence that we do have a plan for the care workforce.

The Chair: And you are shining a light on it.

Helen Whately: Thank you, but you want me to pause, to stop and return to the topic at hand.

Q247 **Baroness Shephard of Northwold:** Former Health Ministers, and the Hewitt review, giving evidence to this committee identified a conflict, which you have touched on, between short-term NHS recovery and long-term population health improvements through prevention, which is what the noble Lord, Lord Watts, has been touching on. They noted that the pressure on emergency services was limiting the growth of non-hospital services. Again, the noble Lord, Lord Watts, has just referred to that. Do you recognise this tension between short-term fixes for the NHS and long-term improvements?

Secondly, what should Health Ministers and NHS England do to help integrated care systems, and the work you are putting into that, balance those demands and ensure accountability for their progress? Accountability is very important, especially when you have such a diverse and diffuse set of players.

Thirdly, could you both give the committee examples of good practice, in your experience, in this area?

Neil O'Brien: That is a great question. The answer is yes and no. Sometimes the long and the short can be in tension; sometimes they are absolutely not. The Prime Minister's recent announcement on the smoke-free generation, the phasing out of smoking, is not in tension with anything we might do in the short term, and it will have huge long-term benefits, not just for those who do not die of smoking but for clinicians who then do not have to—

Baroness Shephard of Northwold: Those are policies, rather than—. You are probably coming on to the rest.

Neil O'Brien: I was agreeing with you. Some of the things that we might want to do for the sake of prevention and the long term are not things that have short-term costs. They are some of the most important things. Sometimes there are tensions, but quite often there are not. The things that we are trying to do to recover our

provision on cardiovascular disease, those translate into fewer admissions relatively quickly, as you know.

One of our rationales for focusing on access in the primary care recovery plan was the knowledge that GPs will be able to do all the things we hope they will do on integration and prevention only if they can be on an even keel—hence, putting in the extra real-terms funding, hence the extra staff, and hence, for the first time really, directly investing in GP technology to increase productivity there. In that instance, we will get to the long-term benefits that we want, and a more preventive system, only if we can fix some of the challenges in the short term left behind by the pandemic by taking the kind of the actions that we are taking through the GP recovery plan.

It is the old, old story in the NHS, where we want to spend more on prevention but are too busy dealing with the present, but I think the story is more complicated than that. Sometimes those things are in tension, but quite often they are not, and sometimes they are well aligned with one another, because the thing that you can do today to take the pressure off right now has the pretty direct impact of saving you money in the longer term.

Helen Whately: I can think of specific examples—to answer your good-practice question—where things are going on for the long term but where there is also often a short-term benefit. The investments that are going into innovation, technology, data sharing, care records, those sorts of things, are for long-term benefits, but they are happening in the short term. One way in which we see that happening is by supporting pilots in areas that are being innovative in their use of technology. We are providing funding to support areas in going further with their innovations and then evaluating them so that we can share that with other parts of the system. That will give the area that is doing the innovation the short-term opportunity of the benefits of that innovation, but for the whole system potentially the long-term benefits as they share those lessons.

Another good example of something that I see as part of the future of healthcare but that is also being driven at pace in the short term is the expansion of virtual wards, or hospital at home. We started earlier this year with the capacity for a few thousand people to be looked after by a virtual ward. A small number of innovative areas were doing these things, and now we have 10,000 virtual ward or hospital-at-home places. That is the capacity now in the system. That has involved setting up multidisciplinary teams to care for people being remotely monitored at home, investing in technology

and telehealth and things to support that. It has happened at pace and will help us with the pressures this winter, but it is also a long-term direction of travel that will be expanded to look after patients with a wider range of conditions—for instance, children who can be supported with their care at home. There are short and long-term benefits.

Neil O'Brien: On the point about local innovations, we also try to learn from what is being done locally and apply that nationally, so it works the other way around.

Baroness Shephard of Northwold: That is really what I was asking for.

Neil O'Brien: The lung health check, which we are rolling out everywhere, was piloted successfully in Manchester. We have picked that up, and it turns you around from about one-quarter of cancers being detected at the early, treatable stage to three-quarters, which is transformative, so we are rolling it out across a large number of relatively deprived areas now.

On things that we have done on smoking, four or five local authorities piloted this thing where they gave habitual smokers free vapes. It tested very well locally, it was very effective, and we are now doing it for 1 million smokers as a national programme. Again, Manchester tested giving women who smoked in pregnancy voucher incentives of about £400 to stop smoking. Evaluation of that locally showed very high BCR, and we are again taking it to be a national policy.

We are co-funding some of these projects with local areas. In Wolverhampton, there is an amazing project where, because everyone now has smartphones, we and Wolverhampton City are giving everyone wearables and an app, so they can measure their level of physical activity and what they are eating. I can get you the number, but an incredibly large proportion of the adult population of Wolverhampton are now doing this, which is all very preventive. There are a huge number of exciting things being done on prevention locally, and we are working with councils to do them in the first place and to take the ones that work and scale them up.

Baroness Shephard of Northwold: These are very good, interesting examples of where things work. Have they sprung, though, from the attempt to introduce integrated care, or from specific initiatives coming from government?

Neil O'Brien: A lot of these are initiatives taken by individual people in individual places. It is absolutely a helpful context to be

in; you have a tailwind, as it were, rather than a headwind in the system we are now in, which is heading towards more integration.

Baroness Shephard of Northwold: Thank you.

Q248 **Baroness Tyler of Enfield:** Good afternoon. Can I take you back last year's National Audit Office report, *Introducing Integrated Care Systems*? You may recall that that included an assessment of the risk that the 10 key elements of integration could pose to the future success of ICSs. In short, four were judged high risk, four medium risk, and only two low risk. What were your thoughts about that assessment? Did you agree with it? What more needs to be done to reduce those risks, and who is doing it?

Helen Whately: The way I look at it is that it still feels like early days for integrated care systems, so it is important to give them some time. That is why we are working with NHS England. Yes, of course, we ask challenging questions of chairs and chief executives, but we also take a supportive approach and are constructive in helping systems to build themselves and get themselves working together and forming their organisations, partnerships, relationships and all of that.

I do not want to repeat what I have said before about oversight frameworks and all of that, but there is an element of giving the system a bit of time. That is one reason why, in the debate about CQC assurance and the extent to which the CQC should be giving integrated care systems a one-word rating at this point versus a narrative, the view that we have taken in looking at integrated care systems is, "Let's be more constructive and more descriptive about supporting the development of these systems, rather than coming in with a big stick at this stage of the process".

Baroness Tyler of Enfield: Okay, I understand that general point, but can I press you a little further? One of the four high-risk areas was about clarity of objectives, and one was about good governance and accountability. I think you said earlier that the fundamental idea behind ICSs was to allow them to take a system-wide, collective view of local population health needs in healthcare and in care delivery. However, our witnesses have told us that we have a situation where NHS England is maintaining very detailed performance oversight of NHS trusts and ICBs.

When will we reach a stage where ICBs, perhaps under a new oversight framework, are taking a leading role in overseeing NHS trusts, and NHS England is getting involved only when absolutely necessary?

Helen Whately: I cannot say to you that, as of that date, you will suddenly see the system working in a different way. At the risk of repeating myself, I think we need to allow this to evolve. Inevitably, some areas will go faster than others. There is also an element of cultural change in this. Clearly, we have a system in which NHS England has had very strong oversight and grip particularly of acute trusts and lots of performance management there. We are moving to a world in which we want to make sure that integrated care systems⁵ can look at their populations and direct resources to meet the needs of those populations and have variety in the priorities and outcomes that they focus on.

One thing that has already happened, looking at the list of metrics and targets against which ICBs are measured, is reducing that number and bringing down the long list in the NHS mandate. That is exactly in response to, "Let's not have quite so many things to look at". But there is a tension there. As a Minister with oversight of end-of-life and palliative care, I am working to get more visibility on what each integrated care board is commissioning for palliative and end-of-life care, what the access in each area is and how good that is.

There is an inevitable tension, which I feel, when you have the responsibility to make sure that people get the care they need, while knowing that we want to provide the flexibility locally to identify priorities.

Baroness Tyler of Enfield: Accepting what you are saying about it still being early days, going back to what the NAO report highlighted, how confident do you feel that there is clarity of objectives and proper governance and accountability in the system at the moment?

Helen Whately: I think there is strong accountability. You said a moment ago that some of your witnesses felt that there was too much.

Baroness Tyler of Enfield: And other witnesses told us they felt that it was very confusing as to whether it was coming down from the department or from NHS England.

Neil O'Brien: There will always be a tension between upward accountability and accountability outwards to the general public and to local clinicians. We need both those forms of accountability.

On the point about the different elements of integration, we are seeing something that I think is inevitable, which is that different

⁵ Integrated care systems include integrated care boards along with other partners.

systems are going at different speeds on different parts of the puzzle. Some systems are doing extremely well on the digital enablers. Some might be doing very well on health and social care colocation/integration and bigger additional budgets. Others might be doing well on avoidable admissions, doing more with locally commissioned GP services and the like. People will move at different speeds on different fronts, but in each of those different dimensions of the integration agenda there is real clarity about what you are supposed to be doing.

I am probably pro more accountability, particularly in publishing data that is not published at the moment. We recently started publishing a bunch of dental data that was available to me as a Minister but was not published for everyone else to look at. We also make data more accessible. We brought together all the data on general practice performance that a normal patient would be interested in into one thing on the Fingertips website called "GP profiles for patients"; you can see how your GP is doing compared to others in the area or nationally. We have also published more data on things like weight. So I do think, particularly when it comes to transparency and the publication of data, particularly where it already exists, that more accountability is a good thing, not a bad thing.

Your question is slightly allied to the question of control versus accountability. In a lot of areas, we are genuinely devolving more control to the local level. Dentistry is one example of that. POD services more generally are fully devolved from the region to the ICBs. There need to be both types of accountability, and I think we are giving good clarity about what you should be doing in all parts of the integration agenda, which are complicated and have multiple elements within them.

Baroness Tyler of Enfield: Thank you. It will be interesting to see what the NAO says when it looks at the whole issue next time.

Q249 **Lord Watts:** The committee has been heard that the role of place-based commissioning and financial decision-making needs to be reinforced. Do you share that view? What challenges do you think need to be addressed? Do you think the September consultation on improving integration commissioning will help, and, if so, how?

Helen Whately: One of the things we have mentioned is the difference between integrated care systems. Some have a very large geography, and some have a smaller geography where there is a clearly recognised boundary, in the sense of community almost. Partly because of that, the place-based level of commissioning that is more localised, for instance across the very

large ICS footprint, makes good sense. Some of the flexibility that has been built into the development of the integrated care system landscape is to recognise that people in an area will be better placed to identify the right geography in which to commission services, rather than somebody in Whitehall saying, “That’s the geography in which to commission services”.

There are probably lessons learned from previous entities of PCTs, CCGs and all those bodies setting nationally what the footprint should be. From what I hear coming up from the system, place-based is the way forward. That is something that was already happening and evolving before the legislation that formalised integrated care systems, so I think we should continue to support that direction of travel.

Neil O'Brien: It is unquestionably easier to do place-based commissioning and have a proper conversation across the piece in a world ICSs⁶. Thinking about my own constituency, one of the places in LLR ICB is Harborough. By having the ICS, we can have a single, easier, joined-up conversation that brings together issues such as, “What can we do to move things in secondary care out to the more local level so they are more convenient? What’s happening with everything in primary care? What’s happening with the community site within that place?” That makes it an easier conversation to have when thinking about these individual places.

Lord Watts: To make sure that we are all clear, do you agree that that is what needs to happen?

Neil O'Brien: It is a sensible way of doing things. Some ICBs’ geographies are very large—I think North East and North Cumbria ICB has 3.1⁷ million people—while others, such as Somerset, are much smaller. But within any geography you want to think about those as individual places.

Lord Watts: What would the challenges be of introducing that system?

Neil O'Brien: It depends on what you mean by “introducing that system”. That is what we are doing at the moment—or, rather, it is what ICSs are currently doing. They are having these place-based systems, and we as the Government are helping to create some of the building blocks that make that a bit easier, not just the creation of ICBs and ICPs⁸ but things like PCNs, which make it a bit easier.

⁶ ICSs include ICBs

⁷ Population of the ICB is 3.1 million: [Home | North East and North Cumbria NHS \(northeastnorthcumbria.nhs.uk\)](https://www.nhs.uk/about-us/our-organisation/northeast-north-cumbria-nhs-trust/)

⁸ The Health and Care Act 2022 created ICBs and ICPs rather than ICSs. ICBs, ICPs, LAs,

Rather than having to get in touch with every practice in your place, however big your place is, you can have a more joined-up conversation. Indeed, those practices and so on are working in a more joined-up way as a result. The structural changes that we are making make those kinds of place-based conversations a bit easier to bring off.

There are huge potential benefits from that. We have been able to move at the pace that we have on community diagnostic centres and reached the huge number that we have in the space of just two years partly because the community estate has hosted them. Lots of small bits of available land have been in the community estate and, by having that joined-up conversation, things that have traditionally been done in secondary care have been able to get out into the community and into a location that is often more convenient for people.

Lord Watts: So you are satisfied that you have identified the challenges and that the system that is in place will address them.

Neil O'Brien: I think the system is in the process of doing so. The job will never be done; there will always be more to do. But certainly the direction of travel has made that much easier.

Q250 Baroness Armstrong of Hill Top: You have been talking a fair bit about how important data is. One aspect that has been brought to our attention is how each part of the system knows what is happening. There is interoperability between the different systems and structures, but everyone who has talked to us has said there is a real problem. We had someone very useful from NHSE, who I gather has now moved on, who talked about having to be less complicated than we were and looking for much simpler ways of making sure that things were integrated.

There are some horror stories about people going into hospital where they have a particular disability or set of conditions. Because of that disability, they go in for something in particular, but their information is not there because the physio will have had handwritten records, the GP will have had a particular system and the other neighbourhood care people will have worked on a different one. The hospital ends up with none of that, and so ends up not treating the patient as a whole person. This is a real issue, particularly for people who do not have a good advocate. How are you addressing these issues of interoperability and making sure that the basics for getting integration to work happen?

Neil O'Brien: That is a brilliant question, and it is a central issue facing the NHS. We are addressing that at multiple levels, because it is crucial not only to the good clinical function of the NHS but to treating people as human beings, which is exactly the tenor of your question. I hope we started to change the culture with the 2022 Act, which changed the emphasis so that, instead of the emphasis all being on information governance and risk, the duty is to share when that is in the patient's interest, as well as taking steps to improve public confidence on that front.

As well as that overview change in the culture, we are putting in a lot of the digital plumbing to make all these things work. One big piece of the plumbing is the shared care record, and we are putting about £50 million into creating that. As you know, that is a system of systems, joining up information from lots of different systems in secondary care, community care, primary care and so on. By 2022 all the ICBs had a basic shared care record. By March 2025 they will have got to what we call maturity level 2, so basically all clinicians throughout the system will be able to read and write to them. Systems that are more mature—we have a framework by which we assess their maturity in every different ICB—are tremendously useful. For example, the north-east has the great north care record, which is used about 400,000 times a week. All the active trusts can read from it and all the GPs are on it. The London one, which is across five ICBs, is another good one. When an ambulance crew turns up to the site of something acute, they can find out an awful lot about that person straightaway.

The shared care record is the whole-system bit of plumbing, but we are also improving the things that flow into it. In general practice, I have mentioned the investment of £240 million in better digital technology for GPs. In the community sector, we are trying to get everyone on to the faster data flows platform. Helen can talk to you about the digitisation of social care, where we spent £48.4 million last year and will spend another £100 million over the next two years, driving up the number of people who have digital records. There is a similar story in mental health. Then there is the federated data platform, which is not a patient record but a management information system to bring systems together. Last but not least, there is the growing use of the app. Over the winter we saw for the first time more people booking their vaccination using the app rather than ringing up 119.

Baroness Armstrong of Hill Top: Because it works.

Neil O'Brien: It will become hugely more powerful over the next 12 months. That, in a sense, is very patient-centred integration.

Everything is on your phone: your access to your GP, your records, your immunisation history and what is happening with your secondary care. Quite a lot of money has been spent and a lot has been pushed through quickly to address what you correctly identify as one of the most long-standing and serious issues facing the NHS.

Baroness Armstrong of Hill Top: And are you keeping on top of asking the questions about whether it is working? Your problem in talking to us is that we probably spend more time in direct contact with the NHS. I know you will have done recently as a patient, Helen, but most of us do that a lot of the time. So you can tell me about the greater record-keeping in the north-east and in London, but I can tell you that it does not always work.

Neil O'Brien: You are right: it does not always work.

Baroness Armstrong of Hill Top: It is about how you keep hold of making sure that they understand how different people interact with that, and how they give support. So my next bit of the question is this: what are you doing on the two big issues for patients? They are wary of their data and are not sure how to use some things but are also anxious about it not being held privately and in secret. What are you doing for those who are disadvantaged, and therefore do not have the same access to their data as you or I do, and for those who are anxious about how their data will be used?

Neil O'Brien: There are several really good questions there. The first thing I would say is that some of what we are building and investing in is not directly patient-facing; it is so that clinicians have access to the data they need to help you without them having to ring up a colleague in hospital, a GP or whoever it may be. It is not just for the patient; it is so that clinicians have the data they need. It is an excellent question.

In some cases, not everybody needs to use new digital or data technologies in order to benefit from them. For example, we are making a big investment in giving all GPs the resources they need to get high-quality digital systems for patient contact. Many of them have already done this and are seeing huge benefits in patient satisfaction and productivity. However, you often find—to rudely stereotype and put it very crudely—that older people continue to ring up but get through more easily because a lot of younger people have gone on to use the online system. So people can benefit from a technology even if it is not they who are using it.

Your question, to get to the nub of this, is absolutely sensible. We are, of course, maintaining all the kinds of information governance and data protection that everyone would expect, because you cannot have people fearing that their data will be misused or given to someone to whom they have not given permission to use it. There are several layers to the answer to your question.

The Chair: Can you be sure to answer the question on how achievable it is to have a single patient record that can be used right across the NHS? You mentioned March 2025. How achievable is that?

Neil O'Brien: The achievability of this is not a single on/off binary variable. We have regular maturity assessments of each of these different technologies, including the shared care record. It is about how usable, useful and reliable they are—this goes exactly to Baroness Armstrong's excellent question—as well as how much they are being used, what you can do on them and what access different people have. I mentioned the north-east: as you look around the system, some of the acute trusts have both read and write access to that shared care record, but some have read access only. We need to get them all to read/write. The same goes for community trusts.

Even in looking at just one ICB and just one of the bits of digital infrastructure that I mentioned, the shared care record, having an assessment of how much progress it has made is not an on/off, yes/no question. It is a question of how much linear progress has been made.

Helen Whately: At the moment, every integrated care system has some level of a shared care record but, in some, more organisations have access to it and can edit it rather just read it, as Neil just said.

Neil O'Brien: The information on it may also be more or less expansive.

Helen Whately: Exactly. It is about building up. But let me shift to the social care side a bit more. Over the next 18 months, all local authorities that have responsibility for social care, together with many community healthcare providers, will get access to the shared care record system. To me, that is a really important part of joining up.

Baroness Armstrong of Hill Top: That was going to be my next point.

Helen Whately: Do you want me to pause?

The Chair: No, no, because we must move on.

Helen Whately: Okay. In social care, you see variety among individuals in how up to speed they are with using technology. Clearly, we have great diversity among our social care providers. Some are very high-tech and using lots of technology, such as digital record-keeping; others might not even have a computer in their building. Something that we have been doing centrally is funding a lot of that adoption in order to get the care providers who are further behind on the path to getting a digital care record for all the clients they look after.

When we started this a year or so ago, around 40% of care providers had a digital care record for their clients. Now, we have got to more than 55%, and we are working to get up to 80% of care providers and the individuals receiving care having a digital care record. It helps with interoperability, and we know that it also helps to improve the quality of care by reducing some of the administrative burdens for care staff. In fact, it reduces some of the mistakes that you sadly sometimes see with things like medication, so it is a good-quality argument, a productivity argument and a joining-up argument as part of that.

Q251 Lord Altrincham: We have an important question about medical training. I should disclose an interest: I have a daughter who is just finishing medical school. What role can medical training play in encouraging integration and multidisciplinary working? Does the department have any plans to direct Health Education England to support integration through its work? How can training be improved to ensure that NHS staff and partners see integrated and multidisciplinary working as the default option?

Helen Whately: I think that progress is already being made on this; I hope that you share my view on that. How healthcare professionals—not just doctors but others—are trained is important in helping integration to progress. For instance, if you train with people from different disciplines and in different settings, you will gain familiarity of them, a range of perspectives on them and relevant experience in them. We are seeing some of the new medical schools—as a Kent MP, I know the one close to me in Kent particularly well in this area—setting out to train their medical students to work in the healthcare system of the future, where we will see more care outside acute settings and more multidisciplinary working. They are working to increase placements for students in primary care, for instance, and are getting students to spend more time in those other settings, working with people from a range of disciplines.

On the nursing side, I slightly digress, but nurses spend more time doing placements in social care settings as well as in NHS settings. It is a really good thing for building relationships and building understanding of different parts of the health and social care system. If you do that in your training, you take it into your experience once you have qualified.

Neil O'Brien: Training also has a role to play in who you are training and for what. The huge growth in the general practice workforce has been in the multidisciplinary team, bringing all the different types of roles into primary care at scale for the first time. You then back that up by having training hubs that explicitly encourage people to work in this new multidisciplinary way; there is one of those in each of the 42 ICBs. It is partly about changing the nature of the workforce so that it is a more multidisciplinary workforce and partly about backing that up by training people to work in a slightly new way.

Q252 **Lord Altrincham:** In our question, we also ask whether you would direct Health Education England to do anything else in this regard. Do you feel, from your standpoint, that it is on track?

Neil O'Brien: HEE has been folded into NHSE, as you know. We are constantly looking at it. In primary care, we have communities of practice that are all about trying to share best practice in areas that have moved into a more multidisciplinary way of doing things with places where less of that has happened so far because they are at a relatively early stage. We will continue to actively look at how we build on this. This new way of doing things, where everything is centred on the patient, will not be done overnight.

Helen Whately: Related to this, an important thing to highlight is that the NHS long-term workforce plan plans for an increase in the healthcare workforce across settings. In particular, demand for community staffing (Around 4%) is modelled to increase more quickly than demand for acute care (Around 2%), is a real sign of the direction of travel, with our health and care system joining up and care out of hospital being closer to home. That also reflects a changing model of healthcare.

The Chair: Do you find any professional resistance among any professions to the idea of multidisciplinary training? Indeed, harking back to what you said about data sharing, are the professions themselves as keen on it as you yourselves clearly are?

Neil O'Brien: Particularly in primary care, there is quite a lot of excitement. One of the best things about general practice is that you are the captain of your own ship—you are not having to wait

for some Minister to sign off your IT programme, you can just go out and buy it yourself—and we are making that even easier for them. Although this is rightly seen as a bigger task, they also now find themselves to be in effect leading a kind of multidisciplinary workforce. On the other hand, there is also quite a lot of excitement about that: you can make things happen. If you want to have a big focus in your PCN on mental health, on physio or whatever is right for your particular place, you can make that happen. There is a bit of, “I’m managing even more people”, so there is a bit of nervousness, but there is also enthusiasm about it. It makes one of the best things about primary care even better.

Helen Whately: I have seen a real enthusiasm for multidisciplinary team working. I have done ministerial visits and I am visiting teams that are doing often innovative things with hospital at home services, for instance, and whether it is GPs, secondary care doctors, community nurses or paramedics, I see these teams coming together and seeming to enjoy what they all bring to the team. They are appreciating the extra access. In the past, if you were a more traditional community healthcare team, it might have been very difficult to get hold of a secondary care clinician based in a hospital. Now, that access and those relationships have been built to their benefit. The teams are enjoying it and the patients are benefitting from it as well.

Q253 Baroness Finlay of Llandaff: Thank you very much for your evidence so far. You have given us descriptions and quite often said that it will take time. I wonder what you both find are the main blocks to change. You have talked about positive change, but there are certainly blocks in the system. We know that there is a workforce shortage, we know that demand has gone up a great deal, and we know that patient pathways are fragmented and need to be pulled back together. We also know that even in nurse training there is a high drop-out rate linked to some placements where they do not feel comfortable. From the information you are getting, as well as the examples of where things are going well, are you hearing a trend of difficulties?

Helen Whately: You want me to shift from the optimism to the pessimism. You have mentioned some of them yourself. Of course there are pressures on the workforce. On the one hand, we are seeing an expanding healthcare workforce, with 48,000 more nurses since 2019 in our health system, but there are still pressures to make sure that you have the staff; you want more doctors too. Neil is particularly close to it on the primary care side. Equally, there are still gaps in places in the workforce, so workforce comes up. I pointed to the long-term workforce plan because, on

the community side, building that workforce is really important—making community a place where people really want to work and see it as an exciting part of the system to work in. Being part of one of these multidisciplinary teams is important in achieving that.

Some of it is in funding flows. There are traditions of where money flows. I referred at the beginning to the Section 75 review and whether we need to go further to help the pooling of funding or to make it easier. There is really interesting stuff going on where social care workers have taken on nursing tasks in some places. It happened a bit in the pandemic with those particular pressures, and we are looking at how we can make that business as usual. Where care workers wanted to upskill to doing nursing tasks, how would the funding flow to make sure that the care worker got paid for doing that extra task, including some of the complexities such as some people being self-funders in social care? Some of these things are complicated. How can the system enable it to happen?

We have talked about data sharing and data technology. Estates are another area where there is no doubt more to do. Sometimes it is management bandwidth. People are trying to achieve a lot of different things and there are a lot of competing pressures. As we look for accountability and answers to our questions, Neil and I both have visions of things that we want to happen. Remember that there are only so many people with so much time, so there is an element of, “Let people get on with the thing they are doing and see it through”, and recognise that you have to give it time in part because of the bandwidth for change and for things to happen.

Q254 Lord Watts: The last question is about shortage of staff. I do not think there is any point in going back to 2019, because in 2019 there was a shortage of doctors and nurses and a number of other skills, and we have an ageing population. Is that not causing a problem for you in moving as fast as you would like to move? Are you not hearing that that issue of shortages is causing problems?

Neil O'Brien: There will always be an argument for more staff. There are 284,000 more people working for NHS trusts and ICBs now than there were in 2010. If I look at primary care, in general practice there are 27% more staff than there were in 2010. There has never been a moment in NHS history when there has not been an argument for more people in every part of the system. The challenge is for us to do the things, particularly when it comes to technology and integration and prevention, that enable us to use those people more efficiently. Having the first ever—it is amazing—long-term workforce plan for the NHS is a big step forward. Making sure that we not only grow the workforce but think strategically about how to grow it and make it work better together is a big

moment in addressing those challenges. There will always be those challenges, but those are major steps towards addressing them.

The Chair: I will take the Chair's privilege and ask you one more question each. If you could wave your ministerial wand, which one thing would you do to bring about better integration across the piece in the areas we are looking at, primary care and community care?

Neil O'Brien: I think the challenge is particularly in IT and data and accelerating the integration there. In some areas, we are moving really quickly. In pharmacy, we are building a whole new IT system that is read and write to connect pharmacies to GPs for the first time in the space of a few months. With things like hospital records, it will take until 2026 to completely finish the job. We are at about 90% now, but it is a grind to get through all those things and to make them happen in a reliable way that does not lead to disruption for clinicians or patients.

Helen Whately: That was an excellent answer, but I should say something different. One thing that is said to me from time to time is that it is all about relationships. Wherever you have great relationships, it really works, and in other places it does not. To me, one of the things is unpicking that. What can you do, where you do not have great relationships, that does not make it just about whether people happen to get on? That is one of the things I would really like to unpick. Let us not just rely on people happening to really get on. What underlies that? How can you get great relationships everywhere? To what extent is that about shared goals, a shared culture, coming together and spending time together? Get the thing that happens, and you can get great relationships to happen everywhere.

The Chair: On behalf of the committee, I thank you very much for your time and for your very full answers. We will do our very best to incorporate some of your views into our report, which I hope you will look at with interest and, indeed, be prepared to act on, whether you agree with it or not. Thank you again for coming.