



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 27 March 2023

4 pm

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

Evidence Session No. 8

Heard in Public

Questions 75 - 82

Witnesses

I: Nora Corkery, CEO, Devon Communities Together; Ivan Annibal, Managing Director, Rose Regeneration; Professor Sheena Asthana, Professor of Health Policy and Director, Plymouth Institute of Health and Care Research.

Examination of Witnesses

Nora Corkery, Ivan Annibal and Professor Sheena Asthana.

Q75 **The Chair:** Welcome to this second panel this afternoon of the Integration of Primary and Community Care Committee. This, as you know, is a House of Lords inquiry. We are delighted to have with us Nora Corkery, the CEO of Devon Communities Together, Ivan Annibal, the Managing Director at Rose Regeneration, and, online, Professor Sheena Asthana, Professor of Health Policy and Director at the Plymouth Institute of Health and Care Research. These are representatives of rural and coastal communities because the committee, as you know, is very interested in how primary and community care is received.

I must first of all declare an interest before asking a question, because until last autumn my husband, David Emerson, was chair of ACRE, an association with which both witnesses in the room were connected.

Thank you very much indeed for coming to see us. As I say, we are particularly interested in some of the communities that you represent. Perhaps I will start by putting my first question to you, Professor Asthana; then I will come to other colleagues in the room. What particular health challenges do coastal and rural areas face, and how does the potential integration of primary and community care services help to address these challenges—if it does? We might make an assumption that it does.

Professor Sheena Asthana: The Chief Medical Officer's really interesting report in 2021 focused on health in coastal areas. I and a colleague submitted a chapter to that on health outcomes, and even I was quite surprised by the findings. We looked granularly, at a lower-layer super output area—LSOA—level, at differences, for example, in GP-recorded morbidity, and, at a slightly larger level, at standardised mortality and life expectancy. We found significant differences on the coast. Coastal communities have higher rates of chronic disease, lower rates of life expectancy and higher rates of standardised mortality.

Particularly concerning was the evidence for children and young people. For example, with regard to admissions for self-harm aged 10 to 24, we found a significant coastal excess. Similarly, there was an excess for admissions under 18 for both drugs and substance use. Because this was a fairly fine-grained analysis, the data are quite solid. Something is going on on the coast.

Why is that happening? It is happening partly because of an older demography. It is happening because of deprivation, which tends

to get hidden by larger units. If we look at a local authority level, or at what was CCG and is now ICS or ICB level, we are not able to see that. With regard to children in particular, there has been a shift towards the periphery in children growing up in poverty.

Other problems are in service provision. The CMO's report found fewer doctors, nurses and GP trainees in coastal areas. If we accept that we have a higher underlying need, we appear to have a smaller supply. This is contested, but I have had long-term concerns about the resource allocation formula. It was distorted with the 2002 area formula, which effectively cancelled out the effect of age. Older demographic areas are still facing that built-in bias.

There are other problems as well, due to lack of digital maturity. I am sorry if this is too long an answer, but there are issues with regard to the current allocations in so far as these are quite strongly driven by what we call the diagnostic coding of comorbidities. I was scratching my head to try to work out why there has been such a shift away from patches such as the south-west in the last six years. We used to have one of the highest levels of comorbidity in our hospital population, and now we have one of the lowest. That does not seem very plausible. What is going on there? My theory, although not proven, is that it is much easier to record comorbidities when you have an electronic patient health record in a trust. If you are still using paper records, you are less likely to comprehensively record those things, and of course there is digital variation.

Finally, we have a crisis in social care. In terms of keeping people out of hospital to start off with and providing personal care, a number of peripheral local authorities, both rural and coastal, are spending about half their entire local authority budget on adult social care alone, and they still have vacancies. They are not able to provide the required level of care.

The Chair: I am sure Ivan will find some echoes of the answer we have just had for rural communities.

Ivan Annibal: Yes, indeed. I want to just mention that, in addition to Rose Regeneration, I am the director of operations at the National Centre for Rural Health and Care. We have been going since 2017 as a community interest company and we have about 50 trusts, universities and royal colleges in membership. I was able to put out a call for views prior to coming to present today. I am based in Lincolnshire, which is a very big rural county.

We think there are five key characteristics to rural communities that make them distinctively different. One is a higher proportion of older people and an ageing population. The second is around mental health, where isolation and loneliness bring some distinctive challenges. The third, which is probably the most obvious, is distance from services, which puts pressure on people who have to travel for regular treatment. Slightly more surprisingly, the fourth is housing. The quality and nature of the housing stock in rural settings often has a significant impact on people's health.

The final one is something that we have described as cultural and attitudinal differences. There are particular categories of people in rural settings who tend to present late, if at all, particularly people working in primary industries such as agriculture and fishing. So we think there are some very distinctive characteristics.

Of the things that we think could make a difference in terms of integration, the first is being able to plan services at a place-based level. ICSs are probably better placed to do that than previous structures. The important thing is that rural places are heterogeneous. We had a very interesting visit from Professor Roger Strasser from the University of Waikato who said, "If you've seen one rural place, you've seen one rural place", which is quite a powerful way of expressing that.

We also think that there is a broader agenda for integration than just in terms of the health community. In rural places, where joining up around housing, education, transport and social care can be brokered, that gives the potential to lead to far greater and more meaningful outcomes.

Rural-proofing is really important. I know it has been criticised for being a bit toothless, but it is a very important aspect of planning and measuring rural services. The National Centre for Rural Health and Care, in partnership with Rural England, has developed a rural-proofing toolkit for health.

A local rural technology health and care strategy platform is also important, because it can bring services closer to people, but the whole IT agenda is a means and not an end in itself. It is more nuanced and complicated than simply thinking you can overcome all sorts of problems by the use of IT.

Finally, the engagement of the voluntary and community sector in rural areas is a really important aspect of getting the best out of integration.

The Chair: Thank you for the very comprehensive answer. Nora, is

there anything you would like to add?

Nora Corkery: I have over 30 years' experience of working in the voluntary sector in Devon. The voluntary sector has traditionally worked holistically within communities, particularly rural communities, on the broader determinants of health. As Ivan was saying, these are housing, transport, access to services, loneliness and isolation.

In more recent times, we have definitely seen changes to the needs of our rural and coastal communities. In particular, coastal communities have more transitory populations. Our rural communities' age profile is increasing much more quickly than in urban communities. The strength of the VCSE sector is its closeness to communities and its ability to work with communities to increase resilience, which includes working to improve health outcomes and around the health prevention agenda.

One big issue identified by the ACRE network is that the focus on planning around the provision of healthcare services and through the integrated care service is on dominant urban populations, with the categorisation of integrated care boards as urban or rural. That disproportionately disadvantages the needs of people living in rural communities. The larger the population, the more the urban need will dominate the planning and the provision of services.

Although great strides have been made in integration, there is a definite cultural clash between decision-makers in the National Health Service and those in local government. The NHS tends to think about the catchment areas of the hospitals that it is working within, while local government thinks much more about serving the population of a whole administrative area. There is a disconnect there. There is an argument to be made for looking at pooling those resources and that joint planning much more closely together.

Healthcare has traditionally been designed on an urban model. The NHS system operates on a principle of people coming to access the services. In Devon, for example, community healthcare services are said to be rurally accessible if they are in the market towns, but there are considerable barriers to people who live in outlying rural villages and remote rural locations. The transport difficulties in rural areas have been very well documented elsewhere, and the cost of travel is also a big factor in accessing services.

I would like to quickly tell you about one thing that we are quite proud of in terms of being experimental and innovative in Devon. This month we have started a joint clinical and VCSE virtual wards

pilot. We believe we are the first place in the UK where there are dual, parallel referral pathways for virtual ward patients, both through the clinical system and into the voluntary and community sector. We are able to provide digital support to those patients. They are provided with devices so that they can be monitored remotely while they are being treated at home. We can send in digital champions and befrienders throughout their period of being treated, checking that they understand their devices, feel confident and comfortable with them, and know what to do if something goes wrong.

Equally, we can provide wraparound care to those people during their time there as a virtual ward in-patient, so that we can make sure they have their medication, there are no problems, their houses are warm and their needs are being met. Sometimes it is just to drop in for a cup of tea and see how they are. It is early days, but we think it is a great example of collaboration between the voluntary and statutory sectors to provide wraparound care.

The Chair: The committee would be very interested to hear details of that, Nora, if you would be so kind.

Nora Corkery: Absolutely.

Q76 **Baroness Osamor:** How can integration improve delivery of primary and community care in isolated communities? Are there any models for organising primary and community care that might be more appropriate for isolated areas.

The Chair: Here, we are looking for suggestions about models that would work well in your communities.

Ivan Annibal: I have three or four examples that are worth bringing to your attention. One is first responder schemes, which are community-based emergency support schemes. In Lincolnshire, we have a charity called LIVES that is CQC-registered and has its own scheme of clinical governance, which means it can integrate with the emergency services and support responding, in very isolated communities, to accidents and other emergency situations much more rapidly than would normally happen. Nikki Silver, the lady who runs it, describes it as an unglamorous version of the air ambulance. That is a powerful example of something that particularly fits an isolated and deep rural setting.

Slightly less isolated but still highly relevant is an initiative called Healthier Fleetwood, which is based on the Lancashire coast. It has been developed by a GP and has developed a whole-community approach to self-care. Because of people's distance from services, building those communal and neighbourly links between people has

led to far greater prevention outcomes in that community than might have been expected.

I have to have two Lincolnshire examples; I will not just talk about Lincolnshire. In Mablethorpe, which anybody who has been to the seaside will know is on the Lincolnshire coast, through towns funding, there is the development of a new £8.6 million clinical trials facility that will operate remotely. It is linked to the Medical Technologies Innovation Facility at Nottingham Trent University and will create a cluster of health and care on the Lincolnshire coast. The very isolated population there is an ideal test population for clinical trials, particularly in relation to medtech and pharma approaches that support people living independently at home for longer.

There are three really interesting examples there. I can share information about these after the session today.

The Chair: That would be very helpful. Thank you.

Nora Corkery: I would like to give you a couple of examples of some joint integrated care service and VCSE place-based approaches that we are doing currently in Devon. One of them is in rural and remote rural mid-Devon, and is based around a mid-Devon GP practice. We brought together a very multidisciplinary team of primary and community healthcare and social prescribers; it was an unprecedentedly mixed team. It was quite logistically difficult to bring them together. We had the meetings in the surgery and at lunchtime so that all the practitioners could be there.

To give you an idea, the group is made up of GPs, practice managers, practice nurses, local social prescribers, local patient participation groups and local VCSE organisations, as well as the ICS, the PCN and Exeter University. It is a very mixed group of people at all sorts of different levels, but all very focused on that place.

The group started meeting in January and has been exploring the profile of its own community and looking at the MOSAIC data. Very interestingly, as a group it has been testing whether you can apply the Deep End principles, which were developed in urban and deprived communities, in a rural or remote rural setting. It has also been looking at the community and primary care section of the rural-proofing for health toolkit to see how it might help the group improve the services it provides.

There are lots of issues already coming up. The key issues from mid-Devon are the increased workload for primary care staff working in rural areas, the time it takes to deliver services that is not accounted for in the funding formula, and workforce. There are huge issues around recruiting and retaining staff, and a lack of affordable housing in rural areas, which was mentioned earlier. That is one example that we are very excited about.

Professor Sheena Asthana: I want to give a bit of a note of caution here because there is an absolute plethora of schemes of all sorts of different types of integration. When we are talking about the integration of primary and community care, there are many definitions of that. It really has been tried across the country. Before I go on to describe a good example, there are two issues here. First, those evaluations quite often do not take account of context. Your question was about isolated communities. Very few evaluations look at context and geography as being part of that.

Secondly, not all schemes have looked at the impact. If you were to ask me what I think are the advantages of integrated care, I would say its potential to create a shift away from expensive, reactive, hospital-based care to prevention, early diagnosis and care within the community. It is about that whole shift, which both improves quality for patients and potentially saves cost. That is the theoretical benefit, but there is not a huge amount of evidence suggesting that those benefits are being accrued, so we have to be careful. We can talk about these wonderful schemes, but let us at least make sure we have some evidence.

Against that background, we have produced some evidence from a really interesting integrated care project in the Coastal locality of Torbay integrated care organisation. Torbay has five different localities, and Coastal is based in Dawlish and Teignmouth. This is an enhanced multidisciplinary team. It used to comprise social workers, community matrons, OTs, physios, mental health workers, et cetera. It now includes general practitioners, community pharmacists and, importantly, what we call well-being co-ordinators, who are from the voluntary sector.

They are co-located, so they are in sites that are often old community hospital sites. They meet every morning as a team to look at the needs of people who either are deemed to be at risk of hospital admission or have been recently discharged from hospital. They target them into support services, which may be proactive social prescribing services or intermediate care services, to prevent them either going into hospital or going back into hospital.

It is quite interesting. We found evidence of lower rates of A&E admission and higher rates of home-based care among this group. All these findings were reaching statistical significance, so that is really interesting. The problem is that we were comparing them against four other localities that had exactly the same model of integrated care, but one of which is doing really well and one is not. It is quite important to look at the ingredients of why those things work, and I can certainly go into a bit more detail about what I think the key ingredients were.

One of the ingredients, sadly for the rural lessons, is probably the fact that we are talking about a relatively small patch. It is only 30,000 patients, so that is on the small end of a primary care network. It is a pretty urban coastal area in that it is around two towns. It is focused around Dawlish and Teignmouth. Those two hospitals are about five kilometres apart, so it is a small enough patch for you to work as a team. You have a small enough population to be able to deal with those referrals on a daily basis, as opposed to having a very large PCN, when it is absolutely unmanageable. It is a small enough patch to have great long-term relationships that allow them to take risks and seize quite a lot of autonomy.

The other factor, which I would like to come on to a little later, is the role of partner GPs. The GPs were definitely showing leadership in this and, as partners, they would claim that they had a lot of investment in their communities and were really interested in working for the greater good of their communities. We are hearing a real concern that this shift towards salaried GPs, as fewer and fewer GPs want to be partners and take on the risks of owning a premises, means that they may be less invested in their wider communities. Again, the VCSE involvement, as Nora and Ivan have mentioned, was really important there. It is a great example, but let us exercise a bit of caution and understand the ingredients that make these things work, because they do not work everywhere.

The Chair: We hear your cautionary notes. Thank you very much.

- Q77 **Baroness Redfern:** The first part of my question is directed to Ivan. What are the main barriers to the integration of primary and community care in coastal or rural areas and how might these be overcome? In particular, this is about the transient population in coastal areas. I will direct the second part of the question to Nora and Sheena. Conversely, there are advantages within those areas that make integration easier. How does that work when you are working with local authorities and you have fluctuations of budgets?

Ivan Annibal: Anybody who has not had detailed experience of coastal settings would be surprised by the level of seasonality. The level of seasonal movement is very significant, and perhaps understated and not fully appreciated. I absolutely acknowledge the importance of that, but the real challenges proceed from the fact that there is not just one type of rural. Planning in a very deterministic way to take account of rural places is almost doomed to fail, so there needs to be a much more nuanced approach to thinking about how individual places function and how they are put together.

The other issue is that the NHS thinks in big terms and thinks that big is beautiful. I know we are not really meant to be talking about secondary care, so I am not, but I want to share with you the way in which the Advisory Committee on Resource Allocation describes small rural hospitals, which is “unavoidably small” due to problems of “remoteness”. That is a very pejorative way of saying “rural”. It reflects this sense that big is beautiful and means it is very difficult to think about the challenges in very small rural places.

Baroness Redfern: That is for specialist services as well, though, which rural hospitals cannot cope with, to put it in context.

Ivan Annibal: We did some work through the National Centre for Rural Health and Care to look at models of rural hospitals in global settings. Across Europe, and in the United States, there are much smaller levels of secondary care that work quite successfully, separately to our model. I know that is not at the core of what we are talking about today, but it is interesting.

The other issue is to do with workforce. There is a huge problem in attracting people to want to work in rural health and care particularly. I heard Andy Burnham earlier talking about workforce as a real issue. The recruitment and retention of people in rural settings is very difficult indeed, so that is a real challenge.

Solutions are based on taking a very holistic overview of what needs to be done, thinking about not just the NHS and the services it delivers but the wider partnership impact around things such as housing, transport and adult social care, and understanding how they connect together more effectively.

The voluntary and community sector also has a huge and increasing role to play, and Covid helped to demonstrate the impact that it could have.

Finally—I will come back to this because it is important—the notion of rural-proofing and using that for the design and development of

services, as well as monitoring their impact, is a potentially potent tool if it is applied thoroughly and properly.

Nora Corkery: I absolutely agree with the need for rural-proofing. There is not a locality approach from a population health perspective at the moment, so we need to move much more in that direction. The ICSs are driven by health and transformation needs. You often find that, when they want to bring services into local, rural and coastal communities, they are duplicating services because they are not aware of what is already there and are not putting the jigsaw puzzle together.

Baroness Redfern: Surely they must know.

Nora Corkery: They know about primary care, but they often do not know about the community health support services that are there. They very often do not have that knowledge on a microlocal level, which is where collaboration with the voluntary and community sector is. We are embedded in those communities and we have that knowledge of exactly what is going on at a very local level. Small, place-based services run by charities and social enterprises are often invisible to the strategic funding bodies in the integrated care services.

The second part of your question was about the advantages we have that would support integration. One is about the opportunity to create cross-sector neighbourhood teams. We are talking about defined geographies. If we can move things down to a much more locality-based level, working with the people who are already working on the ground and learning from the innovation that is already happening, that is the way to create services that really meet the needs of the community.

Lastly, the NHS services have traditionally not been interfacing that much with the broader voluntary and community sector, except in quite narrow clinical support roles. At the moment, we are conducting a community asset map of the village halls in Devon. There are 450. We have audited 170 of them since September, working in partnership with the local ICS and looking at these village halls in rural and remote rural communities as potential health and well-being hubs. They already are, to a certain extent. They are the places where people go for exercise classes, social interaction and lots of other things, but it is about how we can use those assets that we already have in our rural communities as places where primary health services can be accessible and local, working in collaboration with the community and voluntary sector.

Q78 **Baroness Armstrong of Hill Top:** I am really in support of a lot

of what you are saying, so I am sorry if my question and point seems a bit unsupportive. It is not meant to be. I had a constituency that had a very large rural area up in the north Pennines, as well as ex-industrial areas that have been coal mining and steel making. When there were challenges in the health service in the rural part, I spent a lot of time talking to local people but also to practitioners. One of the workforce issues was not specifically cost of housing. There were some housing problems, but in our area you could get a house for 50 grand and it was not a major issue.

The issue was that they did not get the variety of work. If they were a paramedic and they did only the rural patch, they would maybe get three calls a week, which meant their practice declined, they were bored silly and they hated it. It was an issue for specialist services. Because it was an ageing population, many of the midwives did not get enough variety to be community midwives. The same was true with those health visitors who wanted to work with younger people, so there are other issues.

Professor Sheena Asthana: In terms of barriers to integration, I am guessing that we are moving beyond the more narrow definition of primary and community integration into something a little more holistic. One issue is that, in terms of partners, there has always been a real challenge to get education involved, and that is becoming more challenging rather than less so.

That is a real problem because, if we are looking at addressing health inequalities in particular, education is probably the single most important modifier of health inequalities. We need to reach out to children who are experiencing adverse childhood experiences. We are just not doing that at all. In a public health sense, as well as in the delivery of community and primary services, everything is very much shutting the stable door after the horse has bolted. One of the potential advantages of integration and bringing the VCSE sector in is that we can start to get in earlier. I am not sure we are doing that as well as we should.

Part of it is also the way in which we are funding things such as our voluntary community organisations. Often, that will come from dribs and drabs of money that you might have left from your public health budget at the end of the year. You will fund a great organisation that will be doing some fantastic work, and then at the end of that year the money has run out again. You cannot sustain that support. You have learned nothing because there is no embedded evaluation, and it is just such a waste. We have to somehow get a little more coherent about the way in which we use

our budgets so that they are less up and down and embed the evaluation in there.

The third barrier, but also a real challenge to integration that you will probably want to ask further questions about, is digital. When we are talking about particularly dispersed communities, digital integration can be completely fantastic. Unfortunately, within the NHS it is not.

The Chair: I am sorry to interrupt you, but we are going to have a question about digital shortly, if you can just hold that. Ivan, can you briefly respond about the professional satisfaction idea?

Ivan Annibal: There were two things I want to say. On our board we have somebody called Dr John Wynn-Jones, who is part of a global network of GPs. He thinks this issue is about deployment, because in the right deployment strategy a rural GP will see a far wider range of things in a rural setting where there are fewer specialist GPs than if they were in an urban place. There are experiences at a global level where deployment means it is quite attractive to GPs who want to be flexible and try a lot of different things out, because they are more isolated.

The other fascinating thing that happens in other settings, which we do not have enough emphasis on in rural settings here, is the notion of "see, treat". Dr Stuart Maitland-Knibb, who set up the National Centre for Remote and Rural Medicine within UCLan, based in the west lakes, was a military medic. He went from a situation where "see, treat" was at the heart of what he did to finding himself as a GP pushing paper, as he described it, persistently referring people on to acute services. There are other places in rural settings, including in Scotland, where much more lower-level secondary care is in rural settings, and that gives scope for far greater satisfaction.

Baroness Armstrong of Hill Top: We had that. We built a small community hospital and linked the GP to that. There are ways to get GPs out of single practices, which are dangerous now, but for other professional specialists there just was not the variety of work to maintain their professional standards.

The Chair: It is obviously horses for courses on this one.

Q79 **Baroness Shephard of Northwold:** I am going to ask the question about IT, but I want to comment on Mr Annibal's point about the importance of first responders. We have a series of these in the rural and very coastal areas. I live in Norfolk and they are worth their weight in gold. It is fantastic. They have excellent links

with acute services and emergency services. I could not speak too highly of them.

Another point about workforce is that coastal areas have seasonal workers who may work in the care sector in the winter, but in the summer they are in the harbour, so it is another difficulty for coastal rural areas.

I noted Professor Asthana's point about co-ordination with the education system and schools. In rural areas, of course, schools are very widely spaced. It is extremely unlikely that their catchment areas will correspond to anything meaningful within health catchment areas, and that is a barrier to easy co-ordination. You could have co-ordination, but it might mean that the school would have to relate to five or six different sorts of health and social care authorities compared with just the one in urban areas.

My question is about IT. In what ways could existing IT systems and policy be improved to promote the use of health technologies, and what are the possible benefits for patients? What are the barriers to greater use of technology in rural or coastal health services? The answer to the second bit is clearly availability of viable broadband, but I would really like to hear your comments on rural and coastal problems in the context of IT.

Professor Sheena Asthana: I am a real technological optimist. I am taking over the directorship of our centre for health technology and the opportunities are immeasurable. We are not making the most of them at the moment, for a whole series of reasons. Effectively, as I said, if we want to shift the balance of care from reaction to proactive prevention, we need to get into people's homes. We can use wearables. We obviously have to talk to people about how happy they are about that sort of thing, but there is a whole range of wearables as well as environmental sensors. You can even monitor how much somebody is socialising, whether they are falling over and whether they are opening the fridge, let alone all the physiological measurements that you can start to put in place, so it is potentially revolutionary.

I am not sure that broadband is the biggest issue, in that there are a whole load of cloud-based systems and special rural access providers at the moment. The problems are more within the healthcare system and about collecting information. Say your GP has identified somebody who has a series of chronic problems. We want to monitor them. We want to have a trigger point to say, "Hang on a minute. They need intervention. This reading has gone out of control", and things like that.

The real problem we have is that in areas such as mine we do not have what we call orchestration layers. This is a platform where you can bring all your data in, and it gets analysed and pushed out to give a sensible trigger to the right person. We simply do not have those, particularly in rural areas, because rural and coastal areas tend to be more digitally immature. That reflects years of investment. If you go to London or Manchester, you have really fantastic IT. We simply do not have that in our patch.

We can get around that. In the example I used of Coastal, although the community services do not have an EPR system, they have made SystmOne available to their community partners and, indeed, to their VCSE partners. You can start to do that sharing, but we have to level up our digital maturity. It is so unequal at the moment.

I know we are not talking about hospital trusts, but it is a good indication of your wider ecosystem. There are 30 trusts in the country that do not have a comprehensive EPR system. Most are on the periphery, and that is a real problem. We are already joining some records, but there is huge potential. I was watching an episode of "Frasier", which must have been filmed about 25 years ago. Martin had a blood pressure cuff on and, every time Frasier and Niles were irritating him, the beeper would go off and this was sending his records to his clinic. We are still not doing that in my part of the world. It is ridiculous. We need to level up and take this quite seriously. Did you want me to talk about the barriers?

The Chair: Yes, please.

Professor Sheena Asthana: It is not just about getting your EPRs in place. At the moment, a lot of the attention in the sorts of ICBs where we do not have digital maturity is on getting our big hospital EPR in place. We need to be thinking five or 10 years in advance about how we can activate our patients within the home, doing the sorts of wearable things I have been talking about. I have an awful feeling that this is going to be timetabled for about five to 10 years' time while we concentrate on our hospital EPR systems. It is classic within the NHS that so much of our attention, as so much of our money, goes into the acute system and not into patients' homes, in particular, or into community and primary care services. We have to catch up very quickly.

There is another little issue. This might sound like a silly little one to mention, but it is profoundly important. A year or two ago, the Medicines and Healthcare products Regulatory Agency, MHRA, decided that when we use AI in a way that informs clinical decision-making—if we are starting to bring in lots of data, then process it

and put it out to triggers—that requires MHRA regulation. Nobody has done that. Nobody is getting that regulation, so we have a real issue. For example, one of the research projects I am dealing with at the moment is looking at this very thing, which is routinely used in American healthcare. We cannot do that because they have not gone through regulatory approval.

Baroness Shephard of Northwold: That is a highly significant point. I am quite sure it will be reflected in the eventual report of the committee, because “digitalisation” is a word that trips easily off people’s lips, but there are so many issues. Where you have rural and coastal communities, which is what we are talking about here, they are already rather behind in all this in terms of expectation. We find from you that some of the basics are not yet being tackled, and these are urgent issues if we are to make any progress at all.

Q80 Baroness Finlay of Llandaff: I was listening earlier on and you were talking about needing to know what is available. Then we are talking about the need to integrate. I was just wondering who you felt is responsible for holding that large database of what all these resources are that should be linked to a broader population, accepting that you can have a lot on the ground but some people will need access to those specialist services, which are at a distance. That also has to be factored in.

Also, how do you link to the first responders? I know that is very specific, but I certainly know a GP who is part of that and who found that it maintained his whole interest in being a GP, because he was able to develop a new set of skills when he was feeling somewhat burned out with the routine aspects of general practice. There is that cross-linking but, from the way you are talking, it is not clear to me who holds that database. How do you access it?

Professor Sheena Asthana: Nobody does at the moment, and that is exactly the problem. Data are not being shared, and it is probably worse now than it was even 10 years ago with paper-based records, because our information governance has become so extreme. All the regions will have a shared record. At the moment, the only people who can gain access to that shared record are the primary and secondary physicians. I personally think that patients should be able to look at and add to their records. We should be empowered enough to do that.

That sharing does not go on and there is huge risk aversion out there in the system about doing that, but it is also partly about infrastructural readiness. Although it is a techy issue, this business of what we call the orchestration layer, or the lack of the

orchestration layer, is incredibly important. You tend to see more things happening in care homes. You will have a techy provider who will say, "I can give you this really good app or wearable", but the data then goes back to that tech provider, which means you are locked into the relationship with that provider. You cannot then share the data elsewhere. It is surreally difficult and really odd. It is hard to describe how mad the system is.

Baroness Finlay of Llandaff: I have a real concern. What about children who are at risk? How do you share the information that perhaps a school may have where it is concerned about a safeguarding issue with a child? How do you share that across the whole system if you do not have a unified record that goes across all these different barriers?

Professor Sheena Asthana: You do not.

Ivan Annibal: I was going to build on what Sheena is saying. There is a real lack of that. During the pandemic, information governance became slightly less restricted and there were a lot of quite innovative benefits derived from that. Since the pandemic has gone, to our disadvantage we have locked it down too much again.

On the deployment of first responders, the reason the Lincolnshire initiative works well is that it has its own scheme of externally accredited clinical governance by the CQC, so it can be deployed by the emergency call centre, in the same way that ambulances can. To me, that is one little nugget that demonstrates the benefit of having a much more mainstreamed approach to a joined-up plan, but at the moment there is a real lack of coherence around the way it is all managed.

Q81 **Baroness Tyler of Enfield:** I want to focus particularly on health inequalities. I know you have all touched on it in one way or another in the session so far. Personally, I am particularly interested in how you reduce the gaps in healthy life expectancy between various groups. Within that context, can you tell me about the particular issues that you face in rural and coastal areas, and how integration of health and social care could help there? I would be really interested in some very specific examples.

Nora Corkery: In Devon, we have a 15-year gap in life expectancy within our county just between Ilfracombe and Exmouth. We know that generally, the more deprived the area, the shorter people's life expectancy. Very often the analysis of rural communities is deficit-based. You look at a rural community and say, "This is what they haven't got; this is what they're missing".

Often, when there are comparisons between urban and rural communities, the hidden needs of rural communities are not seen. The way that the IMD data looks disguises pockets of rural need and health inequalities, and therefore they do not get responded to. The fragmented funding models at the moment mean that local authority resourcing derives from all sorts of different cost centres. As was alluded to earlier, there are short-term interventions and different funding pots that come and go, and start and stop. People in rural communities who are working genuinely to improve people's life expectancy and healthy life expectancy outcomes get very frustrated with that stop-start bureaucracy.

What can we do? It is about taking an asset-based approach, working with communities, looking at the strengths they have, what the schools and local services are doing and how the community is responding to its own needs. That is where the real innovation can happen. The problem is that it is not often sustained because it cannot be resourced.

To really get to the heart of tackling rural health inequalities, you cannot just look at it from a health system or integrated health and care system perspective. It has to be looked at from an economic and broader social perspective. Look at the needs of the communities as a whole. That is where the voluntary and community sector comes in, because that is what we traditionally have done for many years. We are embedded in our rural communities. We understand them and we work holistically within our communities.

Although we are in the early days with the integrated care service, what is missing at the moment is investment in and support for these cross-sector collaborative partnerships. I talked about the virtual wards example earlier. We could do a lot more of that, where, instead of the health service and the social care services thinking in their traditional silos, they think outside of them and work with the communities. There is lots of evidence to show that that is where you can actually make the real difference to people's quality of life and their well-being.

Baroness Tyler of Enfield: I know time is very short, but if either Ivan or Sheena has any specific examples they want to throw in, very briefly, that would be great.

Professor Sheena Asthana: I worry a lot that, when we look at health inequalities, we look at services, whereas if you look at the trajectories that lead to health inequalities, and the real risk factors, we are starting from early childhood. I mentioned exposure to adverse childhood experiences such as domestic abuse and

growing up with parents with mental health or substance use problems. Poor educational outcomes are critical here, as are job opportunities. For example, in Devon we have four or five of the lowest-wage districts in the entire country, with very few opportunities for our young people and a degree of loss of aspiration and, I would go so far as to say, hope. We have suicide clusters. I am not sure what integrated care is going to do about those sorts of things.

Again, it is just a word of caution. Let us look at some of the structural factors, such as access to sustainable, well-paid employment and certainly levelling up our educational outcomes. If you look at a coastal pattern of educational outcomes, coastal kids do so much worse. They are significantly less likely to go to university. Their GCSE performance is far worse. This is what we have to do something about. As I said, I just struggle to link this to the integration of primary and community care agenda.

The Chair: Perhaps we could, if we had five years in this committee, but sadly we do not.

Ivan Annibal: Can I briefly mention over-75s in coastal settings? What tends to happen is that people will retire into coastal places in their late 50s or early 60s. Once they lose the ability to drive, you see a flow back into urban settings from those individuals. There is not enough imaginative thinking and infrastructure in place to support very old people in isolated rural settings.

Nora Corkery: Can I very quickly mention a piece of joined-up, online, digital data sharing that we are starting to use in Devon? We are using an online platform called the Joy app. That is an online directory of health and social care services, and it has algorithms built in to keep details up to date, monitor waiting lists and provide feedback from service users. GPs and health and social care professionals can access this, and make a social prescribing referral with a few clicks, so they are able to link up treating the medical needs of the person with the support available in the community. Soon, in the next phase in Devon, people will be able to self-refer through that platform.

The Chair: If you could send us details of that, that would be very helpful. Our last question, which we want a very brief and concise answer to, is from Lord Watts.

Q82 **Lord Watts:** Can you outline one key change or recommendation you would like the Government to make to enable the effective and efficient integration and delivery of primary and community care services in your areas? Is there a network for organisations or not?

For example, we have had Manchester here; we now have Devon. Do they have a network system?

Ivan Annibal: We have the National Centre for Rural Health and Care. We have 50-odd trusts in membership.

Lord Watts: You can address the other issue now, please.

Ivan Annibal: My recommendation would be greater devolution of decision-making to ICBs to enable them to really shape their services in ways that understand and link to the specifics, on a place-based level, of the challenges they face.

Nora Corkery: I absolutely agree with devolution. Also, I would recommend unification of primary healthcare and social care budgets at local level.

Professor Sheena Asthana: I would recommend fairer funding, including the digital levelling up.

The Chair: Those are most admirable concise answers and are very useful to us. On behalf of the committee, thank you very much indeed not only for attending today, either in person or online, but for the wide-ranging answers that you have given us, which will be extremely useful. We would be very glad to hear anything else you would like us to know or want to tell us about. There will, of course, be a written record, which you will have the opportunity to have a look at as soon as it is ready. In the meantime, thank you very much.