



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 12 June 2023

4.10 pm

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

Evidence Session No. 18

Heard in Public

Questions 174 - 183

Witnesses

I: Siobhan Melia, Chair, The Community Network; Tom Cottam, Head of Health and Resilience Policy, British Red Cross.

Examination of Witnesses

Siobhan Melia and Tom Cottam.

Q174 **The Chair:** Good afternoon. Welcome to the Integration of Primary and Community Care Committee. We are delighted to have with us Siobhan Melia, chair of the Community Network and CEO of Sussex Community NHS Foundation Trust, and Tom Cottam, head of health and resilience policy at the British Red Cross. Thank you very much for giving us your time this afternoon.

We are talking about patient pathways in the committee this afternoon. To what extent are patients presenting at hospital when they could be cared for more effectively elsewhere? Why is that happening? How far could integration of services stop that unnecessary admission? I use the word “unnecessary”, realising it is not always unnecessary.

Tom Cottam: British Red Cross has done a lot of work on high-intensity use of A&E—so people who frequently attend A&E. We are the largest provider of high-intensity use services across the UK. On top of that, we have done a huge amount of research trying to understand what the drivers are that mean people end up turning to A&E.

First, I will address the point about “unnecessary” use. I appreciate your using the word in that way, because it comes out very clearly from the research we have done that, by the time people end up in A&E, quite often there is a legitimate medical or clinical need for them to be there. We know that over 80% of people receive a diagnosis, and the admission rate is higher than the wider A&E population. Underlying that clinical need are the overlapping, often very complex, unmet non-clinical needs that are compounding that clinical need. Issues such as homelessness and substance misuse feature quite regularly in the research that we have done into this cohort. This is also a population that is far more likely to have a pre-existing mental health diagnosis.

That is the picture. It is the combination of those clinical and non-clinical needs. When people talk to us and come to our service, they tell us that they have almost reached that point of despair where they feel as though they are not able to access the services they need elsewhere. They are often turning to A&E because they feel as though, in their own words, they have nowhere else to turn.

In terms of how integration can support that, quite often people will have lots of interactions with different parts of the system before they arrive at A&E and before they start repeat visits to A&E. We know that there are those opportunities, whether that is

visits to a GP or contact with their community mental health team, but the wider holistic needs that come together to create a point of crisis for people are not being identified at that point. There is an issue there of people and the system not understanding the whole story and not seeing the holistic needs that sometimes make up the reasons why people fall into crisis.

Alongside that, there are gaps in service. Dedicated GPs we spoke to are frustrated that they often do not have the sources of support that they can refer on to, even if they have identified people as needing that additional support.

From our experience of the high-intensity-use services that British Red Cross provides, they work effectively where, once you have identified someone—usually after they have repeatedly visited A&E—that person is able to work with an individual to join the dots of their care. It is a critical point at which to drive integration, because you have someone who takes an often highly personalised, de-medicalised approach and is looking at the holistic needs, and can then work with that person and their strengths to join up the dots between different care providers.

The Chair: You said “someone”.

Tom Cottam: Yes. The service will often be a handful of people who are working alongside that individual but, as I say, taking a very personalised approach to understand the root cause of the reason why they are frequently attending A&E, and working with other providers or other people in the voluntary sector to make sure that those needs are met.

Siobhan Melia: To what extent are patients presenting at hospital? It is to a very significant extent, if you look at the figures. NHS England published the figures of emergency department attendances for the month of May. Across the country, there were 2,240,000, which is the highest ever figure for May and the third highest since records began. There is no doubt that people are presenting at hospital for many of the reasons that Tom has described. Of course, there were three bank holidays in May as well, which tends to generate a different demand and flow into hospitals.

Our health and care system is relatively treatment-oriented. We need to get into the wider determinants of health and the partnerships that can help to build holistic pathways around people. There is a cohort in the population of older people who are getting better services now, post this winter, particularly from the

integration of community services with both hospitals and the ambulance sector.

There are a couple of national models of care now. Urgent community response, which is run by the community sector, has a standardised specification, from 8 am to 8 pm, that is available in all parts of the country. Prior to that specification coming out and services being developed, it was a highly variable access point into physiotherapists, nurses and occupational therapists who can help people in their own homes.

So urgent community response has been very successful this winter, as has a particular way of dealing with elderly people who have fallen in their own homes. Previously, the main route to supporting people was through 999 calls and ambulance dispatch. This winter, in particular, there has been great success in the community sector integrating more with the ambulance sector, identifying patients who are category 3 fallers without harm and then referring them straight into urgent community response.

In terms of integration with the hospital sector and the community sector, there are hospital-at-home services, also known as virtual wards. These have been scaled up this winter with national investment. That means that hospital doctors are discharging patients into community teams but still retaining some medical and clinical oversight. This is very technologically enabled, with people accessing much more complex care in their own homes, which is helping them to re-able much better.

There is no doubt that people are using emergency departments and hospitals at significant levels of demand. If we can continue to have national consistency in the healthcare models, the integration and the availability for the population, we can mitigate and create alternatives.

The Chair: That is possible good news.

Q175 **Baroness Armstrong of Hill Top:** How does somebody get referred to urgent community response?

Siobhan Melia: Most areas will have a single point of contact now, and that was a really big enabler. People can self-refer, adult social services can refer, GPs can refer, hospitals can refer. It has taken a while to have the technology enabled so that there is a single point of access, but the vast majority of systems have that now. GPs and primary care teams more broadly are probably the larger referrers, but, as I said, developing over the winter, the ambulance sector can now refer patients from its call lists.

Baroness Armstrong of Hill Top: Yes, because GPs and community services would not necessarily do that out of hours. It is the out of hours difficulty.

Siobhan Melia: This is part of the challenge. The service was funded for an 8 am to 8 pm model, but I totally agree with you; that leaves a gap where typically you then tip over into GP out-of-hours access, which again can be variable and not necessarily signpost in the right direction for the next day. That is where we are at present.

Q176 **Lord Altrincham:** I have a very similar question, but it is about the barriers between primary and community care. What are the main barriers to integrated working between primary and community care, which aims to avoid hospital admissions? How can these barriers be overcome? What changes to the way the health service operates and commissions services could be made that would put it on a more sustainable footing?

Siobhan Melia: I have worked in the community for all my NHS career and I have a passion for developing services close to people's own homes. There are three main barriers to integration between primary and community care. The first is staff shortages. The second is digital investment and data sharing, which I put together. The third is capital funding for primary and community services, enabling investment in estate and digital; typically, the first port of call for investment in estate is often acute hospitals.

These are pretty significant. Staffing is the main barrier. How can that be overcome? We are imminently expecting a long-term workforce plan for the NHS. That needs to be funded for the duration of the long-term workforce plan. In addition, there needs to be better, joined-up workforce planning at local and system level. To give you an example, there is a scheme in primary care called the additional roles reimbursement scheme. Many of you may have heard of this. It was an incentive for primary care networks to recruit more multidisciplinary team members into local services. The challenge with that is that it means there are multiple organisations looking to employ the same clinical professionals, and there are simply not enough of them to go around.

First, pharmacists, paramedics, physiotherapists and podiatrists are all critical to community-based services. They are sometimes incentivised to work in different settings in primary care, but with different contractual terms and conditions—NHS staff working under Agenda for Change, primary care staff working under more localised contracts. While that is not harmonised, it will be a barrier to integration. In the organisation where I am chief executive, we

employ 5,500 staff. We are in a great position to be almost a workforce bureau for community and primary care, giving people exciting rotational posts and career development opportunities, but the pay and terms and conditions are not harmonised between the two parts of the sector. That would be a really helpful way of overcoming the workforce barrier.

On digital, data and capital, investment is needed in both the digital and the physical infrastructure to build fit-for-purpose buildings and environments that are out of hospital in local communities and which primary and community teams can work together with.

Finally, on the barriers to overcome, we have electronic patient record systems that do not talk to each other very easily, even when they are the same system. We describe it as interoperability; the way in which data flows from one system to another to follow the patient and to be personalised and patient-centric is really important.

On your last question about how the health service operates and commissions, there was a long-term plan policy document that talked about a £4.5 billion investment in primary and community care by 2023-24, which was very much welcomed when it was published. The challenge is that it did not ring-fence investment pots for particular pathways or community-based investments. Because the contractual mechanisms and the terms and conditions are so different in primary and community care, it has been hard to track the real-terms investment over a sustained period in the out-of-hospital and community space.

I have two big pieces of thinking on what should happen in this space: the harmonisation of terms and conditions so that we can jointly plan for the workforce; and a defined and dedicated investment portfolio for the community sector so that we can truly build alternatives to hospital, in partnership with the voluntary and community sector, local authority partners and primary care in the out-of-hospital space.

Tom Cottam: I echo lots of those comments. The one on data and getting that right is critical. We saw from the work we did on people frequently attending A&E that quite often people just are not aware. Using data and sharing it between different providers in different parts of the system creates the full picture to understand that trajectory for people and the impact that is having on acute providers.

Building on Siobhan's point about the role of the voluntary and community sector, when we are thinking about integration we have to think about what integration means and include the voluntary and community sector, particularly when we are looking at populations where we need to address non-clinical needs. There is a huge amount of expertise and capability in the VCS that at the moment is probably not being tapped into as much as it should be.

Thinking about changes that need to be made, the experience from the British Red Cross perspective is that quite often the commissioning arrangements are very short term. Funding is sometimes unpredictable, which makes planning very hard. It means that staff retention is very difficult and providing that continuity of care is a challenge. It is also difficult for our statutory partner colleagues, because they are uncertain about what the landscape looks like in provision when looking at discharge support, support with people's shopping, wider holistic needs and things like that. Integration needs to include that aspect.

Lord Altrincham: Ms Melia, in your submission, did you mean that the estate spending is needed in acute or in primary and community? You said in hospitals. It is an area we have been looking at, but could you clarify that briefly?

Siobhan Melia: It is needed in both, but because of the extent of need in acute, the fact that it is needed in primary and community is not talked about enough. It is absolutely needed in the primary and community care landscape. The buildings are not fit for purpose for modern, local access to healthcare.

Q177 Baroness Armstrong of Hill Top: I will start with Tom, but I am sure Siobhan will want to contribute. I wanted you to think about leaving hospital and the work of the British Red Cross, which I am a bit familiar with, in making sure that there is a very good process to get people out of hospital so they are not back in after a couple of days because the exit was not organised well enough. Could you tell us a bit more about that and what we need to do to make sure that, in future, we get those services better integrated from the patient's point of view but also for the flowthrough of the hospital?

Tom Cottam: There are a couple of points. It is fantastic that you are aware of the work that British Red Cross is doing in this space. We are a significant provider of support for people to make sure that they get home from hospital safely and that those non-clinical needs are met so that you do not get the revolving door of people being readmitted.

We have done some work looking at the discharge to assess model. When done well, it can be incredibly effective. From all sides, people welcome the fact that they can get home earlier. It is where they want to be. We know that it makes for a better recovery. They are able more easily to build the connections that they had prior to admission. Alongside Healthwatch, we did some work looking at people's experiences of that model during the pandemic.

To your question about integration, what is critical about that point is getting the welfare check right before people leave hospital, so that you have a good understanding of those holistic needs. It is not just that they might need clinical support when they go home. Do they have food in the fridge? Do they have someone who can help them deal with issues of loneliness or social isolation, which are often the drivers for people being readmitted?

Once they have been discharged through that model, it is critical to get that follow-up assessment right. We looked at nearly 600 people who went through that experience, and sometimes that initial welfare check did not include very basic things like transport. The guidance was not consistently applied, so people were not asked about whether they needed transport to get home when they felt that they did. Worryingly, a lot of people were also reporting that there was no follow-up.

What was useful about that guidance was that it talked about the different pathways, giving a good understanding of the different types of needs that people might have all the way from pathway 0 to pathway 3. There can sometimes be an assumption that people who might have lower-level, non-clinical needs do not get follow-up because they possibly do not need it, but those lower-level needs are potentially not being looked at and then they escalate. I recently talked to someone who works for one of our services in London about how trying to secure support for people to do food shopping was becoming incredibly difficult. We could provide some support in the first few days, but beyond that it was becoming really difficult.

Those two points of assessment are critical to driving integration, because without that you do not have a good understanding of people's needs and are therefore unable to signpost them to the appropriate sources of support in the community. It is important to get the welfare check and follow-up assessment right.

Baroness Armstrong of Hill Top: I know that the Red Cross does this in places. Is that because you are commissioned to do it, or do you offer the service and hope they will take it up? How does it work in practice?

Tom Cottam: We are commissioned to provide those services. Where we do, we work with a whole range of partners. Quite often, we are the glue and the link that ensures that a holistic view of those people's needs is taken into account and we can support them with the shopping, make sure that their house is secure or that they are feeling able to go and meet friends again, and things like that. We are commissioned to provide that, but we work alongside a whole range of partners to make sure that the people we support have a safe discharge and a good experience.

Baroness Armstrong of Hill Top: Siobhan, what is your experience on this, particularly in Sussex?

Siobhan Melia: The effectiveness of the discharge starts at the point of admission for patients who go into hospital. My organisation runs 320 rehabilitation beds across sites in Sussex, predominantly for older people. We experience the same as the acute hospitals, which is that as soon as the patient comes in we expect our clinical teams to be thinking about that pathway and the estimated date when that patient will be discharged. We expect everybody to work together towards getting a great pathway of care with the outcome that the patient is discharged. We all work to that standard.

There is now a good body of evidence from the Health Foundation about the causes of delays in both community and acute hospitals. The number one cause of delay is people waiting for an assessment for a care package in their own home. That accounts for around a quarter of delays, but there are still delays in our own NHS organisations. We are constantly trying to get everything lined up, whether that is drugs to take away, contact with voluntary sector partners, or transport, so that the NHS can play its role more efficiently and productively, and the target date is met in more cases than not.

In Sussex at the moment, we are working with our partners across the health and social care system. The challenge in delivering domiciliary care from the care market is most marked in Sussex in that patients are not being discharged home in as timely a fashion as possible. That varies between parts of the country. Sometimes it will be about nursing and residential care home placements, but the number one cause in Sussex—and nationally, as the Health Foundation found—is the domiciliary care market. Therefore, the integration opportunity here is in health and social care doing things differently.

Also, as has been well documented, the need to reform and invest in the adult social care market in England has been incredibly

challenging. The workforce challenges are significant in the care sector. Again, different terms and conditions, rates of pay, challenges with cost of living and petrol costs have all contributed to fewer available staff in that market and fewer businesses being able to survive what have been really difficult pandemic years. Therefore, the gap between supply and demand for domiciliary care is pretty significant.

Q178 Baroness Barker: I should declare that, some years ago, I had involvement in the Red Cross work and in looking at domiciliary care provision in Sussex in a different light, which explains why I am going to change my second question to you. First, what constitutes a delayed discharge and who determines what is a delayed discharge?

Siobhan Melia: In simple terms, I can talk about pre pandemic and where we are now. Pre pandemic, it was very much as I described. The assessment of estimated date of discharge happened at source when a patient was admitted. The patient was described as medically ready for discharge, or a delayed discharge when they had breached what the multidisciplinary team had determined to be the date that they were safe to discharge from hospital.

That changed through the pandemic. The nomenclature has changed to "criteria to reside". What is being used at the moment is a categorisation of patients who no longer meet the criteria to reside in a hospital bed. These criteria were adopted early in the pandemic to focus on the needs of patients to be in a hospital setting. Talking to colleagues around the country, we now know that those criteria to reside are being reviewed in collaboration with the British Geriatrics Society and a number of leading clinicians, so I expect that we will move on from that.

In very simple terms, the multidisciplinary team at the hospital to which the patient is admitted, including the doctor, the nurse, the physio and the OT, will have case conferences to determine the right discharge date and pathway for that episode of care. The trigger of that patient being delayed is when it is beyond that, quite simply. Whether that is called medically ready for discharge or no longer meeting the criteria to reside, which is what we currently have, the principle is the same: the patient is ready, but that second part of their patient journey outside the hospital is not ready for them.

Q179 Baroness Barker: You have already explained to us that research has been done to outline the primary causes of delayed discharge. I wonder if I might ask you this. British Red Cross has been doing

its work on this programme for over 10 years now. It has long been known that people who are discharged on a Friday are far more likely to be back in hospital as an early readmission. When are we going to get to the point of having the data that will truly explain to us the full pattern of admission? I am quite interested to know, for example, whether there is a difference between people who do not have children and their patterns of discharge and readmission. When are we going to get meaningful data on inappropriate discharge and readmission, and how?

Tom Cottam: From my perspective, it is critical. I am not sure I have an exact answer for when that time comes. I do not know, Siobhan, whether you have a sense of the challenges.

Siobhan Melia: I share your frustration. The wider determinants such as health inequalities, social circumstances and demographic information can help us to piece this together, but, talking for the NHS systems, we are still in the foothills of doing that. In my organisation, we have had a board-level priority on health inequalities and now health inequities. I know that my non-executive directors are fairly frustrated that it has taken us so long to analyse waiting lists by postcode or protected characteristics. The NHS is moving to a place where those wider determinants and key demographic pieces of information are part of a care record so that we can run those types of reports, giving answers to the question that you are asking.

As for when, it will take some time, because not all organisations are on electronic patient systems, not all systems talk to each other, and not all organisations are in a place of collecting the demographic data. It is the right question to ask, but it will take us some time to get there.

Tom Cottam: It is critical to start from a point of understanding that those wider factors are such an important part of the picture. So much is determined by what we think is important and therefore what data we collect, so I echo that point about really understanding this. We are doing some work to look at the health inequalities in relation to discharge, and it is a really difficult picture to piece together. There is very little research out there even to try to understand the wider drivers that mean that some people will struggle to get access to services to support them once they are at home, while others struggle less. There is a profound amount of work to do to get under the skin of that.

The Chair: We would all like there to be more information. We appreciate that you are saying it is difficult to get.

Q180 Baroness Finlay of Llandaff: Earlier on, you said that health and social care should do things differently, and you gave somewhat of a list. I would like to pursue that a bit further in relation to how the integration of primary and community care with the wider health service could help to ensure that a discharge happens in a safe and timely manner and does not result, for different background reasons, in the revolving door that Baroness Barker was alluding to. We are looking to come up with recommendations, and we can be really radical, so I would like you to be really radical in your answers. Expand on how things should be done differently.

Siobhan Melia: There is a recent document called the Fuller stocktake, and I believe you have spoken to Professor Claire Fuller. Most people I speak to would subscribe to the intent in that stocktake, which is the development of integrated, multiagency, multisector and multidisciplinary neighbourhood teams, very much with the VCS sector at the centre of it, to wrap care around people in their own communities.

That is a fairly radical and different way of joining up the whole of a community neighbourhood team, including local community assets, districts and boroughs, and thinking differently about how we all coalesce around the needs of a given population, giving people access points when they need them, integrating so that people come out of hospital with the right signposting about the British Red Cross, Age UK or any other organisation that is bespoke to their postcode or geographical area.

The challenge is that, although the Fuller stocktake was highly accepted, there is no implementation plan and no investment with it. In order to build services that are more joined up, more accessible and easier to signpost for local people, there simply needs to be some commitment to investment in the areas that we have talked about, such as tackling health inequalities, prevention and local community assets. There needs to be a big investment in the voluntary and community sector.

I sometimes wonder why the British Red Cross processes and systems are not commissioned by every commissioning organisation to an equal standard in the UK. It was only when, in the community sector, there was a national specification for urgent community response, enhanced health in care homes and virtual wards that the levelling up of access in local communities became easier to point to. That came with national data submissions to NHS England, which meant that you could suddenly now compare the compliance of an urgent community response service in Shropshire, Sussex, Penzance and Lambeth with the two-hour target to get to people who need it.

Until we get to a place where we have consistent models of care that are wrapped around the needs of the populations we serve, which was very much in the primary and community integration in the Fuller stocktake, it will be hard to point to how we consistently ensure that patients are both discharged and supported not to have an admission into hospital in their local community. The direction of travel has been well described. I cannot quite see how that radical shift of community assets or different partnerships is delivered without an implementation plan and leadership headspace to do things very differently around local communities.

Baroness Finlay of Llandaff: To pursue that a little further, we heard earlier about the large number and change in mental health patients who are presenting very acutely. There seems to be a change in pattern of the acuteness with which people deteriorate in their mental health and, therefore, the unpredictability of it. I wondered where you also saw the safe discharge sitting with that group of patients, who often have physical and mental health needs, and the role of 111 in all that. We know about the out-of-hours problem, which you have already mentioned, because 8 am to 8 pm is only a third of the 24 hours. We are not solving the problem by discharging people if we have not built in for the whole 24 hours and do not have the information coming out with them from hospital.

Siobhan Melia: I have two initial thoughts on complex discharges for mental health patients. This is where the complete multiagency approach has to step in quickly. The wider determinants of housing, social work support, voluntary sector and health need to step in to ensure that those discharges are safe. Speaking to my colleagues in the mental health sector, housing tends to be a very big factor in that, so that needs to be up front in the discharge process.

On 111, I have spent some time working in the ambulance sector over the last year. Having been in one of the organisations as chief executive, I would say that the 111 team is very multidisciplinary now. The clinicians at the end of the phone will be a range of expert clinicians with GP, mental health, midwifery, dental or pharmacist backgrounds. Where it is identified that mental health patients are accessing healthcare through 111, the response has been to build the right clinical capability in the call centres.

Tom Cottam: From a voluntary and community sector perspective, it goes back to the issue of short-term, piecemeal funding, which was picked up in the Hewitt review. That has to change. It is very difficult to provide that wraparound care if you do not know

whether the people able to provide homelessness support will be there at that moment. With the best will in the world, you are sometimes relying on very inconsistent services because that funding is not predictable enough to allow the sector to plan effectively and retain staff. It is a real challenge in retaining skills. Ensuring consistency in relationships over time is key to integration, particularly when you are dealing with highly vulnerable groups, so that funding point is critical.

Q181 Lord Watts: In your experience, do you think primary, community and social care budget restrictions or budget problems create difficulty for discharge? Where do you think the greatest blockages are?

Siobhan Melia: The funding rules and regulations in the adult social care market can be a barrier. We experienced a more permissible way of working through the pandemic where patients got access to assessments in the right place at the right time. That is the biggest dissonance in terms of funding and policy. Even though the Department of Health and Social Care is the Department of Health and Social Care, on the ground we still recognise a difference in the policy rules and regulations, whether on procurement or assessments for care home placements. It feels different on the ground.

With primary care, although the contractual landscape is different, primary care and community care have worked together for a very long time. Other than my comments earlier about workforce harmonisation and terms and conditions, the way the sectors are funded does not get in the way. The big difference is where patients are waiting for particular assessments, whether it is continuing healthcare assessments or assessments for funded care home placements versus being a self-funder. That is where the budgets and the restrictions on budgets feel as though they can sometimes get in the way of the best decisions for the patients at that given time.

Q182 Lord Kakkar: I turn to the question of whether there is evidence that integration of primary and community care, and, indeed, policies of health promotion and addressing matters of prevention, have a demonstrable impact on reducing demand in A&E and for hospital services. We have received evidence recently that suggests that that is not the case, and that all this activity in the community, very good for patients as it is in delivering more holistic care and driving broader opportunities for the individual, does not have an impact on demand in the secondary care system.

Siobhan Melia: As I mentioned in my opening point, demand on the secondary system is very significant at the moment and is definitely at its highest level. Are people accessing A&E services instead of things that should be available in primary and community? I am not sure we have made that causal link. You can suggest that perhaps people cannot access appointments in primary care, but I have not seen national evidence on that. While pointing to the fact that A&E attendances have gone up, demand has gone up in all parts of the sector.

Is there evidence that public health and a focus on prevention eases demand in secondary care? The context we are operating in now is very different. If you look back at the Marmot report, and many other reports that have pointed to an investment in upstream healthcare prevention and population health, there has been evidence over time suggesting that investment in primary and secondary prevention, in wider determinants of health and in bringing in the voluntary sector is likely to improve outcomes for populations, but of course that takes a considerable amount of time.

That is where the challenge is at the moment. We have peak demand on all healthcare services in all parts of the sector, and we have a growing need to invest in the wider determinants, population health and reducing health inequalities. The challenge is how to ease the demand down in order to create the investment headspace and practical space to do that. There is evidence over time from reports that have focused on the wider determinants and the need to invest in population, public health and prevention, but at the moment the demand is so high that it is hard to look at the context with a degree of immediacy.

Tom Cottam: Going back to the work the British Red Cross did to look at the drivers of high-intensity use, there was some very clear evidence. Quite often, you get the intervention after people have attended A&E several times. It is defined as more than five times a year, but we are working with people who have attended A&E tens or even hundreds of times. Once we can identify them, they are referred on to that service and it provides that wraparound, de-medicalised, very personalised support to address the underlying root causes, which are often unmet social and emotional needs.

There is a demonstrable impact on reducing demand in that cohort to divert people from continuing to attend A&E, because we have created other routes that address some of the drivers, whether those are issues related to loneliness or substance misuse, or just

resolving some of the housing problems that we talked about, which are a significant issue.

Lord Kakkar: It would be very helpful for us to receive that evidence, because this is the fundamental question: for the short and medium term, is it right to argue that driving forward these policies, important as they are, will have a meaningful impact on demand in the secondary care system? Is the argument that these will have to be invested in anyway because it is the right thing to do in order to drive improved short and medium-term outcomes for individuals and populations, but it will be difficult to demonstrate a profound impact on resource utilisation in the secondary care system over that time?

Tom Cottam: From the high-intensity-use work that I have talked about, there is clearly an imperative to do both. From our perspective, fulfilling improved outcomes for those individuals is paramount, while recognising that in order to make the case for wider rollout, demonstrating that reduction in demand in secondary care is critical. There is emerging evidence that that is possible. The point that Siobhan made is very pertinent; we are at such levels of demand at the moment that it is a real challenge.

Siobhan Melia: There is evidence from this winter about admissions that were avoided for category 3 fallers, who were otherwise sitting and waiting for an ambulance to be conveyed and for them to be taken into an A&E department. There is a growing body of evidence just from this winter that says that there was an alternative pathway. The patient was identified quickly enough, they were referred to it and they were seen within two hours. This was at the peak of winter when ambulance response times were very challenged, particularly for category 3. There were very emotional stories playing out through the media of the real impact, particularly to elderly people who have fallen and have waited too long.

We can pick particular pathways where an alternative solution for that patient group has been put in place, and we can demonstrate avoided admissions. We need to be able to do that in a much more scalable way in order to build exactly what you have described: a body of evidence that says that investment over here is a scalable proposition with great outcomes for patients and that it reduces demand for a particular patient cohort in the hospital services. That evidence base is emerging rather than already there.

Lord Kakkar: If you could share the emerging evidence that you have with us, we would be most grateful.

Siobhan Melia: Yes.

Baroness Barker: The word that I am becoming increasingly sceptical about is "pathway". "Pathway" seems to indicate that there is a route and that people know where it is and how to steer people down it. Following up on Lord Kakkar's point, whose responsibility would it be to gather the data and evidence that Lord Kakkar is asking for?

Siobhan Melia: In our current context, the integrated care boards have the helicopter view of system-level data. As NHS providers, we submit information to our integrated care system partners and to NHS England. There are two routes by which data is aggregated up. I would say that the first port of call is the integrated care board. Then the regional and national teams at NHS England also pull up quite a lot of data.

Q183 **Baroness Osamor:** What one change would you like the Government to make that would better integrate services so that patients flow through the health and care system more safely and effectively?

Siobhan Melia: My passion is the community sector in its widest sense, including voluntary and community assets and local government partners. I would like to see greater investment and prioritisation in the community sector, with ring-fenced investment and standardised specifications so that we can level up the access to out-of-hospital-based services for populations across the country and invest in collecting the data to be able to provide the evidence that many of you have asked for today.

Tom Cottam: I agree wholeheartedly. It is fundamental to make that shift, understanding and valuing the need to address the non-clinical needs that people are often dealing with alongside their clinical needs. There is a really good opportunity in the major conditions strategy, which is being proposed shortly, to signal that shift. We know that it is so important to people who are dealing with often multiple, long-term conditions that they receive that wraparound care. That shift from thinking about only acute pathways to thinking about what we can do to rebalance that from a community perspective will be really interesting to see. I hope that it features very heavily in that strategy.

The Chair: Thank you very much on behalf of the committee, not just for those short, sharp answers, which will give us lots to think about, but for all your evidence today. I think I speak for everybody when I say that it has been extremely helpful to us. As you know, this session is recorded and you will be sent a transcript to check for any errors. We have already asked you for several

other things, which we would be grateful to receive. If there is anything else you have not had the opportunity to tell us that you think we should know, we would be grateful to receive it. In the meantime, thank you very much indeed for your attendance on this very hot afternoon. I apologise for the lack of air conditioning, which does not exist in the Palace of Westminster.