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APPG Primary Care and Public Health

Inquiry into Managing Demand in Primary Care: the case for a National Strategy

National Voices is the coalition of charities that stands for people being in control of their health and care. Our membership covers a diverse range of conditions and communities, and connects with the experiences of millions of people. For more information, please contact: sarah.hutchinson@nationalvoices.org.uk

1. What needs to happen and who needs to be involved to help assist people in looking after their own (b) long term conditions?

People with long term conditions and other complexity are now the 'core customers' for the NHS, using 70% of its resources, including two thirds of primary care consultations. Despite this, primary care in most areas is still providing a 'legacy model' of care: reactive, episodic, and more or less paternalistic.

This not only lets down the people the NHS is meant to support; it places avoidable pressure on primary care services. The failure to take a more proactive approach to managing long term conditions can result in avoidable use of urgent and emergency services.

People with long term conditions are already looking after their own conditions most of the time. On average they spending three hours per year in contact with health services, and the other 8,757 waking hours managing their own care.

Effective chronic care models would provide proactive and person-centred support to self-manage as a fundamental approach to mainstream care. Supported self-management aims to help people develop the skills, knowledge, confidence and motivation they need to manage their health outside of NHS services, and to stay as well as possible, for as long as possible.

National Voices believes that a new, person-centred and community-focused, approach to supporting people with long term conditions is urgently needed. We advocate a new model of care for people with long term conditions, one which starts with asking not what is the matter with them, but what matters to them, and brings together a range of support to meet their medical, psychological and social needs. The model is evidence-based: the programmes, interventions and approaches that we describe have been shown overall to improve people's outcomes, create a better experience of care, and ensure that healthcare services are used in the most appropriate ways. The model should be offered to everyone with a long term condition. The elements of this model are as follows:

Personalised care and support planning: Care planning consultations bring together patient and clinician on equal grounds, recognising their respective expertise They give people the opportunity to identify what matters most to them, what their health-related goals are, and what kinds of care and support they want to draw upon to support them in managing their lives and conditions. Care and support planning is a process, repeated regularly. It enables people to make contingency plans for episodes of worse health, with the aim of avoiding escalation and hospitalisation; or where a hospital stay becomes necessary, to recover and return home quicker.

Care and support planning is already entrenched in social care, following the Care Act 2014, and some limited and targeted use is being made within the IPC programme and the MCP and PACS Vanguards. However, a growing number of GP practices around the country have implemented the Year of Care approach, and evidence from these suggests that the change of mode can be cost neutral, as people attend fewer episodic consultations and single condition clinics. This approach has the potential to create system savings through reduced use of unplanned and emergency care.

Social prescribing: Following the care planning consultation, people may need help to access the non-clinical types of support they have identified as helping them to meet their goals. A systematic mechanism allowing referral to a wide range of community support, often known as social prescribing, should be in place in GP surgeries. Social prescribing is currently only truly systematic in a few places, including in the evaluated social prescribing model in Rotherham, where referrals have been planned and designed in partnership with a single VCSE 'broker organisation', and the Ways to Wellness programme in Newcastle.

Community based, non-clinical support: There must be a range of non-clinical support available to which people can be referred. This is very diverse, and can include self-management education courses, walking groups, artistic and cultural activities, cookery classes, etc. It can also include services that help people tackle underlying problems that have an effect on their health, such as poor housing conditions, debt, or addiction.

There is a growing evidence base for a range of interventions that support people to manage their own health, provided by voluntary and community sector organisations. Realising the Value, a recent NHS England funded programme to strengthen the case for change, developed the evidence base on a number of approaches, including self-management education, peer support, and health coaching.

2. Is it necessary to commission self-care and how can this be done effectively?

Self-care itself cannot be commissioned – it is something people do for themselves. However, as set out in the framework above, there are a range of approaches and services which support people to manage their conditions which both commissioners and providers can help to support and develop. To commission these approaches to health and care, commissioners will need training to understand the benefits and how to achieve them. Skills for Care have developed a range of relevant training.

Commissioners should work in partnership with patients, carers, the public, staff, and the voluntary and community sector to design and commission services. Each group holds expert knowledge, and coproduction can help shape more effective services that meet people's needs more efficiently.

The model should be effectively targeted. Long term conditions are disproportionately concentrated among people who are poorer, older, and from ethnic minority backgrounds. These groups are likely to have lower levels of health literacy and therefore be less equipped to manage their health, and to best access effective services. The impact of a person-centred model will be limited without segmentation to target those with the highest needs.

Multimorbidity – having more than one long term condition – is also an important factor, and increasingly services must be capable of working with people holistically rather than as a collection of single diseases, each with its own 'pathway' of care.

3. What training is necessary to support primary care staff in educating people to look after themselves and who is providing this training?

Primary care staff should be offered training in person-centred approaches. Most important, establishing systematic personalised care and support planning in primary care requires both staff training (for GPs, nurses, healthcare assistants and receptionists) and facilitation to change processes in order to redesign the consultations and the system of recall and review. The best-evidenced example is provided by the NHS organisation Year of Care Partnerships, based on the successfully evaluated Diabetes Year of Care programme. The training includes significant attitudinal and behavioural change towards person centred care.

Not everything needs to happen within primary care: effective interventions such as information and education for self-management, peer support etc., and can be sourced from community assets. Other interventions can be provided by integrating professionals and services such as physical therapists or pharmacists with primary care.

Some of the skills that may be useful within the primary care staff team include those which enable more effective, person-centred consultations, such as attentive listening, reflective questioning and motivational interviewing, and skills for health

coaching and for shared decision making. This is not about teaching 'self-care' per se, but equipping staff to work in a more person-centred way, in turn helping patients and carers to develop the confidence motivation they need to manage their own conditions.

Staff should be trained to understand the impact of health literacy on people's capacity to manage their health, and of interventions that can improve this. Low health literacy has a stronger correlation to ill health even than ethnicity, deprivation, and education levels.

4. How can local health expertise such as pharmacy, health coaches, patient groups and charities, etc. be incorporated into the system to help manage demand?

The VCSE sector provides a wide range of health and care services, including hospices, advice and information, peer support, advocacy, befriending, support to rehabilitation, care planning, and activities that can prevent ill health. Voluntary organisations hold expertise about the people they work with, which should be harnessed (while recognising that the pressures on voluntary organisations mean they are not a 'free resource').

Investing in, or working closely with, the voluntary sector can help health and care services work more efficiently, better meeting people's needs and narrowing the three gaps identified by the Five Year Forward View. The recent VCSE Review final report, the Richmond Group's Untapped Potential and outputs from the Realising the Value project all include more information about this.

A commitment to real partnership working across organisations, sharing responsibility and information, and developing joint solutions is crucial to delivering the model of care. Where local community support is mapped, this information should be shared across local government, general practice, dentists, pharmacists, etc., to help ensure people can be pointed to the help they need where and when they need it.

5. What else has to happen to improve joint working locally to engage people in their health and wellbeing and so reduce service demand?

In 2013 the Department of Health and its arm's-length bodies adopted a common vision of the goals of integrated care, provided by National Voices, and a shared commitment, but these have been diluted and obscured by a number of developments, including over-reliance on an ineffective funding mechanism (the Better Care Fund).

There has been a failure to produce meaningful outcome measures designed around the needs of people, instead of 'system measures' such as hospital admissions. The context of overall underfunding of health and social care has forced providers to

focus on survival rather than collaboration, and drained away money that was meant for 'transformation'.

As the recent National Audit Office report indicates, local areas leading integration have defaulted to focusing on small targeted groups of, usually older people, with complex conditions, who cost 'the system' a lot of money. Many people are missing out, including children and young people, those with continuing mental health needs and those with more than one long term condition.

There needs to be a renewed shared national commitment to provide person-centred coordinated care, based on the definition in the Narrative for person-centred coordinated care[3], and with person-centred outcome measures derived from that narrative.

6. What impact have Government policies such as the Five Year Forward View and GP Forward View had in managing demand, and how can we move towards that much sought after whole-systems NHS?

It is probably too early to judge this, although there are some early promising findings from some of the Vanguard sites. However we are concerned that the FYFV agenda on person-centred, community focused health and care– has stalled somewhat. Severe financial pressures have focused attention and resources away from 'transformation' towards 'sustainability'. Almost all of the money earmarked last year for transformation under the Five Year Forward View was diverted to filling hospital deficits; and this has now been followed by another £800 million recouped from CCGs' planned spend on community and mental health care.

It is vital that this agenda is championed at the highest level, to demonstrate to local services this should be a priority in order to deliver effective and sustainable services. Transformation funding must reach primary and community services, where there is the best chance of supporting people to stay well through supported self-management and a new model of care for people with long term conditions.