National Voices

# National Voices' response to: The Integration of Primary and Community Care Committee

## About National Voices

National Voices is the leading coalition of health and social care charities in England. We have more than 200 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of people: patients, service users, carers, their families, and the voluntary organisations that work for them.

## Introduction

Joining up health and care services from the point of view of people who use them has been at the heart of National Voices' work for over a decade. We have therefore strongly supported the integration agenda and are pleased that the case for integration of services across the NHS with social care and beyond, has now been accepted. Both the Five Year Forward View and subsequent NHS Long-Term Plan placed the integration of health and care services at the heart of the NHS agenda. However, despite multiple reform programmes, and significant structural change, from the perspective of people who use health and care services the 'cracks' between services remain all too visible.

We believe the fundamental success measure of the integration agenda should be whether the experience of people who use health and care services improves. We recently published a shared vision for integrating care in partnership with key organisations across the health and care system.

In our conversations with both disabled people, and people with lived experience of long term conditions, lack of continuity of care and the complexity of navigating the health and care system are recurring issues. Creating more joined-up services is therefore a priority. However, it is important to note that structural integration is not necessarily a pre-requisite or a guarantee for improving care. For example, the addition of a care navigator or coordinator to the mix of professionals working with an individual – to give them a single point of contact within the system, and to transfer the labour of coordinating support – may achieve similar aims to bringing services into one structure.

Charity number: 1057711
Registered office: The Foundry, 17 Oval Way, Vauxhall, London SE11 5ER
Twitter: @NVTweeting
Email: info@nationalvoices.org.uk

While we have sought to focus our response below on issues related to the integration of primary care and community health services, integration across the whole system matters. The same core principles need to apply right across NHS and to the integration of the NHS offer with social care services. Achieving full integration from the perspective of people who use services, remains some way off.

Below we set out our responses to some of the questions posed by the committee.

## Questions

### 1. What are the main challenges facing primary and community health services?

The key challenge from the perspective of people who use health and care services, across both primary and community health services, is access. Access to services was a major challenge before the pandemic, and is now worse. Across all of our conversations with people who use health and care services, challenges in getting an appointment in primary care are a recurring theme – with longer waiting times and more complex processes around booking and triage. These are particularly acute for those who have additional needs – for example those who may need longer appointments; who need support with communication; or are digitally excluded. At the same time waiting times for community health services have increased, and eligibility thresholds have risen, leaving more people waiting for their conditions to decline before they become eligible – a situation contrary to both individual and system interests.

One of the factors exacerbating access issues is the second key challenge – the workforce – with staff shortages impacting right across primary care and community health services. These are well-documented by other experts, but the need for a solution is now critical. The ongoing delay to the NHS workforce plan, the lack of consultation with people and communities in the development of the plan, and the decision not to produce a coordinated plan across health and social care are all causes for concern. Recently, we joined with 85 patient charities and professional bodies, calling on the Government to commit to a comprehensive and fully-resourced response to the serious challenges faced by the NHS and social care workforce, which continue to badly impact the experiences of people accessing health and care.

Another factor has been the introduction of new systems and processes for accessing primary care and some community health services. Most notable

among these has been the shift online and towards remote consultation. Our research has demonstrated clearly that sweeping generalisations about digitalisation are ill-founded. While for some groups digitalisation has increased barriers to access, for others it has brought them down. However, "digital-by-default" services can particularly exclude groups who are already at risk of health inequalities. It is therefore critical that people are offered choice and flexibility, and that new approaches need to be designed *with* the people who will use them involved. Too often this has not been the case.

Another key challenge is the knock-on impact of backlogs in secondary care, which has left more people managing their conditions in the community for longer, while they wait for treatment. This has increased the demands on primary and community health services – further exacerbating access issues. In 2021 we set out core principles that should inform the work to recover services following the pandemic, which still stand. While the integration of services has the potential to deliver on these principles, we also note within them that structural change has the potential to distract from the work to improve services for people. This must not be allowed to happen.

Turning to solutions, we would endorse the priorities for reform that were identified by the Fuller Stocktake – namely improving access, including to urgent services out-of-hours; providing more proactive, personalised care for people who have long-term conditions, with an emphasis on continuity of care; and helping people to stay well for longer. We believe our members, in the voluntary, community and social enterprise (VCSE) sector have a critical role across all three key aims, but particularly in relation to the third aim around supporting people to live well.

National Voices will shortly be publishing its own vision for the future of Primary Care which is currently in development with people with lived experience of long-term conditions and disabled people, our members and professionals from across the primary care space. The key themes emerging include the importance of:

1. Improving access and triage to put choice, personalisation and equity at the centre, for example, through expanding and empowering the front-of-house-team and investing in improved website and telephone system models.
2. Modernising communications, putting choice, personalisation and equity at the heart, through improved systems for recording and respond to communication needs, better training and support for staff, and stronger accountability where communication needs are not met.

3. Making support for people with multiple long term conditions more joined up - by embedding holistic approaches to reviews of long term conditions, ensuring clinical pathways don't take siloed approaches and by resolving communication issues between organisations.
4. Equipping primary care professionals to meet people's needs in holistic ways, by investing in voluntary and community services that build community connection and help people to live well, but also in systems which make it easier for staff and GPs to see what support is available to people in their local neighbourhood.
5. Developing clearer standardised processes for diagnosis of health conditions.
6. Making it easier to book longer appointments in General Practice.
7. Tackling the inverse care law – especially around access to GPs and dentists
8. Ending the wrongful refusal to register people experiencing homelessness, people living nomadically, asylum seekers and refugees.
9. Working in partnership with people, communities and VCSE sector organisations.

We recognise that Dr Fuller's recommendations take as read a need for significantly greater integration of primary care and community health services and a blurring of the boundaries between the two, to ensure that people can access services near to where they live in whatever way makes sense to them. We support this approach and believe our principles align with it.

## 2. What are the key barriers preventing improved integration, and how might these be overcome?

The key barriers to integration are the long history of working in silos; the existence of strongly demarcated organisational divides lines which impact key issues such as pay and conditions and ways of working among staff as well organisational culture and vision; structural incentives towards competition towards collaboration; and competing targets. There are also a range of practical barriers such as challenges around sharing data and the fact that organisational geographies are not coterminous – this can be a particular challenge for VCSE organisations which have often grown up around "natural" communities or neighbourhoods (i.e. those understood by local residents) rather than in relation to administrative geographies.

Despite these challenges, there are numerous examples of integrated

services joining up different parts of the system in different parts of the country. These include "anticipatory care" programmes which involve multi-disciplinary teams from across sectors working with particular groups of individuals who may have complex needs. The best services take a person-centred approach – starting with what matters to people, not what is the matter with them. Multi-disciplinary team working is often at the heart of these models – and these seem to be particularly effective where decision-making power is delegated to teams, to work out together how to best meet and individuals' needs. Another key approach is colocation, which helps to reduce the "friction" people feel between services, and can support staff from different services to work together. However, it is important to note that colocation does not necessarily drive integration if it is not backed up with strong communication and alignment of systems and processes. From the individual's perspective, models which offer a key point of contact, ideally including out-of-hours support, can also help reduce the friction and cover over the cracks between services.

Our experience suggests that there is not one "best practice" model, which should be replicated, but rather a range of approaches that should be tailored to local circumstances – taking account of local needs and the existing assets across the community. Crucially the existing capacity and strengths of the VCSE sector should be considered as part of the development of new services.

## 3. Pressures on primary care have been well documented. How would you assess the current state of community care, in particular the integration between both areas?

Our assessment of the current picture is that while some individuals are still getting good support from health and care services, no area of health and care provision is immune from the pressures of high demand and reduced capacity. This means that services are too often failing to meet people's needs and the people most affected are often those who may need additional support to access services – for example people who have specific communication needs, such as Deaf people, people who don't speak English fluently and more (see recent research from our member SignHealth for example).

The ongoing underfunding of social care has left more people struggling to cope without support, increasing the demand for community health services such as district nursing and physiotherapy. Yet, in many cases, these services often also lack capacity to respond (see for example the recent report from our member Age UK). This means that people are often forced to

wait as their condition deteriorates, increasing reliance on friends and family and, in many cases, on stretched VCSE sector services.

## 4. What are the implications of the Government's long-term workforce plan for the NHS on primary and community care staffing?

The ongoing failure to publish a workplan is significant cause for concern, given the critical impact of staffing shortages on all parts of the NHS and social care. However, we are concerned that the plan currently under development has not been developed in partnership with people who use health and care services and that the current NHS plan will not be joined up with plans for the wider health and care workforce across social care and VCSE sector services. We hope that the plans due to be developed by Integrated Care Systems will be more aligned with the principles set out in our recent statement on workforce challenges.

## 5. What is the impact of recent structural changes to the NHS in England (enacted through the Health and Care Act 2022) on integration between primary and community care services?

National Voices has welcomed the creation of Integrated Care Systems (ICSs). We believe the drive towards collaboration, rather than competition, and the refocusing of health services on creating health for people, rather than providing services, is right. ICSs have enormous potential to deliver a better health and care system for the future but, from the perspective of people who use health and care services, it will be some time before this makes a difference to their day-to-day experience.

To some extent, this is inevitable, given the significant structural and cultural change required to realise the vision of ICSs. We believe it is important that ICSs are given time to bed down and to start to deliver before any further structural change is considered. This is likely to be a process that spans many years and more than one political cycle.

However, while we believe that ICSs are, broadly, the right structures for the health and care system going forward, their existence in itself is not enough to deliver the kind of change we need. Integration could deliver a range of outcomes desirable to the system – including around the flow of funding and the management of demand in the system – without changing the experiences of individuals, or potentially even by changing the experience of people accessing care for the worse (we have seen other customer-

facing industries generating efficiencies for themselves by transferring labour to the consumer: for example, the introduction of self-checkouts in supermarkets). If we want to ensure that ICSs deliver their promise for people, we need to make sure they are measured against things that matter to people. These may not necessarily be the same as the issues that would be prioritised by system leaders or politicians.

## 6. Is the current primary care model fit for purpose and servicing the needs of patients?

The Fuller Stocktake sets out a compelling case for reform in primary care, critically widening the definition of primary care to encompass other services which are delivered in or near our homes. We think this makes sense.

From the perspective of the VCSE sector, partnership working is challenging across the system – Primary Care is not unique in this regard – and one of the greatest challenge to partnership working is constant structural change which forces VCSE sector organisations to build and rebuild relationships across the system every few years.

As ICSs continue to develop it will be important to ensure that VCSE sector organisations are supported to develop meaningful partnerships with relevant parts of the health and care system and that there are clear mechanisms for coordinating the "ask" of the VCSE sector across systems, to minimise the need for charities to build and maintain multiple relationships, and to help them find the right level at which to connect. Not every charity will need a relationship with its ICS, for some PCNs may be the right level at which to connect, but helping leaders from all sectors to navigate this requires some planning.

## 8. To what extent could improved access to out of hours and 24/7 services contribute to alleviating pressures on the health system?

The lack of access to out of hours services is a significant challenge. In recent research for the British Red Cross it was shown to be a significant driver of high intensity use of Accident and Emergency services. Ensuring people know where to turn when they need support out of hours would make a significant difference.

## 9. To what extent have Integrated Care Systems (ICSs) been able to deliver the aims they were set up to achieve?

As noted above, we believe it is too early to expect ICSs to have delivered on their key aims. Significant structural change like the creation of ICSs take many years to bed in and to start to make a difference. ICSs need to be allowed time to do this.

Having said that, we can already see that the best ICSs, which are starting to make inroads into the change that is needed in their communities, are doing this by being brave enough to share power with people and communities and to devolve decision-making down to the most appropriate level – which, when it comes to prevention and health promotion, is often the neighbourhood level.

We believe that VCSE sector organisations have a critical contribution to make to ICSs – both as strategic leaders and providers. The VCSE sector is already a major provider of community health services (responsible for around a third of services) but also has a critical role to play in providing support that responds to people's social and emotional needs – which is critical to enabling people to live well. Ensuring that we can shift resource into communities to deliver wrap around support that addresses people's needs as individuals, rather than treating people as a series of body parts or conditions, will be crucial to achieving the aspirations set for ICSs around prevention and early interventions. We have set out key principles and advice for ICS leaders around engaging with the VCSE, which we hope can inform the approach going forward.

## 11. In what way could the existing infrastructure be enhanced to improve the use of health technologies, and what are the possible benefits for patients?

We believe technology has a role to play in future health systems, and many people already embrace technology – including wearable devices and apps – to help them maintain their health and manage their long-term conditions. However, we know from our wider research – on developing digital approaches; on the provision of remote care and support for carers and on Unlocking the digital front door – that there are risks to over-reliance on technology to improve access to care and support, particularly for those already at risk of experiencing health inequalities.

Technology is not a good itself – for it to make a difference to people it needs to be developed *with* them – with people involved in identifying where

technology could make the most difference, as well as in developing solutions. Often, the focus of health technology is on managing demands on the health and care system, or on monitoring service users, but we would like to see a greater focus on the use of technology to support people to live well with a condition. There also needs to be a commitment to maintaining choice around the use of technology – with alternatives offered as a matter of course.

We know that data-sharing is often a major barrier to integration at service level and that data-sharing across the boundary between statutory and VCSE sector services can be particularly challenging. Overcoming these barriers will be vital. VCSE leaders must be fully involved in discussions around developing new data sets to inform strategic planning, as well as protocols for sharing information, not only to ensure that VCSE sector organisations involved in the delivery of health and care services can share information with other partners, but also so that insight from the VCSE sector can inform local strategies and plans.

## 12. Could you please outline one key change or recommendation you would like to see to enable effective and efficient integration in the delivery of primary and community care services?

Our core recommendation is that the measures by which we judge the integration, not just of primary care and community health services, but all health and care services, should be developed with the people and communities that use them, and should be rooted in what matters to them. The key test of integration must be whether it improves the experiences of people who use health and care services – filling the gaps between services and support, and reducing the friction of moving between different parts of the system, so that people can access timely care and support that meets their needs in ways that work for them.

Charity number: 1057711
Registered office: The Foundry, 17 Oval Way, Vauxhall, London SE11 5ER
Twitter: @NVTweeting
Email: info@nationalvoices.org.uk