National Voices written submission to Health Select Committee Primary Care Inquiry

September 2015

About National Voices

National Voices is the coalition of health and social care charities in England. We work for a strong patient and citizen voice and services built around people. We stand up for voluntary organisations and their vital work for people's health and care.

We have more than 140 charity members and 20 professional and associate members. Our membership covers a diverse range of conditions and communities and connects with the experiences of millions of people.

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Executive Summary

1. Person centred, coordinated primary care starts from the perspective of the person and works with them to identify the care and support that fits their life, allowing them to work towards the health and wellbeing goals most important to them.

2. There is growing evidence that 'person centred, coordinated care' can improve service user experience and ensure the most appropriate use of limited healthcare resources. National Voices believes that primary care should be better supported to deliver more person centred, coordinated care.

3. Person centred primary care involves:

- Coordinated care
- Care and Support Planning, taking a House of Care approach
- Multidisciplinary teams and joint working across services
- Partnership with the voluntary and community sectors
- Training and development for staff in person centred approaches
- Recognition that people have different levels of health literacy, and strategies to tackle this
- Harnessing digital technology to ensure better access to health care and support, and to enable people to better self-manage.

4. Person centred primary care also offers increased flexibility of consultation times, develops ways of ensuring that services are co-designed and meets the needs of local people', works closely with community pharmacists to provide seamless support, identifies and supports carers, and works to ensure smooth transitions between hospital and community.

5. Primary care, and the work of primary care professionals, is vital to achieve person centred care. However, the constraints of current models and funding prevent this from being fully realised. New models of primary care will not only support a more person centred approach, but, we believe, ease the current pressure on GPs through more multidisciplinary working, colocation of services, and through fully utilising a wide range of approaches and support that help people to manage their own conditions where appropriate.

Introduction

6. Primary care is the foundation of the NHS. The role of GPs is vitally important to the health and wellbeing of the population: they provide generalist services close to home, they offer consistency and personal relationship; they ensure that people get the specialist care that is right for them. Despite this vital role, primary care has been underfunded, building pressure in both primary and acute services - and on GPs themselves, leaving the service at risk of severe shortages. This underinvestment is not sustainable.

7. National Voices believes that enabling primary care to work in a more person centred way will help ease the pressure in the primary care system while supporting better health and wellbeing outcomes. Person centred care is particularly important given the changing health and care needs as the population ages, and medical innovation supports people to live longer, albeit often with long term conditions. It recognises that to manage their health, people will often need 'more than medicine', and develops new primary care structures to deliver this.

8. Person centred, multidisciplinary primary care should be the bedrock of the health system. The Five Year Forward View sets out an ambitious vision for person centred health and care. Primary care is a fundamental building block to achieve this vision, and crucial to achieving the Secretary of State's goal of high quality care.

9. Despite this vital role, primary care has been underfunded, building pressure in both primary and acute services. This underinvestment is not sustainable. A new approach to NHS funding, that prioritises primary care, and both primary and secondary prevention, is urgently needed. This must include full consideration of social care funding. Where good quality social care is not available, people's health and wellbeing is put at risk, with consequences for demand for GP and hospital care. The Secretary of State has rightly identified improvement in the quality of healthcare as a priority; person centred, coordinated primary care is a powerful tool for achieving this.

Person centred primary care

10. National Voices believes that the future of primary care must be person-centred, making the best use of professionals' intention and skills to make people the priority (not the system) and offer proven support to people with long term conditions and disabilities. Person centred care is achieved when people are fully involved in decisions about their care, and are supported to manage their health in their homes and communities. Primary care services can work in equal partnership with citizens, carers, volunteers, the voluntary and communities sector, and the local community to help individuals and shape services.

11. Engaging, activating, and involving people in their health and care are key goals within the Five Year Forward View. Involving people in their care not only improves experience and

health outcomes, but as our evidence for person centred care resource shows, can improve serve user experience and ensure the most appropriate use of limited healthcare resources.

12. Some key evidenced interventions to build individual involvement include:

- Effective health promotion and prevention
- Action to improve people's health literacy – that is, their ability to use information for health and wellbeing decisions
- Support for self-management, including structured education
- Support to share in decisions about treatment options
- Personalised care and support planning.

13. Primary care can play a crucial role in supporting and delivering person centred care. While there is no single model for achieving this, there is a range of ways in which primary care, and in particular GP practices, can ensure people are fully involved in their care.

Coordinated care

14. A vital element in person centred primary care is recognising that people rely on a range of professionals. As such, person centred care must also be coordinated care. This means that care should be coordinated around the individual, so that they can easily access the support they need from GPs, nurses, mental health teams, pharmacists and the voluntary and community sector all working in partnership.

15. National Voices and TLAP developed the 'Narrative for person centred coordinated care' which explains what good care looks like from the perspective of the individual. In essence, primary care should seek to provide care that means that:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

The overarching narrative has been adopted as the definition of integrated care, and has been used by a growing number of local partners to set a standard for care.

16. **Recommendation 1: We would ask primary care practices and professionals to recognise that many local areas are now working towards this type of integrated working, and consider how they can support this.**

Multidisciplinary teams and co-location of services

17. It is not only GPs who can deliver coordinated, person centred primary care. The environment of multidisciplinary teams, co-location of community services and social care, and availability of specialist advice and expertise on both physical and mental health at primary care level would provide for multiple combinations of staff expertise and deployment to work with people to support their health and wellbeing.

18. Ideally, primary care would be able to take a strategic approach to strengthening joint working, so that care is experienced as coordinated. Within the practice there should be

more joint working across the team. Practices should recognise the role of nurses and administrative staff in supporting more person centred care. Primary care should be capable of collaborating with external teams, working closely with other health and care professionals, including specialists. Community pharmacists can also play a much more developed clinical role. They can offer advice and support to help people with one of the main tasks of self-management, which is the management of medications. If they are enabled to access and edit medical records, they can act as an important connection between patients and GPs. Community pharmacists may see patients with long term conditions more frequently than the GP or nurse, offering an additional source of support.

Recommendation 2: Primary care can be provided through multidisciplinary teams, including community pharmacists, through joint working with other services including the voluntary sector. Co-locating services, both NHS and external, within primary care buildings, can help practitioners achieve more coordination and improved access.

Care and support planning

19. Care and support planning is a defined process which helps people set their own aims, and then secures the support and care that are needed to achieve them. It is the key that unlocks person centred, coordinated care, and helps identify ways to help people to manage their care and health and avoid unnecessary acute care. People work with a medical professional or other supporter to think about what is important to them, how they can manage their health and care, what other support they might need. National Voices has produced a Guide to Care and Support planning, which explains the four stages: prepare, discuss, document, and review. The role of care and support planning has also been explored in relation to particular health problems: for example, the Year of Care programme for diabetes, a report by Arthritis UK on the role of care and support planning in managing musculoskeletal conditions, and an ambitious programme of investment by the British Heart Foundation.

20. The House of Care model provides a mechanism to enable local areas to structure delivery in a way that facilitates care and support planning. This Framework does not make assumptions about the 'best' solutions, instead supporting health and care systems to create services that help people to develop the knowledge, skills and confidence to manage their lives and conditions successfully. The Royal College of GPs supports this framework and along with National Voices is a member of the Coalition for Collaborative Care.

21. Recommendation 3: Primary care services should consider adopting care and support planning as the foundation of their work with people with long term conditions.

Partnership with the voluntary sector and communities

22. Strong relationships with the voluntary and community sector are essential for effective care and support planning, and are integral to achieving coordinated services and supporting joint working.

23. The local voluntary and community sector can support person centred care by working as a full partner in the design and delivery of person centred primary care. This sector is able to make key contributions to health and care, and the number of volunteers in health exceeds the size of the formal health and care workforce. Voluntary organisations provide a huge range of support vital for holistic care, including advocacy, information, advice and education, practical and emotional support, peer support, befriending, building community awareness, recovery support from physical and mental ill health and support for self-management.

24. This work gives voluntary and community organisations a position of trust, expertise and access to marginalised and excluded communities. It means they can be natural partners for primary care services. Social prescribing is one model for building partnerships between primary care and voluntary services. This gives statutory professionals access to, and enables them to refer into, local community sector provision of health-supporting activities. This can ease the pressure on GPs who may feel unable to provide proper support for the difficulties that patients report – stress, motivation to take exercise, debt, social isolation – offering them the opportunity to refer them to someone with the time and expertise to help. Social prescribing services may be co-located with GP practices or community centres, and may utilise community development approaches to identify the needs and demands, as well as assets within the community.

Recommendation 4: The voluntary and community sector are recognised as integral partners in the delivery of primary care, to help people develop the skills and confidence they need to manage their health, and to enable primary care to offer 'more than medicine'. Measures to support this could include the use of voluntary care coordinators within practices, and involving expert patients within the multidisciplinary teams to offer peer support, as well as social prescribing.

Training and development

25. Those providing primary care, in whatever role, are the first point of contact with people. They need to be supported to continue to develop the skills to start from the perspective of the person – rather than looking at the disease in isolation, or starting from what works for the organisation. Practitioners need access to training and support to work with people to identify the care and support that fits into their life, and which meets their goals.

26. This change in the 'philosophy' of care must be supported at all levels by wider changes across the primary care system to ensure that structures, commissioning practices, and payment support systems do not create barriers to change.

27. The experience of primary care practices that have implemented person-focused interventions is that new systems are required, and that creating an understanding and buy-in from all staff, including receptionist and administrators, is necessary. Training and continuing professional development can play a key role in helping people to review and reflect on their person centred practice and to understand care from the point of view of the person with goals.

Recommendation 5: Training in person centred approaches should be available to all members of the multidisciplinary team.

Health literacy and patient activation

28. Health literacy – the extent to which people can understand and use information about their health and care – varies considerably. People may lack the basic numeracy and reading skills they need to understand information, but even people with high levels of education can struggle to understand the information they need to make informed decisions about their health and care. In addition, many people struggle to take control of their health because they lack the confidence or skills needed.

29. Primary care professionals who recognise the fact that people have different levels of health literacy and activation are crucial to delivering high quality, person centred care. Methods such as teach back, where patients are asked to explain their understanding of what they have been advised, can be useful. Understanding an individuals' level of health literacy and activation means that information can be delivered appropriately, and that people who struggle with understanding and activation can be offered support to develop this, for example through peer support and other voluntary sector programmes.

30. A number of pilots are currently exploring how the concept of health literacy can be used to improve services, including use of the Patient Activation Measure and the Health Literacy Questionnaire, both currently being piloted in England, which maps community needs and explores the services required to address these.

31. Recommendation 6: Primary care staff should be offered support to recognise, and provide services that can be adapted for, different levels of health literacy and activation. Services to develop health literacy and activation can be introduced through partnership with the voluntary and community sectors.

Further recommendations for implementing person centred primary care

32. Access to health records: Being able to access one's health record, so as to be able to recall decisions and the reasons for them, to understand one's condition(s), and to review treatments including medications, is an important enabler for people to be fully involved in managing their own health and care. Evidence shows that online record access can support self-management, shared decisions about treatment and people's commitment to courses of prevention and treatment. People should be supported to have easy access to their full records, be able to add their own data, and to make corrections.

33. Digital technology to improve access to care, and support self-management**:** Primary care must embrace the potential of digital innovation for improving health and care. Technology can be used to improve access to primary care, through electronic health records, and online consultations making it easier for people who cannot easily attend appointments to ask for advice. There are also a wide range of apps which can be used to support self-management of conditions such as asthma, for example helping people to monitor their conditions, share at-home test results with GP services, help them to manage exercise and healthy eating, and reminding people to attend appointments, or take medication. Primary care should embrace these new innovations, and support people to access and use them.

34. Development of Patient Participation Groups (PPGs): GP practices and their commissioners should invest time and resources in developing these groups as 'critical

friends', ensuring they are representative of the local community. They should be used to influence local services at a strategic level, as part of ongoing efforts to improve services.

35. Smooth transitions between hospital and the community: Better GP triage at the hospital gates could ensure people are dealt with in the right place by the right team. Primary care services should also work closely with hospitals to support people who are discharged from hospital to avoid a return.

36. Identifying and supporting carers Informal carers provide a huge amount of care, easing the pressure on formal health and care services. They play a vital role in health and wellbeing, which has been recognised by the Government through the Carers' Strategy. However, they also often experience poor physical and mental health, which can put at risk their own wellbeing and that of the person they care for. Primary care must play a central role in identifying carers, ensuring they get the health care, including mental health care, they need, and in putting them in touch with support services. Developing strong relationships with local carers and other voluntary services, alongside strategies for identifying which patients are carers, and who is providing informal care for patients with acute conditions, can help ensure that carers get the support they need. This is of particular importance when carers may themselves be experiencing disadvantage, such as young carers or carers who are themselves living with long term health needs.