

#NVPrinciples

Timely access to care: Principles for recovery

1. Introduction and Background

Timely access to care is now the most pressing concern of people who live with ill health, disability or impairment, and what they talk to National Voices members about. Delays, waits, service disruptions and cancellations are now so widespread that it can seem difficult to find areas of healthcare that aren't affected. It is important to also state that good, timely care is still going on in many places and for many people – but it is far less reliably so. Primary care, community services, mental health, so-called elective and specialist care and urgent and emergency services are all impacted – people can find it difficult or impossible to get the help and support they need in a timely way wherever they turn. The problem is now so systemic and far-reaching that it threatens the very fabric of the health system's claim to being a 'universal' service. Without access, you don't have anything else either: personalisation, quality, safety, assurance.

Rebuilding timely access to health and care needs to be top priority for all system leaders now. But it is no good trying to fix just one part of the system. A too narrow, politically driven focus on just one pressure point (let's say elective waits or face to face appointments) risks simply creating more problems elsewhere. You can only deploy your people once, and if you don't have enough people, you cannot provide enough care. We need an approach that thinks about **the whole system and its context and the whole person and their circumstances**.

2. Openness and Transparency

We believe openness and transparency need to be the core foundation of all communication around this situation. We owe it to the people who wait for care or struggle without support, and we owe it to the people who work as hard as they can and still cannot meet all the need. Clear communication needs to be developed and delivered that's aimed at the public, that explains the pressures and what is being done to mitigate them. Narratives about how people working in health and care are not putting in enough effort need to urgently be rejected. **We need to be honest about the relative level of funding health and care in England have received in the last decade**, how this compares to other countries, and how our workforce, capital and services offer are substantially smaller in the UK than they are for countries of similar levels of wealth.

Large numbers of people struggling with access to health and care does raise the political temperature, but it is really important that in trying to manage the politics of the situation we don't end up undermining and demoralising the people who are still working hard to provide as much access as possible. It is also **important that we do not put off people from**

seeking help. Too much of the emphasis is given to the idea that people 'expect too much'. In our experience that is seldom the case. People's expectations of health and care services are often modest and usually moderated with a deep sense of gratitude for hard working health and care staff, people also are very understanding on the impact Covid has had on services. It is particularly dangerous to deploy the 'high expectations' narrative when facing communities who are traditionally underserved by the health and care system.

Health service use is uneven, and it is important we don't deter people who actually need more, not less health and care – thereby making the inverse care law even worse.

Clear, practical and supportive communication and information also needs to be provided to people who are directly affected by delays and cancellations. National Voices was central to the development of this ambitious standard: <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/01/C0855-i-good-communication-with-patients-guidance-v2.pdf>.

It is important that this high quality standard is actually implemented with urgency now, to safeguard and support people holistically and with kindness.

People also need to be given up to date and practical information about average waits, maximum waits, guaranteed standards, available support and ways to get advice from professionals in charge of their care. We stand ready to work with the NHSE on the 'my planned care' self service portal. It is important that this is properly user tested and that alternatives are provided for anyone who cannot use an online portal.

The [Accessible Information Standard](#) needs to be realised in all communication. This is a high impact action to reduce health inequalities. A focus on inequality and inclusion needs to guide all processes design around access. The system can be very difficult to navigate at the best of times. These aren't the best of times. Many people need advocacy to be able to access services. We need to go much further than just providing information to people who are more likely to struggle with access: peer support, peer advocates, care coordinators and link workers can all make an important contribution here – often the best place to commission such services is from the voluntary and community sector.

3. Workforce

Workforce is the main rate limiting factor for a person-centred and inclusive recovery. The health and care system simply does not have enough people to provide enough services. This has been exacerbated by Brexit, Covid and years of under-funding. We urgently need an independent, ambitious, costed workforce plan that covers all health and care sectors and sets out achievable goals for growing the health and care workforce.

Clinical workforce is obviously crucial, but also hardest to grow quickly. So we also need a **strong emphasis on creating better non-clinical support** across all areas of health and care practice: good administration, good management, good front of house teams, good peer support, social and practical support, to free up clinician time, focus clinical input where it adds the most value and to support people with their needs and ambitions. In primary and community care, much more could be made of the role of pharmacists, physiotherapists and other AHPs.

The size of the health and care system is dwarfed by the size of the contribution made by informal and family carers – supporting them well with their own needs, including for respite, is a high impact action that will make the whole system more resilient.

4. Digital

A well designed and person-centred digital or remote service offer can play a crucial role in maintaining and improving access to care. For too long, 'digital' was hailed as the saviour of an overstretched and under-resourced health and care system. Now, suddenly, in response to criticism, face-to-face is pushed as the only 'true' access, particularly to primary care.

We need to stop obsessing about channels of care delivery and focus on outcomes: inclusion, personalisation, choice, timely and appropriate access. Many people are happy for many of their health issues to be discussed online or on the phone. Others need a face-to-face interaction. Often a blended approach is best, making best use of the advantages of all the different channels. We need to stop incentivising or measuring digital or face-to-face, and start incentivising, measuring and paying for inclusion, personalisation and shared decision making.

The clinical and non-clinical workforce need to be challenged and supported to stay focused on these outcomes – one size does not fit all, and where processes become overly rigid or unresponsive, people will end up being excluded. This also applies where **new models of care, such as regional hubs**, are developed. A proportion of people will only be able to access those if help is provided for transport and accommodation costs (see for example: <https://www.healthwatch.co.uk/news/2021-11-08/waiting-lists-are-inevitable-its-how-we-manage-them-matters>).

5. Communities and their organisations

Universal health and care is based on a promise made between the people living in this country that the health and care system will be there for everyone at a time of need. This **trust in the reliability of our collective safety net is stretched to breaking point** when too many people experience delays, near misses, harm or distress because they cannot access the services they need.

People who might have less confidence in their ability to self manage ill health, or are less trusting of statutory providers, often because of previous experiences of community harm or neglect, will be more impacted by this further **loss of trust**. We need to all collectively work hard to maintain people's expectations that it is possible and necessary for the health and social care system to meet people's needs and to do so in inclusive and person-centred ways. We also need to ensure that people working in the health and care system can do so free from harassment and abuse. People can feel angry and let down when access is hard – we think there might be learning to be applied from the mental health space on how to better manage such feelings, both in staff and users.

The formal health and care systems aren't the only players influencing people's chances of health or illness, their expectations and the resources they can draw on to support themselves. We need to collectively prioritise health and wellbeing outcomes in how we think about all services (housing, education, family support), products (food and drink, social media etc), environments (high streets, parks, meeting places, accessibility) and communities themselves. **We need to prioritise connection, purpose and collaboration to support health and wellbeing and to help people cope.**

Health and care services will never be able to meet all needs if communities aren't supported and enabled to play a full role themselves- communities of place, identity, practice and interest can play a massive role in holding and supporting people. Connected and purposeful communities don't on the whole spontaneously emerge. They need resources, support and insight to grow and work their magic. The voluntary, community and social enterprise sector has a role in this, as an insight partner, enabler, advocate, connector and provider. The VCSE in turn, also cannot play its full role for free. **Clearly there is a big role for the VCSE to support people who wait, and it will be a very effective use of NHS resources to pay for such support**, not least because the voluntary sector can draw in additional resources and assets to bring to the challenge.

Good signposting and community connection for people who are waiting for care needs to be built into all pathways and communications – as well as peer support and advocacy for people who are at risk of exclusion.

Communities and their organisations can also play a role in exploring and designing innovations that might enable better timely access for more people: self referrals, group consultations, peer led education and support, are all areas where innovation should be prioritised and led by people and communities themselves.

6. Conclusions and recommendations

Government and system leaders need to

- **Communicate clearly** the pressures services and staff are under but at the same time confirm that people are entitled and encouraged to use services where they need to
- Urgently develop a **costed and comprehensive workforce** plan that is based on verifiable assessments of present and future need
- **Review levels of Statutory Sick Pay** to reduce the financial hardship experienced by people who are waiting for care
- **Assess and publish levels of unmet need** that go beyond numbers on official elective waiting lists and include primary and community care, mental health and chronic condition management
- Ensure that the ICS agenda remains focused on **different ways of working that improve access for people**, rather than just on different structures, governance and regulation.
- **Publish at regular intervals data about waiting times, cancellations and referrals**, and make this information usable for people to make decisions about their care
- **Do everything possible to keep Covid rates down**, since high infection rates directly impact the service's ability to accelerate all other care
- **View access as a system wide problem** that needs a system wide response, avoid focusing on one access point only, which will only shift unmet need around
- **Stop incentivising the use of digital or face to face channels** of care delivery and focus on choice, personalisation and inclusion
- **Ensure that all proposed solutions to supported self management, self referral and information giving are**

inclusive and are purposefully being used to reduce the inverse care law

- Demand of service providers and commissioners that all service change needs to be co-produced with communities and assessed for its impact on inequality

People planning and delivering services need to

- Communicate clearly how exactly people can access which service locally and ensure that all parts of a pathway are in fact able to deliver the arrangements communicated to patients
- Ensure that the imminent NHS restructure and creation of ICS doesn't distract from the job of improving access to care and create system wide agreed plans for timely access
- Give people full access to their care records, in ways that work for them, and ensure that the data on their records is accurate and relevant
- Implement the [communications standard](#) for people who are waiting for care and ensure that people whose care is disrupted understand that they are still your patients
- Clearly signpost to non-clinical sources of support and pay community groups and the VCSE to provide such support (helplines, peer support, advocacy)
- Put in place strong support for carers, again in partnership with community groups
- Understand inequalities of service use and publish and put in place plans for how you will tackle those, including where new service models create barriers for some, such as transport or accommodation costs.
- Abide by the Accessible Information Standard, and include the needs of non English speakers in its remit
- Implement consistent care planning, shared decision making and social prescribing approaches across all services and pathways so that people are fully informed and well supported to cope and live as well as possible

- Explore the contribution personal health and care budgets could make to enabling people to access the support they need, for example around physiotherapy or mental health where there is a lot of private provision.

The VCSE, including National Voices, need to

- Continue to build strong relationships with the statutory system (including healthwatch), with each other and with infrastructure organisations to create coherent and holistic support offers
- Support people who are waiting or unable to access services with information, practical and emotional assistance and advocacy
- Collate data and insight on people's unmet needs and inequalities around ability to access services
- Advocate for holistic, community and person centred, and equitable support models that help people cope when facing access difficulties to statutory services
- Focus service development and outreach on communities traditionally underserved, even by the charity and voluntary sector
- Engage with the emerging ICS leadership groups to emphasise improving timely access for people across the whole system and all its services, rather than prioritising structural decisions and processes

National Voices

National Voices is the leading coalition of health and social care charities in England. We work together to strengthen the voice of parents, service users, carers, their families and the voluntary organisations that work for them. We have more than 190 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people.

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