D R A F T 24 N O V 2024

Reading Patient Voice Group
Response to NHS Change Consultation 2024

Q1: What does your organisation want to see included in the 10-year Health Plan and Why?

We want to see the NHS return to a position of high public satisfaction and with an even greater contribution to national life. This means reduced waiting lists, a right balance between physical and mental health, between community and hospital care but also reduced inequalities of life expectancy and healthy life expectancy across our population, and a more widespread common culture of health awareness and responsibility. Above all, we want to return to the situation where the citizen sees the NHS as an available and helpful partner.

We think that the progress that we wish to see will require improvements in the spread of best practice. It will need improvements in organisational culture in the NHS, in management and leadership at all levels. To this end we want to see action on eliminating inequalities between groups of staff. We want to see both medical and management practice at lower performing organisations brought up to the better. To this end we suggest partnering of organisations with cross-placements to bring about the changes needed.

Investment should follow need not necessarily apparent success – it is quite wrong to punish patients for the apparent failings of managers – capital is not a reward for managers but an investment for patients. Responsibility and autonomy can be rewards for success.

The culture of fear must end, and the victimisation of whistle-blowers be decisively stopped through national intervention where necessary. Patients are also fearful that a complaint could impact their future treatment, which is unacceptable. For all parts of the NHS to become better learning and faster improving we should move to a no-fault system of investigation and compensation so that the defensiveness which permeates the NHS can be relieved. This is a big cultural shift and will need development and determined support.

When bringing worse performers up to the better, patient experience needs to be a leading consideration. In evaluating patient responses to surveys such as FFT or the annual GP patient survey which are ultimately subjective, we recommend interpretation by comparison, such as using percentile rank to evaulate the response. In general, the understanding of statistics is poor in the NHS. Wide understanding of statistical significance could improve decisions.

Patient engagement and involvement can help keep services improving for the patient.
The effectiveness of the Patient Participation Group (a patient-led group meeting at least

bi-monthly) should be a factor contributing to the assessment of a GP practice's performance.

GP practices are as various in performance as other organisations, but at present their commissioners seem to have little influence on them. Those falling behind should be brought up to better standards. Because of the risk of practices failing, we want to see alternatives to the GP partnership model explored, piloted, evaluated and developed. That should include services provided by directly employed GPs. We must see the shortages of GPs and other community clinicians resolved with better recruitment and retention. In this respect the existing workforce plan is not ambitious enough in supporting training.

Care and diagnosis should be better organised around the patient – a good example is the ARC clinic for multi-specialist assessment of frail elderly patients in Berkshire East.

Current poor rates of early cancer diagnosis pose a broad challenge to popular culture and NHS access. Fierce gate-keeping and shortages of clinician time have resulted in some patients seeing the NHS as rebuffing or brushing off their concerns rather than responding. New diagnostic technology, new diagnostic centres and a new welcome to patients' concern could make real improvement.

GP practice management should be a recognised career with specified and funded training and professionalisation.

Planning practice is not sufficiently responsive to the availability of health care. Planning applications can be refused if utility capacity (for water, sewage, electricity or gas) is insufficient. However, applications cannot be refused if primary, community or secondary care capacity is insufficient. The law should be changed.

New scientific and technical means will improve understanding, diagnosis and treatment. Let's bring them in as fast as we can understand and accommodate them. BuNew scientific and technical means will improve understanding, diagnosis and treatment. Let's bring them in as fast as we can understand and accommodate them. But let us balance improvements in wide public health with treatment of acute disease as we do so.

Much of the progress we want to see depends on action and support outside the NHS. Social care must be improved so that patients do not need to stay in hospital when fit to leave. Voluntary and charitable organisations could contribute better to health care, with IT interfacing making possible communication and integration with the NHS.
All branches of government, national, regional and local, should take into account the health implications of their actions so that the social determinants of health are improved, being so influential on health and health inequalities. All functions of local government should feel the influence of public health in their decision-making. Health-influenced regulation of social media should be developed and active leisure opportunities expanded, especially for young people. Commercial or other occupational

health departments need a new accountability to a more active Health and Safety Executive with sound medical expertise.

Schools can play their part in bringing about a culture of responsibility and awareness of health and good habits, including healthy eating and cooking.

The food industry and manufacturers of household and individual goods should play their part in improved health through diet and environment, with a change in national food culture needed. The mechanisms of human nutrition are still being explored – let's ensure the public interest is secured and public health centrally involved in this new work. As understanding increases public protection should be secured through legislation.

Q2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Virtual Wards

Spread Virtual Words/Hospital a t Home across the whole country. This is a proven, highly successful innovation that significantly reduces the need for emergency services, the number of ambulance journeys and additional needs for support from health and social care. It leads to faster person-centred care and reduces NHS costs. Improvement Teams should be set up to promote and provide support for this innovation. Provide central support for the evaluation and introduction of supporting technologies.

Community Health Centres

Given the space limitations and locations of many GP practices, it would make sense to set up conveniently located Community Health Centres which could be walk-in centres for minor conditions, promotion of preventative care, and on-going care of serious chronic conditions.

Diagnostics

If we want to see improved early detection of cancers and other serious disease we need to improve easy access to examination and diagnostics, widen screening and increase health checks. These could be at GP practices where there is capacity to do this but sometimes community health centres may offer a better alternative.

Preventive Care

The shift of health care from hospitals to communities cannot be separated from the shift from disease treatment to disease prevention. Prevention is most likely to occur outside

hospital and treatment in hospital. A shift to prevention will bring about a shift out of hospital.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

The question is taken as meaning better use by all parts of the NHS, local government and the third sector.

Problems with the introduction of technology to manage access to primary care

This is an area in which we have some knowledge. Some of these points will apply much more widely.

1. It is too easy to assume that most older patients have adequate technical abilitiies. Many do not and they are major users of health and care services. The skills needed to read emails and make simple searches are insufficient to set up or update apps or install programs. This group do not find the "help" that helpful. "Help" often lacks step by step detail and a straight forward print option.
2. There is no overview explaining what software is generally available to patients and careers with Internet access. It is not clear how all the surgery web sites and various health and care apps and programs fit together. Sometimes it is like a jigsaw puzzle with no picture. At other times there can be options with different scopes and usability. This is confounded by suppliers making exaggerated claims such as "the fastest way to get the care you need".
3. Some software is of a poor quality. The functionality between Windows, Apple and Android devices should be identical. The wording and style should be consistent throughout each product and in line with standards and common usage. It can be difficult for some users if vendors demand that a specific browser is used.
4. Some patients will not migrate from a mobile phone to a smart phone. They fear they are too complicated.
5. NICE scope is limited to Health and Care, Social Care, Community Care and Individualised Care. There are technology opportunities in each category which Nice can review. The current scope does not appear to include software products used by patients and GP practices like EMIS Patient Access or the NHS App. No national organisation is comparing similar software offerings. If NICE does not cover this, there is a good case for either including it or setting up a separate review organisation, perhaps sponsored by the Consumers' Association.
6. The NHS is interested in a competitive supply of applications and thus defines interface and security standards. Specific products are not endorsed. The downside is that this requires a high level of skill at the surgery and at the trust level to assess the competing products in terms of functionality, performance and support. In general GPs have neither the time nor expertise to choose software systems, nor to shape the full Internet offer to patients. One outcome is that practices within any one PCN can have different systems and similarly trusts within any one ICS can have different systems. Without destroying the market, some level of consistency should be imposed.

7. It is difficult for partners or practice managers to access any external audit of a practice's digital maturity. Thus it is difficult to visualise the financial benefits and risks of investing time and money into the further use of technology. External support is needed.
8. One practice in our area, and there are probably others, restricts access to all their online systems to the working day or less. The convenience of online work 24/7 is lost.
9. ICBs hold devolved commissioning powers for primary care. As commissioners their governance of GP surgeries is timid. This has wide-ranging ramifications. A significant proportion do no bother to report their monthly FFT results. There is no guidance on what is an adequate sample size. Our guidance would be at least 100 responses monthly. There is no scrutiny of plans and action to improve patient experience based on feedback from the monthly FFT surveys and annual GP Patient Survey. The skills base of PPGs in making better use of technology is overlooked, especially here in Britain's Silicon Valley (Heathrow to Swindon).
10. Both the GPPS and FFT results would be better presented as a percentile rank. This makes it clear which practices are in the top or bottom 10%.
11. The timeliness of the two main sources of patient experience reporting at GP practices is a concern. Both are intended to drive improved performance and both have too long period between the patient cut off for data input and the availability of national results. The annual GP Patient (GPPS) Survey cut off is the end of March but results for all practices are only available in mid-July. The monthly Friends and Family Test (FFT) results for all practices are only available 12 weeks later. The feedback loops are too long.
12. Recent experience underlines the importance of communication with patients in introducing new technology. Multiple channels need to be used over a long period. It is relevant to segment patients by their digital maturity. The messages need to evolve based on feedback from each segment.

Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Primary care access must be an easy process not a struggle so capacity must be increased and perhaps habits of over-enthusiastic gate-keeping put aside. More regular and frequent health checks will help. Integrated assessments for the frail elderly are needed. Technology will surely improve this area.

The upper age limits on screening programmes should be regularly re-examined. With an ageing population the upper age limits on medical trials should also be re-evaluated.

Prevention requires all the wider determinants of health to improve, from early years support, through education and leisure, with control of social media and mental health support for young people, to good work, good food and healthy communities and support for the elderly. This is a whole government and whole nation requirement. The various responsibilities should be clearly allocated and made known to the public.

The NHS should find a way of making its separate campaigns more joined up – and all contributing to a stronger culture of health and fitness. As an example, the transition to "care navigators" has not been effectively communicated.

The best employers support health but some work saps health. There should be a new approach to occupational health and health and safety at work which lifted the standards of the least motivated employers?

Schools, colleges and youth organisations have a special role with regard to health and can start awareness, habits and practices which will last a lifetime.

Q5: Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

Quick to do, that is in the next year or so

Comparative review of leadership and organisational culture at all levels of selected trusts with best and worst organisational cultures. Report, revise training approaches.

Set up review of no-fault versus adversarial safety and compensation approaches (not under a judge) and recommend.

Bring long-running whistle-blowing disputes to mediation.

Set up cross-government mechanisms to represent current understanding of the wider determinants of health.

Revise criteria for performance of GP practice PPGs in consultation with the NAPP and introduce them in assessments by the CQC and commissioners.

Pilot/assess utility of community health centres.

Pilot/assess the Brazilian model of improving community health with all-age, household health visitiors.

Refresh the Dimbleby report on Food Strategy and move to an Action Plan for a fuller and updated implementation .

Firm up central control of software adoption in primary care.

Pilot new on-demand access routes for under-diagnosed conditions.

In the middle, that is in the next 2 to 5 years

Develop a new approach for the Health and Safety Executive to make occupational health care more effective.

Provide more health checks, revised screening, enable more objective self-awareness of health.

Neurodiversity – develop approach which emphasises assessment more than diagnosis.

Pilot/assess/shape community preventive care with GPs, new centres, public health, local government, local organisations.

Long term change, that will take more than 5 years

Revitalise equipment, buildings and technologies in the acute sector.

Bring in a no-fault safety/compensation approach.

Fully implement the new Food Strategy

Establish mechanisms at all levels of government to enable government with consideration of the wider determinants of health.

ADDENDUM

CHALLENGES OF CHANGE

Managing changes to new ways of working

It is widely recognised that understanding the human dimensions of change is a key factor in change and transitions to new ways of working. A major challenge is to build trust, clearly explain why change is necessary, and give all the people involved the information they need to understand the benefits to patients and staff of any proposed improvement.

Initial data collection, including surveys and interviews with staff at all levels will be required to identify:

- Current pressure points
- Local opportunities for improvement
- Personal and organisational obstacles and challenges

This data will provide an insight into the organisational culture, including the perceived degree of local autonomy and the role of senior management leadership and support. This will be useful to local or central improvement leaders in deciding the where, what, how, who and when of any proposed improvement.

Doing things differently - Collaboration

It is essential to avoid simply cost cutting improvements. Designing and implementing these improvements are likely to require new cross-department and cross-organisation communications. So, a collaborative approach will be required for any successful and sustainable transition. This includes closer working with Health Watch, patient representative and other third sector organisations.

Communications

Successful collaboration depends on two vital elements:

The human element - thoughtful, honest and reflective communications and relationships.

The information systems – shared relevant, timely and reliable information so that everyone is working from the same data about patients, including patient records, staff resources, finance, and current and planned outcomes. The challenge is to ensure that Hospital and GP IT systems have the capacity and skills to provide this information within the current financial constraints.

Adult Social Care

An even wider challenge and is the wider and difficult challenge of linking these with adult social care where there are currently a variety of local information systems.

Other Challenges

Staff working under pressure

All the identified challenges will be taking place with most staff heavily overloaded dealing with back-logs and often insufficient resources.

Improvements are likely to come slowly, and this will increase the incentive to start with small projects where positive outcomes can be realised quickly and where there is strong commitment from the staff involved, and energetic and enthusiastic local leadership supported by senior management,

Limited building space

- The constrained GP practice estate
- Limited space in pharmacy premises for dealing effectively with pharmacist's wider responsibilities

Managing changes in roles and responsibilities

The new organisation of ICBs and ICPs have involved major changes in roles and responsibilities, with new relationships having to be set up within and between different levels. One simple example is the changing the role and influence of district nurses, with the growth of new allied professionals in PCNs.

This requires new reporting processes, and, in some cases, the development of new skills and new relationships. This has already started, but there is more work to be done in establishing the right level of communication and monitoring of outcomes to enable these organisations to generate reliable regular information which will enable staff at all levels to learn from experience and change course when needed.