

THE UNIVERSAL HEALTHCARE NATIONAL INQUIRY

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I sit on a man's back, choking him
and making him carry me, and yet
assure myself and others that I am
very sorry for him and wish to ease
his lot by all possible means –
except by getting off his back"

Tolstoy, 1991 [1886]

Acknowledgements

When undertaking research and development work, we recognise that everyone's views are always partial. Not everyone can see the problem in the same way, or experience the efforts that have been made previously to overcome them. This report honours individual, group and collective views, bringing them together in key recommendations. Public engagement and coproduction is both rewarding in its outcomes, but also hard to do. No matter how much you engage, people can feel left out. We thank NHS Sussex and NHS West Yorkshire for being open to and committed to this collaboration, which challenged how the NHS meets needs universally.

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Both health systems have been working on access, working in partnership with communities, working with and supporting the voluntary sector as a partner,

and developing programmes to transform. By participating in this research and change process both ICSs intended to learn more about providing universal healthcare.

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The Innovation and Change Lab programme described in this report was independently evaluated by ResPeo.

Foreword

by Lord Adebowale, CBE.

This report faces up to the reality of using and providing services in the NHS that people experience every day. By being honest and open about the reality of the systemic challenges the NHS faces – which in some populations is a crisis, given the decrease in active life expectancy, the real growth in poor health in children and young people, the inequity in provision and the workforce chasm, the harm of waiting – and by exploring this reality as a system (people, communities, services together) this report shows that answers can be found, and that the NHS is both sustainable and vital.

The NHS was founded on a mutual relationship between services and people. This report brings the NHS back to those founding principles, and shows that even though care has become more complex and health need has changed, if you start with understanding need (not demand) and develop solutions with people and communities, you can secure change.

It is easy to fall upon what we think we know about change in the NHS, and to make assumptions about what citizens want or need. This report shows how those assumptions are getting in the way of the NHS meeting current and difficult challenges, and advocates for taking an evidence based approach to understanding health need. It promotes using that evidence to frame decisions, and having a clear collective view about what universal healthcare looks like for the whole population.

The report redefines commissioning in a way that's really valuable, based on the needs of communities from which you build a platform for commissioning. All high performing health systems start with need. The NHS can, and should, do the same.

The report uses tried and tested methodologies to present solutions to current systemic problems. The challenge is not that we don't have answers, the challenge is in what the NHS values and pays attention to in terms of data, decisions, and funding. More of what the NHS has always done, and more power ceded to solutions that have not worked before, will not get the change needed by communities and the NHS. This report shows that

much of what is needed is not operationally difficult, but it does challenge historic power. In a sense, the report describes the low hanging fruit: everything in this report is doable, from providing targeted continuity in general practice to meet need to funding services fairly and reaching out to easy to ignore communities. The only reason not to do these changes is because the NHS chooses not to. We have to ask ourselves, for instance, why children and young people's mental health – given the crisis they are experiencing – is not a critical national performance measure.

This report – with its focus on measures that matter to people who use and provide NHS services, using data to challenge pervading assumptions that are taking the NHS in the wrong direction, collaborating with people and communities to find solutions that work that bring in their own mutual contribution – shows that universal healthcare is a choice, and is possible. It is one of the tools in the argument for a better NHS, an NHS that's true to its founding values, confident and capable of meeting current challenges and averting a future permacrisis.



Lord Victor Adebowale

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Executive Summary

Universal Healthcare

Healthcare that all people have access to, when and where they need it.

The NHS Constitution (2012) for England requires the NHS to provide comprehensive healthcare for everyone that is 'coordinated around and tailored to the needs and preferences of patients, their families and their carers'.

Yet, despite claiming that 'the NHS belongs to the people', our analysis indicates that access to and benefits from the NHS are by no means equally distributed. It may be more accurate to say that 'if the NHS belongs to the people, it belongs to some people more than others'.

Our approach

The Universal Healthcare Network, a group of concerned health and care leaders, put forward three 'propositions' of the ways in which the NHS – despite its best intentions – has played a role in delivering unequal healthcare:



1. Medicalising poverty and providing 'sticking plaster' approaches that make the problem invisible. People are turning up in primary care with health issues that stem from poverty because they have nowhere else to go.



2. Providing services that are not accessible to all despite the fact that the vaccination programme showed us that, in crises, the NHS can reach out to communities to make sure access is equal.



3. Not being frank and open about the reality of the rationing of services. This is depicted in 'I am not forgotten', one of the National Voices' 'I' statements (National Voices, 2020).

The National Inquiry comprised three elements: Firstly, we conducted Innovation and Change Labs in Sussex and West Yorkshire Integrated Care Systems (partnerships of organisations that come together to plan and deliver health and care services in their area). Secondly, we conducted a set of additional case studies to illustrate the three propositions. Thirdly, we undertook a literature review that underpins the concept and the three propositions.

Key findings

Primary care's reactivity means that general practice is struggling to meet social need and that appointments 'skew' to a small group of patients.

When general practice focuses on medical solutions, it faces challenges when people present with social needs or medical symptoms linked to their social circumstances. Around a **quarter of general practice appointments are significantly influenced by social situations**, rising to about half for those experiencing turbulent life contexts. Worse, the limitation of ten minute appointments leads some patients to book multiple appointments. Consequently, people who turn up to see GP practices frequently year-after-year – **persistent attenders** – **are effectively pre-booked for next year too** (see [Chapter 1.1](#)).

'One-size' services do not fit everyone

Since our world is unequal, **providing the same service to everyone perpetuates existing inequalities**. This means that if you just increase the availability of GP appointments, those who are already accessing them benefit more, while those who are not benefit less (see [Chapter 1.2](#)). This approach is also correlated with lower morale in general practice.

People whose first language is not English need extra support

Given that these people find it harder to communicate their needs and advocate for themselves, they find it harder to access services.

They shared their problems accessing translation services in primary care and communicating with pharmacies to collect prescriptions. Accessible health-focused English classes give people the tools they need to take control of their lives and improve their health (see [Chapter 1.2](#)).

The VCSE sector is well-placed to help primary care reach out and build trust in communities, as well as meeting social need

The voluntary, community, and social enterprise (VCSE) sector are experts at reaching out and building trust in a community, and often provide more flexible and tailored approaches compared to the NHS. They often focus on specific neighbourhoods, deeply integrate within the local community, and have equitable communication with the people they serve. By co-designing their services with the community, as well as their strong partnerships, they have the flexibility to respond to people's social needs as and when they arise (see [Chapter 1.3](#)).

Children and young people are underserved by primary care, particularly in terms of mental health services

We found that young people **don't access as much care as they need**. Young people make fewer, shorter appointments in primary care compared to other age groups and are among the least satisfied groups. This is because **primary care isn't designed for them**. **Demand for mental health support, in particular, vastly outstrips capacity** (see [Chapter 1.4](#)). Where children and young people are actively involved in designing health services, outcomes are improved.

Primary care in poorer communities is unequal and different

In more deprived areas, there tend to be fewer primary care professionals per person and fewer appointments, in comparison to less deprived areas, meaning that **care is harder to access**. There is less money available to practices in poorer communities in relation to the community's needs. There also tends to be lower screening levels, fewer planned hospital admissions, and more emergency admissions, indicating that **services are less preventative**. This is despite people in deprived areas having **greater health needs** (see [Chapter 1.5](#)).

Key Recommendations

Understand who is registered in general practice, and provide services that fit their needs

To identify what the community needs, we recommend a two-pronged approach of **listening to the community** and **investigating GP records** to support persistent attenders. We recommend **focusing on persistent attenders** as it yields the greatest benefit for the invested time and energy. Then provide for this need, **matching the services to the nature of the need that has been identified and its complexity**, which will include a proactive approach to providing (longer) appointments and continuity for people with complex needs, which in turn increases GP morale (see [Chapter 1.1](#)).

Design multi-disciplinary teams (MDT) around known needs, not assumptions about them

Often PCNs (primary care networks, groups of GP practices) and INTs (integrated neighbourhood teams, groups of GP practices working with other local healthcare providers) assume that persistent attenders are people with comorbidities and so convene an MDT (multidisciplinary teams, where everyone involved in someone's care gets together) for those cohorts of persistent attenders by default. Instead, we recommend that they **check if a person needs or would benefit from an MDT** intervention before convening one. If they do need an MDT, then it should be **built to match their needs** (see [Chapter 1.1](#)).

Identify who isn't accessing appointments, reach out to them, build trust, and help them transition back into NHS services

Analyse appointment data and see who isn't accessing appointments. Reach out to these communities to understand their concerns and

empathise with them. Listen specifically to those communities who we usually ignore. Build trust by collaborating with individuals who are already trusted by the local community, such as charities and community champions. Then we can adapt our services to help people transition into them (see [Chapter 1.2](#)).

Make your own luck with the VCSE sector

We recommend that the NHS reaches out to the voluntary, community, and social enterprise (VCSE) sector to help meet social need, and to reach out and build trust in communities. They are happy to help but they need the relationship to be mutually beneficial.

The VCSE sector particularly needs the NHS to provide them with sustainable funding, clear roles, and to share data effectively with them (see [Chapter 1.3](#)).

Sort data sharing so that your community can help you

We currently rely on a system of signposting – recommending that people contact another organisation – for people transitioning between NHS and community services. But this does not work effectively: signposting means that people often have to repeat their needs to each organisation, and there is little support for people moving between services. A digital data sharing 'referral' system enables people's data to be securely sent between organisations, avoiding the issues with signposting (see [Chapter 1.3](#)).

Co-produce services with children and young people, and invest in mental health services

We recommend that services are co-produced with young people to better meet their needs, through asking them to help **review services against the 'You're Welcome' standards** and **creating a youth forum**. We also recommend **increased investment in mental health support** for children and young people

(across health and the VCSE sectors) to find ways to meet needs at every level of the healthcare system (see [Chapter 1.4](#)).

Create a needs-based funding model for primary care

We recommend that local integrated care boards (people who buy NHS services locally) should make sure practices in poorer communities are not at a financial disadvantage as a result of national funding formula, and should be funded based on the level of need in the communities they serve. This involves first establishing a model of need and then developing the funding model. The approach that we suggest is collaborative and means that no practice should lose money under the new system (see [Chapter 1.5](#)).

Learning about the Innovation and Change Lab process

Involve the community from the outset

A major element of the Innovation and Change Lab process is helping the healthcare system to see itself from different perspectives, and helping the system to see itself as a part of the community that it serves. The community members and the stories that they share are instrumental in this.

The biggest gains are made when the community is involved from the outset, at the design process, where they can help make sure that the whole system is represented during the workshops. Their continued involvement as partners in the inquiry and solution finding is the one thing that keeps the system in an innovation mindset, to help them change for the better.

Support from systems leaders

Innovation and Change Labs involve a move from a hierarchical way of working, to a more egalitarian way of working together that unlocks the knowledge, skills and creativity of all members of the system. System leaders need to support the programme throughout, in order to give rank-and-file healthcare system professionals and members from the wider community the permission, space, and support to lead system change.

This support is particularly important in the early stages of the process, where people need resources, and at the end of the process, where learning from the Lab process and the prototypes is applied to the whole system.

Support open, honest, non-judgemental inquiry

The Innovation and Change Labs involve a process of open and honest inquiry into how the healthcare system works and why it works in this way. The process follows three stages: challenging assumptions, empathising with others, and letting go of the old ways of working. We work to overcome judgement, cynicism, and fear at each stage respectively.

The workshops should reflect the diversity of the local community and everyone should be given the support they need to get involved as equals. This means that workshops need to be well structured, use a variety of communication methods, and that extra support should be given to anyone who needs it.

How to implement these findings

The best thing to do is to just start somewhere, maybe taking the data slides and seeing if they look like your health system, or taking the propositions and discussing them locally. There are real possibilities opening up because of the Fuller Stocktake and move to integrated teams; because of the openness between hospital, mental health, community, primary care, and VCSE sector in places to work together; because the NHS did some novel things in COVID, including working with community leaders.

We also have to make this issue visible to our communities. If it's not visible, no one can help the NHS, and we have seen no evidence that more of the same is going to work.

There are a few immediate possibilities for bringing this learning into your work:

1. Take this learning and intelligence into the development of integrated neighbourhood teams (INTs). Check who is turning up frequently in general practice, look at their needs, check what can be managed at practice level and where practices need MDTs. Review the composition of your INTs based on that intelligence.
2. Set up a programme of transformation for children and young people in communities, coproducing solutions in collaboration with families, 'young' Healthwatch, schools, and the VCSE sector. Add children and young people's health and metrics into the dashboard of the Integrated Care Board (ICB) to make these a focus. The finance and performance committee at the ICB should be reviewing whether children and young people are getting a fair share of funding.
3. Fund the coordination of the VCSE sector and Community organisations that are providing support for health, so it's easier to partner with them. Provide service contracts that span years to give some sustainability and security, and to make sure the VCSE sector can focus on the work, not on bidding for the work. Leaders need to co-design (and fund) the collaboration between the VCSE sector and the NHS.
4. Develop a proactive approach to providing access to people who are turning up frequently (you may as well – they are coming anyway!) and provide continuity to them by using small teams in the practice. Your local business intelligence functions can help you with this. The data is all available – you just need to ask the right questions.
5. Help general practice, PCNs and INTs learn together at what point of acuity/complexity they each need to intervene. Otherwise, you will get duplication and fragmentation.
6. Don't settle for unfair funding. Work locally to make sure that poor people don't get less access to funded services. Start with a fair funding approach by funding based on *need*, not *demand*. Once you understand need – you can use John Hopkins adjusted, or you may have developed your own model – you can make sure that how you distribute resources is based on current need, not on historic patterns.
7. Remember that whatever you do, it's not the final end point: you will need to keep adapting. For instance, social prescribing is a transition from a dependence on general practice to people getting support in their communities; outreach health checks are a way to develop trust, to help people return to/try out mainstream NHS services.

Introduction

Overview and background

Universal healthcare means that everyone has access to healthcare when and where they need it.

The COVID-19 pandemic made it clear that people's health is directly linked to their wealth (Marmot *et al.* 2020), and that, despite its best efforts to cut health inequalities, the NHS is (possibly unknowingly) complicit in providing unequal healthcare. This issue was identified in the King's Fund's submission of evidence to the Joseph Rowntree Foundation (Buck and Jabbal 2014).

In 2021, a group of concerned health and care leaders formed the Universal Healthcare Network (Appendix 1). Our purpose was to establish a collaborative programme of work to uncover the reality of inequalities and service provision, and to work through how best to secure services that are designed around health needs.

The universal healthcare propositions

The Universal Healthcare Network identified that the NHS has been, with the best intentions, complicit in providing unequal healthcare in three ways. This Inquiry sets out our investigation into how the NHS can address the challenges of Universal Healthcare by how it designs and provides services based on health needs.



Medicalising Poverty

Medicalising poverty and providing 'sticking plaster' approaches that make the problem invisible. People are turning up in primary care with health issues that stem from poverty with nowhere else to go.

In our work in primary care we have been finding that in some instances around half of people who frequently attend general practice are there because they are struggling with life. Providing access to health because there is nowhere else to go does not solve the problem. It is a sticking plaster solution. Whilst clinicians are doing their utmost to support people, this is not necessarily the most effective way of helping people or the best use of healthcare resources. It also hides the extent of the problem.

The NHS does not measure or report where 'poverty medicalisation' is happening. We wanted to find out how much general practice understands about who turns up in practices, and if there are better solutions to meet the needs of people struggling with life than offering them an appointment at the practice.



Service Design

Providing services that are not accessible to all. The vaccination programme showed us that, in crisis, the NHS can reach out to communities and make sure everyone has equal access.

We are not hard to reach but easy to ignore communities

Fatima Elguenuni, Community Activist and Grenfell Community Member

The vaccine programme has shown us that when the NHS wants and plans to reach the whole population, it really can. From Vaccine Buses and Vaxi Taxis to collaborating with faith leaders and organising pop up stalls in shopping centres, the vaccination programme went out to the people.

This is a salient lesson. People struggle to access mainstream services for several reasons: because low paid work doesn't give time off for appointments, or because people have lost confidence in themselves and health services, or because they can't afford to get to appointments. If the NHS is going to address health inequalities, it needs to make sure services are accessible universally.

Integrated Care Systems will know where communities, populations and people are not getting access to the healthcare that they need. Reducing inequalities means people securing the health services they need within their reach, and building trust to help people engage with the NHS. The NHS is awash with reports on how some people get more access to healthcare than others (see section 4). Something more fundamental is needed. What might happen if the NHS really focused on meeting need rather than demand, and on guaranteeing the universality of health services?



The Reality of Rationing

Not being frank and open about the reality of the rationing of services. This is depicted in 'I am not forgotten', one of the National Voices' 'I' statements (National Voices, 2020).

When she was at National Voices, Charlotte Augst called on the NHS to be frank and open about the extent and nature of rationing as a result of the workforce crisis and pandemic, when so many services are closed or postponed (August 2021). The NHS needs to be investigating how resources are allocated and used to meet health need, making sure that resources are used fairly. Who gets access and who gets services can be based on historical allocations reflecting a time when health needs were different. This needs addressing.

GP practices in poorer communities provide less access because of the national funding formula. This issue extends beyond poverty and racism. From our work in primary care we know that young people don't access general practice as much as we would expect, especially given what schools and families are saying about children and young people's needs and the known dramatic rise in mental health needs in this age group.

Overall, the NHS pays much more attention to how it reports its performance on adult care than on children and young people. You get more of what you pay attention to, and the NHS is not equitable in how it measures performance, understands needs and allocates funding.

The Inquiry Method

This Inquiry comprises of three approaches:

1. A literature review that underpins the concept and the three propositions (see [Section 4](#)).
2. An Innovation and Change Lab in two Integrated Care Systems (Sussex and West Yorkshire).
3. A set of additional case studies to illustrate the three propositions (see [Section 2](#)).

Literature Review

A non-systematic rapid literature review method was applied, sourcing thematically-relevant peer-reviewed literature. The review supported the approach to this national inquiry described in the Innovation and Change Lab section, of understanding the 'status quo' and working with a wide range of stakeholders including communities to develop insights and solutions. Key themes from the rapid synthesis of the literature concludes that there is a strong rationale for open and transparent co-production approaches to tackling universal healthcare challenges. Overwhelmingly, the literature indicates that primary care cannot adequately meet community needs without attending to social determinants and aspects of health, and

that community and voluntary organisations play a significant role in tackling universal healthcare challenges. The literature review is woven into the findings in Section Two of this Inquiry report. The full review can be found in [Section 4](#).

The Innovation and Change Lab

Innovation and Change Labs are an evidence-based process, designed to tackle complex problems: situations that are characterised by flux and unpredictability. The process is shown in Figure 0.1.1. Many competing ideas are in circulation; in short, there are no 'right' answers.

The Labs demand innovative and creative responses, and adaptive leadership. They bring together a group of diverse stakeholders, generating a team committed to acting together. The purpose of this team is to develop a common understanding of the challenge and to develop a set of actions to address it. The ambition is to make a real shift in the way the team works together. It is a way of working to co-create inclusiveness. Innovation and Change Labs:

- Improve outcomes and experience for users
- Help staff do a good job
- Make best use of what we've got

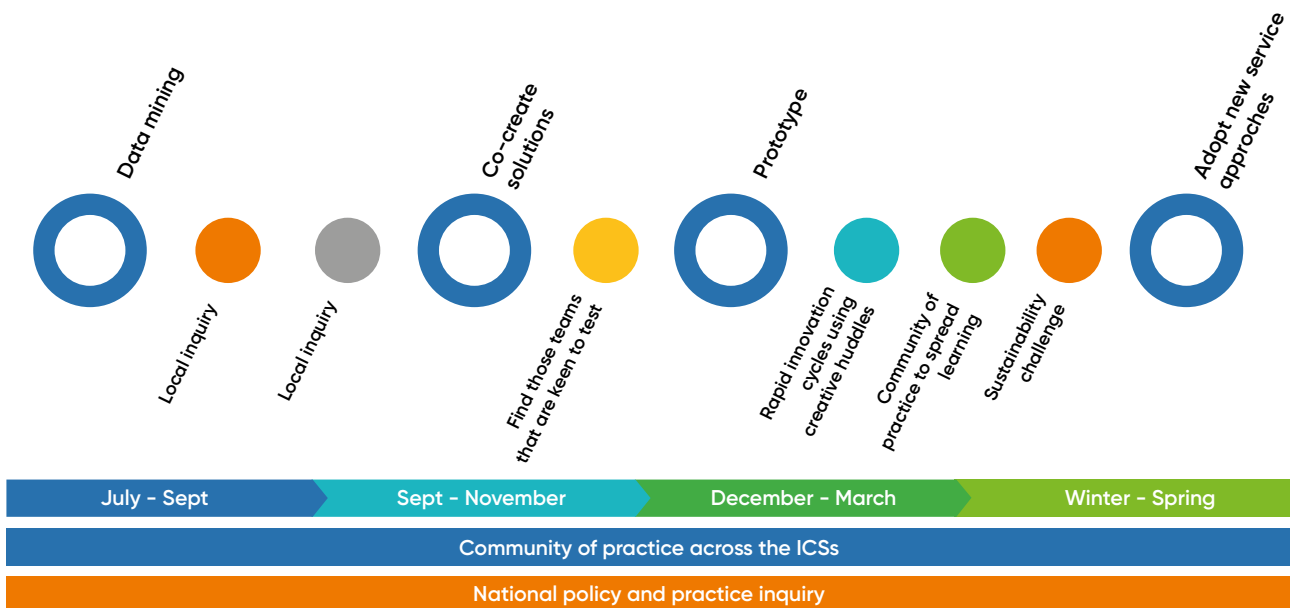


Figure 0.1.1: The Innovation and Change Lab Process

Two places within the partnering ICSs (Bradford and Hastings) provided the focus for the co-creation of approaches that addressed the inequalities that were identified through a data mining process.

Stage One: Data informed understanding of the issue

There is no shortage of data linking deprivation to health outcomes and showing healthcare suffers from inequalities (in terms of outcomes). We find that data can be a real catalyst to changing how the issue is understood and can trigger action, if it is meaningful and provokes questions and discussions. Providing yet more new data is not useful, but sharing data that can illuminate questions that matter to people certainly can be.

Whilst there is ample data about health workstreams, this draws the health system into the very approach that we are challenging here.

The task for this part of the process was to present a practical reality for local people and for services in relation to the three propositions of 1. Medicalising poverty, 2. Service Design and 3. Rationing.

We used data to uncover what is really going on in terms of the three propositions, and to make the willful and unwillful blind spots visible in the system. This data work 'found' a small number of key illustrative stories to develop an informative local narrative and acted as an invitation to develop new approaches.

Stage Two: Working out what we can do

The data informed a system-wide inquiry, bringing the whole system (services, communities, professionals, NHS, social care, VCSE sector) together to develop a shared understanding of the issues and the role the NHS plays in unequal service provision. From here we developed a set of working hypotheses – why we think, as a system, we have ended up organising services in a way that contributes to unequal healthcare.

The process for this Inquiry draws on insights from the Warm Data Lab (Bateson) and U Lab (Scharmer 2013). This model of inquiry recognises that how we 'see' the problem then determines what we choose to do about it.

We took the 'cold' hard data and added to it intelligence on the interrelationships between professionals, people, organisations, executives, front-line – the vital relationships that guide responses to rational data.

Our proposition is that the NHS's contribution to unequal healthcare is not conscious – it is the result of many people trying to do the very best in a complex context. Only by understanding how the NHS is reacting to this context will we understand the 'blind spots' and be able to take effective action. This process of inquiry itself also exposes where there is a real commitment to change that can be actioned.

Through a series of workshops, the place systems (Bradford and Hastings) were able to co-design solutions based on the exploration of these blind spots. This stage goes from diagnosing the problems to co-designing potential solutions and includes finding out what local people (professionals and citizens) have an appetite to act on. The prototypes (experiments) are agreed and teams step up to test these in practice.

Bringing together a group of diverse stakeholders through the co-inquiry Stage One, the process develops a shared commitment to improving quality together.

This stage includes:

1. Identification of participants for the Incubation process through Design Teams (see [Appendix 2](#) for a full explanation), which requires ‘the system in the room’. In other words, it needs to include coverage of all of the levels of the system (frontline to executive), the full makeup of the system (range of services), and public participation from across the community.
2. A series of three Incubation & Construction Workshops and Inquiry Visits are depicted in Figure 0.1.2.

The main output of the workshops is that people think differently about existing work areas (for example, how best to support people presenting to primary care with social determinants, or how to design services close to where people live and work using learning from the vaccine programme), and have a commitment to do things differently together. The workshop facilitates the formation of a number of ‘initiative teams’ around these areas, ideas or innovation domains, that they have the energy to work on.

These new thought areas are formed by bringing people together to construct new insights about their system (including their own role in it) and new high-leverage options to shift it. They form new and stronger relationships within their team with other stakeholders. They build their capacities to work together and to lead and effect change.



Figure 0.1.2: Incubation and Construction workshop plan

Stage Three: Prototyping

Fail faster, succeed sooner

**Attributed to David Kelley,
founder of IDEO**

Prototyping means:

- Trying it out before you adopt
- Rehearsing for the Future
- De-risking your idea

Prototyping is an approach to developing, testing, and improving ideas at an early stage before large-scale resources are committed to implementation. It is a way of project and team working which allows you to experiment, evaluate, learn, refine and adapt. It also makes sure that ideas are fully explored before any conclusions are drawn. The specific prototyping process for the Innovation and Change Labs is shown in Figure 0.1.3.

Prototyping:

- Involves relevant people at an early stage
- Develops ideas with the people who will help you find the answers
- Makes ideas tangible and tests them

- Refines those ideas
- “Informs and improves any eventual project framework for change”

(Nesta and Think Public 2013)

The system-generated solutions were prototyped in small experiments, with all prototyping teams networking together to share learning in a community of practice. The Universal Healthcare Network supported facilitation and challenged the initiative teams, prototyping the changes they wanted to make in practice. Prototypes were tested iteratively and with the oversight of a senior executive or board member to make sure that they inform and are informed by local strategy.

The Lab is a place to work up ideas, get peer review, develop innovation techniques, all to be tried out in real time in the Trust. The testing over four months refined the prototypes into models; these were then subject to business scrutiny in terms of how likely they were to be sustainable, and their impact in relation to the overall objectives for the Innovation and Change Lab.

The final solution designs were ‘challenged’ at ICS level to support sustainability and spread. At the time of this report, the learning from these prototypes is being embedded across the two ICSs.

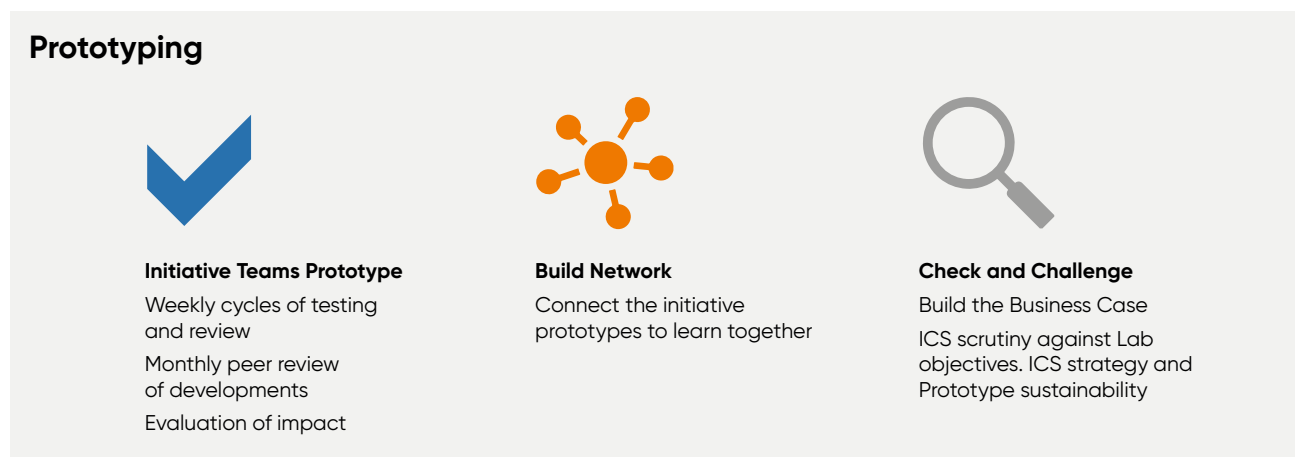


Figure 0.1.3: Prototyping plan

Stage Four: Community of Practice (CoP) Review

Two types of community of practice took place:

1. CoP on the theory and practice of the Innovation and Change Lab, provided for the Design Teams and system leaders.
2. CoP for all participating in prototypes to share insights and learn how to do their prototype better.

The review workshop brought together the learning from these communities of practice to generate the inquiry findings and the 'lessons learnt' for the two Integrated Care Systems.

The Full Innovation and Change Lab method is provided at Appendix 2. A Toolkit has also been developed to support other places available [here](#). It includes:

Process:

- A 'how to' webinar with supporting materials, to share the process of co-creating universal healthcare,
- A data pack and workshop design for places to start their own inquiry into universal healthcare.

Lessons Learned

- Video blogs on the key issues of collaborating with the VCSE sector, and transforming primary care,
- A universal healthcare inquiry newspaper.

Case Studies

The Inquiry took the emergent themes from the Innovation and Change Labs and sought examples both from within the Labs and from the wider NHS and care system. We sought out ordinary clinicians, managers and volunteers doing extraordinary things to make healthcare fair for all. There are, of course, thousands of examples. In Section Two of this report, we share just a few examples as a means of showing how developing fair services for all is within reach.

SECTION 1:

**INQUIRY
FINDINGS**



1.1 Start with need

Primary care is largely reactive, with general practice waiting for people to come to them before determining what they need. This approach results in general practice having to meet social needs and the health problems these social needs generate, and a small group of patients persistently occupying a large proportion of appointments year on year. To address these issues, we propose a proactive approach wherein GP practices examine who their persistent attenders are and design a response to meet their needs. In particular they should tackle the social causes of symptoms, provide continuity of care where appropriate, and form multidisciplinary teams around individual needs.

Reactive care is unequal and 'medicalises poverty'

Primary care cannot meet health needs without recognising and addressing the interplay between ill health and the context in which people live (the social determinants). Whilst those determinants are not the sole responsibility of the NHS, the NHS does have a role in making those determinants visible to policy makers, and ensuring that it does not overreach its role into medicalising poverty.

It is understandable that in a busy general practice, it can seem easier to wait until patients present themselves before determining what they need. Then it's just a matter of providing the best service with whatever is available. However, this approach can lead to problems if the services GP practices have available don't meet the needs of their patients.

When general practice is designed to address medical needs with medical solutions, it becomes challenging when **people present with social needs instead, or present with medical symptoms that arise from social circumstances**. General practice is picking up the burden of poverty in communities, effectively 'medicalising poverty'. This does not

provide a solution but **merely treats symptoms, failing to address the root cause**. For instance, a patient experiencing fuel poverty may display symptoms such as depression due to fuel debt, or asthma caused by them living in a damp and mouldy home. Prescribing antidepressants and inhalers alleviates the symptoms but does not address the fuel poverty that is the root cause. Whilst social prescribing can help people who are struggling with complex lives, many of the solutions lie in and with communities.

When general practice is primarily required to offer ten minute appointments, patients might book multiple appointments in an attempt to resolve their issue, but if their problem remains unresolved, their only option is to book more 10 minute appointments. Consequently, people who turn up to see GP practices frequently year-after-year – **persistent attenders – are effectively pre-booked for next year too**. Although only 3% of patients in an average practice might be persistent attenders, they occupy a staggering 20% of GP appointments each year, as depicted in Figure 1.1.1. That's equivalent to the resources of a whole GP for a medium sized practice. Conversely, close to half of patients registered at a practice won't book a single appointment in a given year. A proactive approach would pre-book longer appointments for those with complex needs, and provide both multidisciplinary responses and continuity of MDT in anticipation. This would not only secure better quality, but it also improves GP morale (see Section 3).

Primary care demand is notably driven by social need

We conducted GP appointment audits where we asked GPs to indicate the reasons for people having an appointment. We found that at least a quarter of **appointments in general practice are significantly driven by people's social situations** which might include home/family difficulties, social isolation, language/cultural difficulties or financial difficulties.

Persistent GP attenders for the last 3-5 years: only 3% or so of the list but 20% of GP appointments

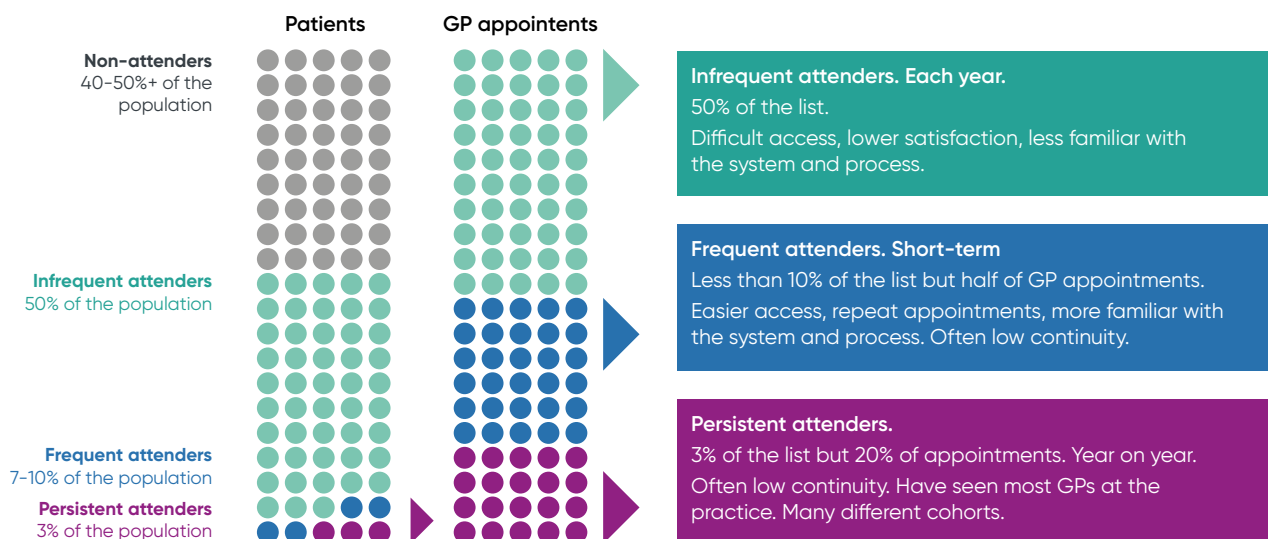


Figure 1.1.1: How patients access appointments.

Among people with a turbulent life context, approximately half of their appointments in general practice were driven by social situations. They have conditions that other people are coping with, but due to a messy and complex life context they cannot cope.

Social struggles also frequently drive persistent attendance. It's often assumed that persistent attenders will be older people with complex chronic comorbidities, but this is rarely the case.

Instead, persistent attenders come from a wide range of different age groups including many young and working age people with no existing long-term condition labels. **People attend persistently because their needs haven't been met**, or haven't been met in the right way for them. If GP surgeries identify need, and provide for it, they can reduce the demand on their service.

I found there were a whole load of people who had a social need, but were constantly coming back to the GP practice, because we didn't have enough social services.

Sheinaz Stansfield, Practice Manager, Oxford Terrace and Rawling Road Practice

Tracey Cabache is Director of Torbay Communities. She explained how **social need has also grown as a result of austerity and the corresponding cuts to preventative services**. See [Chapter 1.5](#), where we discuss the need for preventative services, particularly in areas of deprivation.

Once austerity hit in Torbay, a lot of the preventative services that were being provided by the statutory sector just disappeared. So, you know, we had a massive supporting people programme here, enabling [older] people to stay at home longer and, you know, reducing the likelihood of them, you know, becoming unwell and all sorts of other things. When all that just disappeared. And that's government, that's national government cuts.

Tracey Cabache, Director,
Torbay Communities

There's only ever one question and that's 'what matters to you?' And the answers vary over time. And those of us that are in the pay of the public purse – health, education, local authority, coupled with the voluntary sector, charities, faith sector – our job is to listen to what matters. And then to work with residents to deliver on the things that are important to them.

Dr Mark Spencer, GP Partner,
Mount View Practice

Identify what the community needs

To achieve significant improvements we recommend a two-pronged approach of **listening to the community** and **investigating GP records to support persistent attenders**.

Listening to the community

Listening to the community and acknowledging their needs **gathers meaningful qualitative data**. This approach not only provides a deeper understanding of a community, but also fosters trust and establishes meaningful relationships (see [Chapter 1.2](#)). Additionally, it generates enthusiasm and motivation within community members to be part of the solution and to provide support for the rest of their community (see [Chapter 1.3](#) on asset-based community development).

It's not just about asking the question 'what matters to you' – it's listening to the answer that's going to make the difference. Many case-study interviewees and Innovation and Change Lab participants spoke about how residents had previously experienced tokenistic 'engagement exercises', where people didn't really listen to them and their local residents but instead told them what they would do to them. Genuine listening can be proven by using a 'You said, we did' approach. 'You said' refers to repeating back to someone what you have heard, so that you can check that what you heard is what they meant. 'We did' refers to being able to dictate the action that you took as a result of what people said.

For example, Dr Mark Spencer explained how, in Fleetwood, they had created a Youth Hub, with the aim of supporting young people on Universal Credit into work or full time education. When the volunteers at the Youth Hub conducted a listening

exercise with young people, they heard how young people’s poor mental health held them back, and that they had difficulty accessing mainstream NHS support for this. The PCN was able to bring its mental health practitioners into the hub, alongside its young people’s social prescribing service, as well as providing one-on-one counselling on-site by a local charity, Counselling in the Community.

The Youth Hub is housed in a building owned by the Fleetwood Trust. The Trust has recently been successful with a bid for £1.1 million from the Government’s Youth Investment Fund. This will enable the expansion of the youth hub, creating a safe space for young people to gather in, complete with their own cafeteria. These are both things that have been requested by young people themselves, who will be involved in the design of these spaces too.

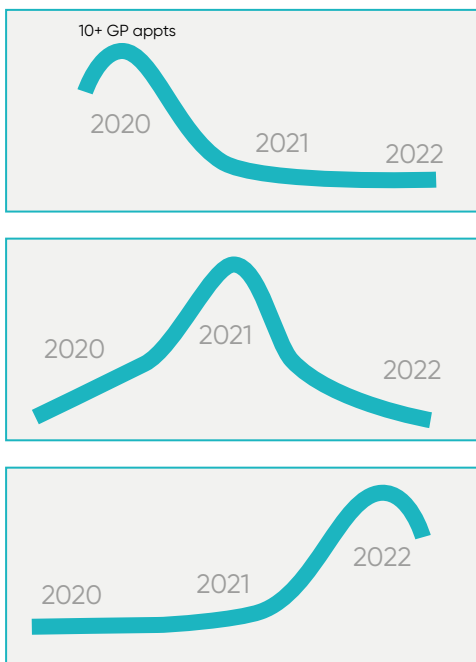
Investigating GP surgery records to support persistent attenders

We recommend focusing on persistent attenders as it yields the greatest benefit for the invested time and energy (Hufflett 2020).

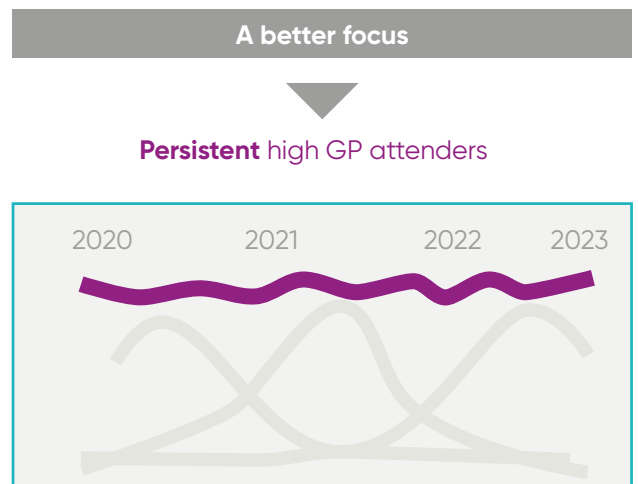
Figure 1.1.2 depicts how persistent attenders are people that attend GP practices frequently year-after-year. They are distinct from episodic high attenders, who may temporarily have high attendance as they are experiencing an acute issue.

This targeted approach benefits everyone at a GP practice. Persistent attenders get their issues resolved quickly; the practice uses its resources more efficiently, and saves money; other patients at the practice benefit from a fairer distribution of resources that makes access to a GP easier for everyone.

Not short-term, episodic high attenders



but



Year on year and into the future

Figure 1.1.2: Episodic high attenders versus persistent attenders.

Firstly, we need to identify who our persistent attenders are. Whilst we all have our ideas (and prejudices) sometimes it doesn't turn out to be the people who we thought it was. We need to test our assumptions against data. Each practice's appointment records are a rich mine of this data. By running searches on the patient list we can **find out who has been attending persistently**.

Next, we **look for patterns in persistent attenders beyond primary care usage**. For example, do they share particular demographics? Or health conditions?

Now, we can conduct a deep dive into a range of people individually. We can manually create patient history maps, such as those in Figure 1.1.3, to **understand how services have interacted with a person**. Patient history maps are a chronological

history of a person's service interaction, giving summary information at each stage. Go back from the present day to as far as the records allow. We can see, for example, where people have been told to use a different service, or where there has been 'failure demand' – that is, where people have failed to receive a service that meets their need, so keep returning with the same problem. We can also see which services have been effective for the person (Malby 2020a). The maps are created manually and should only take 60 to 90 minutes to complete as they are a summary and no confidential patient information or identifiers are required.

Looking at these patient history maps helps us to **understand why services and systems act as they do**. They help to uncover the patterns of thinking in our health and care system, and give us the opportunity to think differently.

Case History	
1989	Oesophagitis. GP1
1989	Urine infection. Nurse 2
1989	Oesophagitis. GP2
1989	Hpylori eradication therapy. GP3
1990	Med review, smoking and alcohol advice given. 1 bottle of wine per night. Nurse 2
1992	Neck problem. Painkillers prescribed. GP1
1993	Deafness. Weight gain. High alcohol Intake. Blood test and referred to gastroenterology. GP1
1993	Did not attend gastroenterology appointment.

Figure 1.1.3: An example fictional extract from a case history map (full maps can be two or three pages long).

Prototype: Identifying persistent attenders (Hastings)

This prototype developed a search on practices' patient lists to identify persistent attenders. They segmented the persistent attenders into different categories (an example is given in Figure 1.1.4).

They found a number of young women aged 18-24 years old who persistently attended. By contacting these patients and creating patient history maps they discovered that they were often neurodiverse, had poor mental health and difficult relationships.

This prototype group is considering how they can support these particular needs, and if these patients would benefit from increased continuity of care.

Read more in Section [3.1.1](#)

Persistent attenders are likely to be a number of different types of people who require a different response. For example, they might be:

- People with clear social needs (e.g. poor housing, poverty, isolation)
- People who need support to manage their health and context
- People with multiple conditions in primary care that are at risk of becoming unstable
- People with multiple conditions in primary care that are already/becoming unstable
- People with multiple conditions who are high users of both primary and secondary care, who are unstable

(Malby 2020)

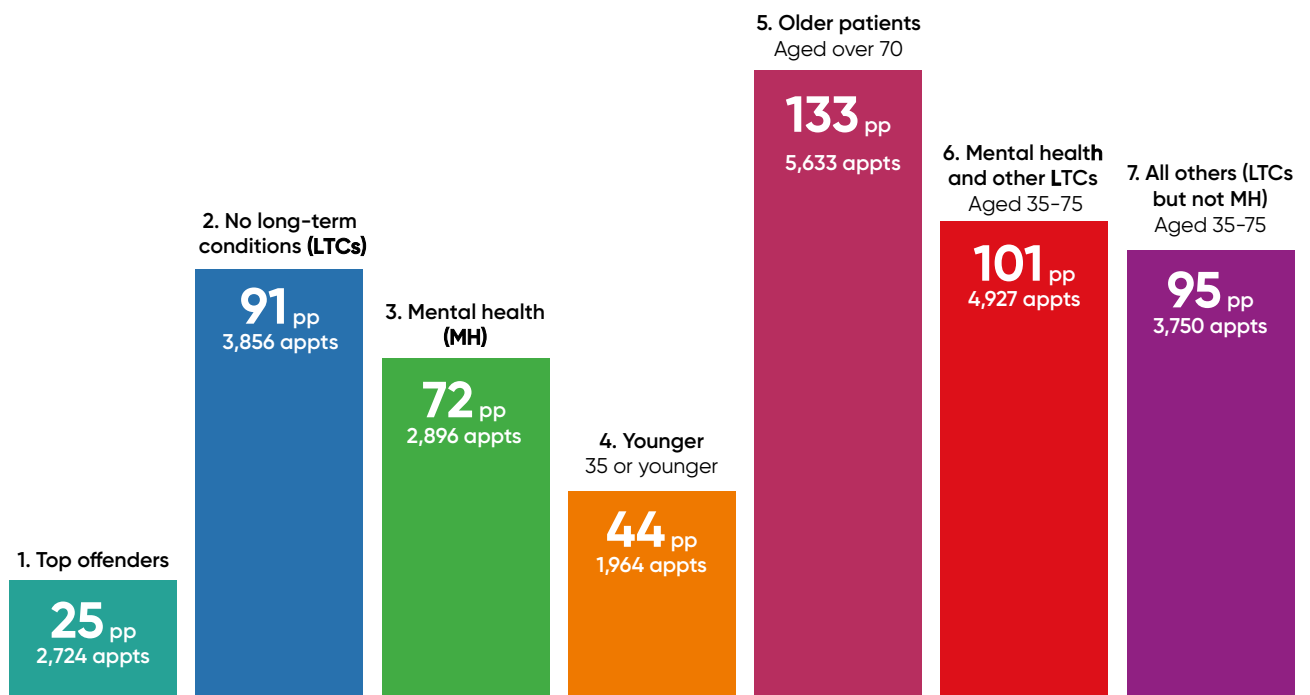


Figure 1.1.4: The segmentation of persistent attenders at one practice in Hastings.

Provide for need

In order to provide for people's needs effectively, general practice should **match the nature of the solutions that they provide to both the nature of the need that has been identified and its complexity**. Prevention should also be offered for infrequent attenders. Dr Mark Spencer and Sheinaz Stansfield were working with different communities with different needs, which required different solutions.

Mark is a GP in Fleetwood, a deprived area with particularly high unemployment levels among 18 to 24 year olds, and where only 20% of children had achieved 4/C or above in English or Maths at the age of 16. He sought to build hope among young people and to raise their aspirations through education and work. The Youth Hub is run as a partnership approach between local voluntary organisations, the primary care network, local GP surgeries and receives funding from the Department for Work and Pensions (see [Chapter 2.1](#)).

Healthcare is not the route out of poverty, education is the route out of poverty.

**Dr Mark Spencer, GP Partner,
Mount View Practice**

Conversely, Sheinaz had a number of frail and elderly patients who weren't eligible to receive support from the local council's adult social care team but who still needed support. She employed a frailty nurse and a care navigator. The frailty nurse helped patients to plan their care, and offered the opportunity for patients to have longer appointments with the same person each time, improving continuity of care. The care navigator, also known as a social prescribing link worker, helps connect patients to services that are available in the community (see [Chapter 2.2](#)).

We now have the frailty nurse and the care navigators who help those frail and elderly people better.

**Sheinaz Stansfield, Practice Manager,
Oxford Terrace and Rawling Road Practice**

Tackle social causes of symptoms

Is there a better way to improve the people's health and wellbeing than just prescribing more medicines and making appointments to see a GP?

**Dr Mark Spencer, GP Partner,
Mount View Practice**

Earlier in this chapter (1.1), we gave the example of a patient experiencing fuel poverty, and how they might be offered the solution of antidepressants for depression caused by fuel debt, or an inhaler for asthma caused by living in a damp and mouldy home. This is a good illustration of someone with a clear social need. Instead of offering a medical solution, **general practice could work proactively with the VCSE sector to address the social causes of the symptoms** (see [Chapter 1.3](#)).

Prototype: Fuel Poverty Referrals (Hastings)

Citizens Advice officers worked with a respiratory nurse at the Station Practice, Hastings, to identify patients on the practice’s list whose health conditions were most likely to be exacerbated by living in fuel poverty.

These patients were sent targeted text messages to make them aware of the impact of the cold on their health, and to invite them to contact Citizens Advice.

Read more in section 3.1.2

Offer continuity where appropriate

A ‘typical’ persistent attender will have had 15-20 appointments in the last year, and have seen 8-10 different primary care professionals, none for more than one-third of those appointments. This is depicted in Figure 1.1.5. The case notes often reveal multiple repeated tests and inconsistent diagnoses (Hufflett 2020).

People with multiple conditions or health needs in association with social context challenges and who are at risk of becoming unstable are likely to benefit most from **continuity of care**. They are also likely to benefit from being proactively managed with pre-determined, longer appointments with the same primary care professional each time.

People who need support to manage their health and context may benefit from a **care navigator** or **co-ordinator** to help them to access help through the NHS or within the community, which might include services such as life coaching or counselling (see [Chapter 1.3](#) on how primary care can make its own luck with the VCSE sector).

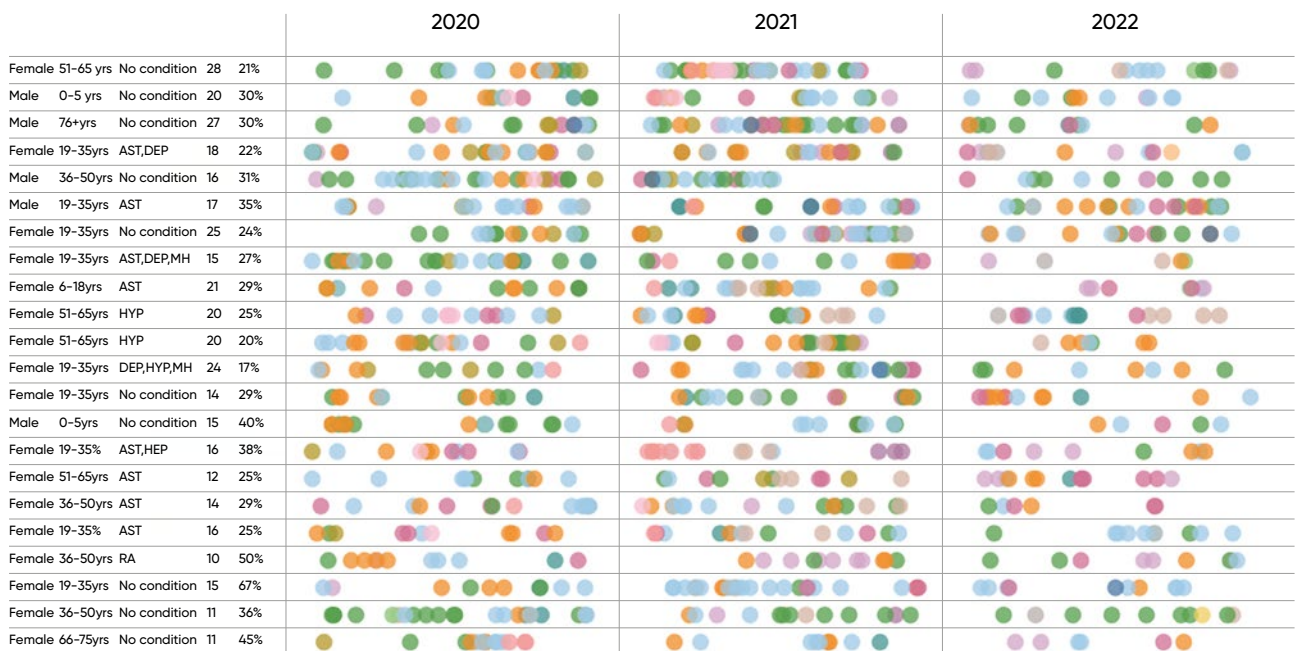


Figure 1.1.5: Example data of clinician contacts for frequent attenders, each different colour represents a different clinician

I think other roles with care planning and MDT (Multi-disciplinary team) experience can provide continuity better than GPs. GPs have a role to play with some patients but I think that complex patients, patients who are isolated in the community, they need a different type of continuity.

**Sheinaz Stansfield, Practice Manager,
Oxford Terrace and Rawling Road Practice**

Form multidisciplinary teams to meet individual needs.

People with multiple conditions in primary care that are already/becoming unstable should have a complex care lead assessment and are likely to benefit from a **complex care nurse** and/or a **multi-disciplinary team** (MDT) intervention (where everyone involved in someone's care gets together to help them, e.g. GP, social work, mental health team, and community care).

Remember to **check if a patient needs or would benefit from an MDT intervention before convening one. If they do need an MDT, then build it to match their needs.** Often PCNs and neighbourhoods assume that persistent attenders are people with comorbidities and so convene an MDT for those cohorts of persistent attenders by default. However, persistent attenders might not have comorbidities, and might benefit more from social support in the community, or a different configuration of an MDT (see Figure 1.1.4 for an example of the range of needs for people who attend persistently in one practice).

People with multiple conditions, or whose life is unstable and who have one long term condition, who

are high users of both primary and secondary care, and who are unstable, are likely to benefit from **high intensity team intervention and a collaborative care plan** across all the services that they use.

Prototype: Managing persistent attenders (Bradford)

Having identified persistent attenders at Horton Park and The Ridge practices, this prototype group recognises that the MDT approach will not suit all patients, and are therefore exploring alternative options such as community matrons, social prescribers and care co-ordinators. They are also identifying who would benefit from increased continuity of care, and offering care-coordination and navigation where a GP appointment is deemed unnecessary.

Read more in section [3.1.3](#)

Prevention for rare attenders

Appointments for persistent attenders are, in essence, being paid for by rare attenders. The per-head practice budget relies on having people who attend rarely to offset the cost of having to provide a service to persistent attenders. This means **it's important to keep rare attenders satisfied too, to keep them in your practice.** If they're experiencing long waits for appointments or can't get through on the phone then they could choose to take their business elsewhere (Malby 2020b).

It's also important to prevent complex health needs from developing. It's cheaper for the practice and better for the patient. Many of the rare attenders are teenagers and young people. Half of adult mental health problems start before the age of 14, and three-quarters before the age of 24. Obese children are much more likely to become obese adults (RCPCH 2020). It is therefore important to help prevent health issues among young people (see also [Chapter 1.4](#)).

Prototype: Increasing uptake of sports and activities (Hastings)

In this prototype, council-run physical activity sessions were adapted to meet social needs and reduce demand on health services. They found that sessions for men's mental health and for menopausal women were particularly needed.

Read more in section [3.1.4](#)

Build 'metrics that matter'

The final element of taking a needs-based approach, after having identified the community's needs, and having provided for them, is to **monitor your performance**. How will you know whether or not your needs-based approach is working?

As well as taking a 'You said, we did' approach to listening to the community, as previously discussed in this chapter (1.1), consider what other **qualitative and quantitative measures** you can make both **of the specific ways in which you hope to provide for need**, and also more generally **whether or not you are meeting the needs of people in your area**.

Our first recommendation was to work proactively with the VCSE sector to address the social causes of people's symptoms. That means measuring the number of people whose issues were resolved in the VCSE sector and how many subsequently returned to the surgery with the same complaint. You can also take an asset based approach. Malby et al. (2019, p.9) described Leeds City Council's approach of counting friendships as a performance metric in their work on Asset Based Community Development.

We also suggested considering a care navigator or coordinator for specific patients. To measure its effectiveness, track how many of these patients have one assigned and if so, gather patient feedback on their experience.

Increasing continuity of care for certain patients was also a suggestion. To measure this, track how many different clinicians these individuals see over a period of time (Figure 1.1.5).

Our last recommendation was to make sure that patients requiring a complex care nurse and/or a multidisciplinary team receive appropriate interventions tailored to their needs. To measure this, check how many patients expected to need an intervention have it, and if so, assess if it matches their current needs.

When creating metrics, expect some differences in responses. If everyone gives the same answer, measuring it becomes unnecessary. Instead, reconsider your question and try different approaches to get meaningful insights.

You also need to make sure that you measure what truly matters, rather than just counting things for the sake of it. For instance, counting contacts between a health professional and a patient is unlikely to be helpful, as it is the content of those contacts and the strength of the relationship that truly matters in meeting a patient's needs.

Good approaches to knowing whether or not you are meeting the needs of people in your area are centred around firstly knowing that you are meeting the needs of everyone you see in the GP surgery, and secondly, knowing that those that you do not see do not need you. The former can be assessed by asking patients about their experience. The latter can be reached by deciding whether there is any systematic relationship between who accesses the surgery and who does not. For example, we discuss in [Chapter 1.4](#) how young people are less well served by primary care than any other age group.



1.2 Reach out, build trust, and transition communities into accessing services

We've learned that 'one-size fits all' services are not suitable for everyone. Instead, we must adjust services to make sure everyone can access them. During COVID-19, the NHS demonstrated this approach by physically reaching out to communities, listening to their challenges, and building their trust by working with charities and community leaders. They then made necessary adaptations to the services, enabling people to access the support they needed. This approach is still needed today for many communities who are 'easily ignored', particularly those people who do not have English as their first language, and cannot advocate for themselves.

1.2.1 One size does not fit all: Adjusting services to needs

The idea that treating everyone the same is fair (a 'one-size fits all' service) can be misleading. In an ideal world with equality, equal services would lead to equal benefits. Yet, **since our world is unequal, providing the same service to everyone perpetuates existing inequalities.** This means that, if you just

increase the availability of GP appointments, those who are already accessing them benefit more, while those that are not, benefit less.

The NHS Health Check is a one-size-fits-all service offered to everyone aged 40-74 without specific pre-existing conditions. The health professional asks everyone the same questions and takes the same measurements. As shown in Figure 1.2.1, despite the NHS Health Check being offered to everyone equally, the take-up rate is higher among older people, and lower in poorer areas. GP appointments are overwhelmingly accessed by people over 30, despite the known increase in need amongst children and young people (see Chapter 1.4).

Differences in take-up rates for a common offer (e.g. GP appointments, screening) might be because in some instances **the NHS has an attitude of "Come to us, we can't come to you"**. This attitude puts the responsibility on people if they can't access or use the services provided. This approach tends to keep people out rather than providing equal access.

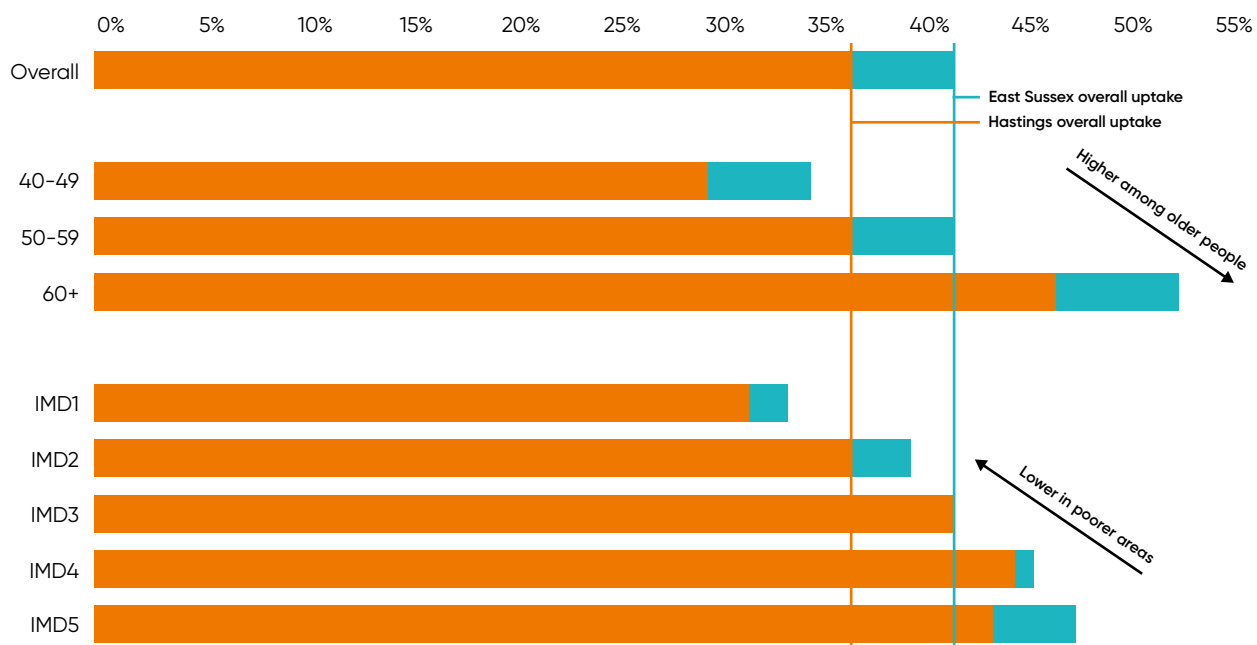


Figure 1.2.1: Different take-up rates for a common offer. NHS health check offer take up (40-74yr olds) Hastings & East Sussex

In reality, some people struggle to access mainstream services because they can't afford to take time off from insecure jobs, because they have lost confidence in themselves or health services, or because they simply cannot afford transportation to get to an appointment. This way of working means that the people who need the services the most might be the ones least likely to receive them.

Designing NHS services to meet need fairly and universally is a three step approach: reaching out to communities and listening empathetically; building trust; and finally, working to transition those that are not getting access into mainstream services, or rethinking the model of service provision (as we are with children and young people's mental health, working with schools, communities and the VCSE sector).

Lessons from COVID-19: Reach out

During her role as health equalities lead for the Bradford District and Craven Vaccination Programme, Rukeya Miah BEM, noticed that certain communities were hesitant to accept the vaccine. **Instead of giving up on them and blaming them for not accessing services, she reached out to these communities to understand their concerns** (see Chapter 2.3).

Rukeya spoke with each community individually, and actively listened to their worries and showed empathy. She discovered that many people in the Asian community in Bradford were worried about potential infertility from the vaccine. Elsewhere, Eastern European communities were reminded of World War 2 by the vaccine centres, and black African and Caribbean communities had historical memories of drugs being tested on black people in France during the 1920s. **Each of these communities had different fears and concerns, which needed dedicated time to address.**

Rukeya explained how it was important to 'meet communities where they are' both in the sense of physically moving services to community venues, and also reaching out to listen empathetically to local communities, especially those who are most often ignored.

Reach out physically and deliver services to people where they are

Reaching out physically means **going out to trusted community venues** like community centres, parks, places of worship, schools, local businesses, libraries, and shopping centres (see [Chapter 1.3](#) on how primary care can make its own luck with the VCSE sector).

We reached out to people physically with the COVID-19 vaccine. We vaccinated people in community venues, and some innovative places even had buses to take the vaccine out to rural areas. Making physical access to vaccination services more easy, attractive, social and timely increased their uptake. This is known as the 'EAST' framework in behavioural science (Service *et al.*, 2014) and it was originally derived from the MINDSPACE framework (Dolan *et al.*, 2010).

The EAST framework simplifies lots of behavioural research into four easy maxims. It's straightforward to apply. After listening to young people, Rukeya found that their principal issue was needle phobia. She was inspired by a piece of behavioural research that suggested that vaccinating people in a shopping centre might reduce their anxiety. The spontaneity, and the familiarity of the shopping centre setting made it easier, and more timely for people. It was also a *social* experience, with people encouraging their friends and relatives. Rukeya also reported that the staff attracted lots of attention in their clinical uniforms, and felt very proud of themselves.

If people are frightened, or not coming forward, then we need to put it in a place where it's less frightening [...] you could actually hear the conversations, you know, encouraging each other.

Rukeya Miah BEM, Health Equalities Lead, Bradford District and Craven Vaccination Programme

Prototype: Health & Wellbeing Festival (Hastings)

Inspired by the lessons from the COVID-19 vaccine in terms of reaching out to the community, and meeting them where they are, this prototype sought to promote health services in Hastings' shopping centre. This was, however, a 'one-size fits all' approach. As a result they found that whilst they attracted lots of people over 50 years old, they had very few young people. They learnt that, to make the biggest impact, they needed to tailor their offer carefully to communities who don't yet know about the available health services.

Read more in section [3.2.1](#)

Sheinaz Stansfield, the Practice Manager of the Oxford Terrace and Rawling Road Practice found another physical way of connecting with her Muslim community. She would chat with them on a Friday, on their way back from prayer (see Chapter 2.2).

And as a leader, what I prefer to do is actually reach out to people in a meaningful way. So I used COVID, as an opportunity, you know, put my Punjabi suit on, I would go to the mosques. And we've got five different groups of Muslim people within literally half a mile of my practice. They don't connect with each other because they're different factions of Islam. But as a practice manager, I was able to go and connect with them. [...] So I started to go for walks on a Friday [...], which is when Muslims go off to pray. [...] So that's why it would happen on a Friday lunchtime, I would catch people on the street, I would have conversations with people on the streets.

Sheinaz Stansfield, Practice Manager, Oxford Terrace and Rawling Road Practice

Listen empathetically to 'easy to ignore' communities

The goal of reaching out is to genuinely **understand and empathise with the perspectives of the people you meet**, enabling you to assist them in accessing services. This involves being open and vulnerable, reflecting on our own experiences, even the challenging ones, to put ourselves in their shoes and share their feelings. Active listening, observing non-verbal cues, and sensing their thoughts, emotions, sensations, and needs are essential elements of this process.

The COM-B model of behaviour is a helpful tool to understand people. It says that for individuals to adopt a behaviour, they need capability, opportunity, and motivation (Michie et al., 2014). By applying this model, we can recognise barriers that impede their access to services and so better address them.

It's crucial to **include groups that may have been previously ignored**. Historically, these groups are labelled as 'hard to reach,' but in reality, they are part of our communities and can be reached on public transport. Often it is helpful to work with voluntary sector or community organisations when approaching these groups (see [Chapter 1.3](#)). The reason we tend to overlook them is that they often lack power and cannot advocate for themselves. Yet, by making the effort to engage, listen, and provide support, we can bridge this gap, and help them to access services.

We are not hard to reach but easy to ignore communities

Fatima Elugeni, community activist and Grenfell community Member

In Hastings, we worked with several people whose first language is not English who required special adjustments to help them access services. Many healthcare professionals were unaware of the significant disadvantages these individuals faced because they find it harder to communicate their needs and to advocate for themselves. One major challenge was that they lacked translators for their booked appointments. Translators told us they can't be available for all the population all day long to ring and make appointments – they need a time of day when they can ring with the person that needs their services.

Prototype: Translation services in primary care (Hastings)

People who do not have English as their first language face difficulties if they don't have an interpreter booked for their appointments. In some cases it becomes impossible for them to communicate with the primary care professional they meet, even to make alternative arrangements. Translators also have limitations in making appointments over the phone and online due to surgery policies and data protection regulations.

The Sussex Integrated Care Board is now actively working to address this issue.

Read more in section [3.2.2](#)

Translation could also cause problems for communication with pharmacies.

Prototype: Prompt delivery of prescriptions (Hastings)

If there are problems filling prescriptions, or when a prescription is ready pharmacies usually attempt to contact people. Some pharmacies were able to translate these messages for people whilst others were not.

Members of the local pharmaceutical committee and people, for who English is not their first language, are working to ensure pharmacies are informed of people's language needs, and that all pharmacies have systems that can translate messages.

Read more in section [3.2.3](#)

Others viewed translation as a temporary fix and believed that offering accessible English classes was the best way to empower people to take control of their lives and improve their health.

Prototype: Open access English for all (Hastings)

Having to rely on translators or family members to help when using health and care services can be disempowering, and present a barrier to people using services.

They established informal, flexible classes, in a community hall, that are led by the community and their needs. This prototype hopes to roleplay appointments between the English students, and trainee primary care professionals. They are also hoping to be fully community-led and self-sustaining, through training up their current students to become future teachers.

Read more in section [3.2.4](#)

Build trust by collaborating

The act of having reached out to people in trusted community spaces and practised empathetic listening will have already built trust, but this can be augmented by **collaborating with individuals who are already trusted by the local community**.

During the COVID-19 pandemic, homeless people were moved to non-smoking hotel rooms for safety. Traditional stop smoking services didn't work well for homeless people, due to their constant movement and various life challenges (see Chapter 2.3). Julie Clare, Senior Wellbeing Advisor at Wellbeing, collaborated with Crawley Open House, a local charity, to help homeless people to quit smoking.

Collaborating with Open House was crucial in establishing trust with the homeless community, who have often experienced mistreatment from public services. As the homeless people already trusted the staff at Open House, they were more inclined to follow their recommendation to contact the council's wellbeing service for support to quit smoking.

Working with charities and community organisations can be a starting point to build trust with 'easy to ignore' communities (see [Chapter 1.3](#)).

Building trust can be further enhanced by having **champions and advocates within the target community**. The council's exceptional service to the first person they met through Open House turned him into an advocate, leading him to recommend the service to his friends.

Our first client at the homeless scheme really found the benefit in using a vape and was successful in stopping smoking. He had an engaging personality and turned out to be an advocate for us in Open House and promoted our service. It was lucky we found this person who took it all on board and was happy to tell other residents and friends about the Vape Programme

**Julie Clare, Senior Wellbeing Advisor,
Crawley Wellbeing**

Rukeya supported this approach of enlisting the help of community champions. She aimed to increase vaccine uptake by building relationships with community leaders, engaging in conversations with them, and debunking vaccine myths.

You need to get people from the community with lived experience. To gain the trust [of the community]. I think trust is the biggest thing that I would flag up with anyone.

**Rukeya Miah BEM, Health Equalities Lead,
Bradford District and Craven Vaccination Programme**

She was allowed to record some of these conversations and televise them locally.

A very senior well known leader of the black community [...] Nigel came forward and he advocated that he wanted to be a committed champion, [...] And he came and he brought his wife, and his wife was quite anxious. And then we were able to persuade Marsha on the spot. [...] She said, I liked the way you spoke to my husband, and it reassured me listening to that conversation. I feel less anxious, I'm happy for you to vaccinate, I will go on camera and be a case study

**Rukeya Miah BEM, Health Equalities Lead,
Bradford District and Craven Vaccination Programme**

The prototypes in Bradford and Hastings where the NHS was reaching out to communities, all benefited from the support of the VCSE sector and community leaders (see [Chapter 1.3](#) and sections [3.2.5](#), [3.3.1](#), [3.3.2](#)).

Transition people into accessing services

We started this chapter (1.2) by discussing the importance of creating adjustable services to enable everyone in our local community to access services, and we gave the example of the adjustments needed for non-English speakers. **After reaching out, empathetic listening, and building trust, we gain insights into what changes are required to make our services accessible to people in our local communities.** We are also likely to have gained lots of information on what they need from their services which can be used to further inform service design (see [Chapter 1.1](#)).

For instance, Julie shared how they adjusted stop-smoking services for homeless individuals, considering their unique challenges and constant movement (see Chapter 2.4). They introduced vapes, assigned a dedicated advisor, and maintain more frequent contact, calling people weekly instead of fortnightly. They also collaborate with Open House to locate people when they cannot be reached. This approach strengthens relationships between the advisor and the people they work with and provides specialised support to better assist homeless people.

We don't always need separate services for each community or entirely bespoke solutions for each person. Instead, **having flexible services that can be adjusted to fit the needs of those we serve is often more effective.**

Prototype: Primary care for people with drug and alcohol dependency (Hastings)

After speaking to people with drug and alcohol dependency, it was discovered that they face challenges in accessing General Practice due to difficulties in scheduling appointments, fear of stigma, and lack of trust in healthcare professionals.

To address this, a clinic was set up within a local charity, where the GP practice care coordinator provides 30-minute individual meetings. These longer and flexible appointments, scheduled from 10 am to accommodate clients' lifestyles, helped individuals build trust. As a result, many were able to transition to mainstream GP services after just one or two appointments. However, some individuals still require additional support before they can make this transition, and this model continues to assist and support them.

Read more in section [3.2.5](#)

This is not an additional service but simply an adaptation to our existing model of delivering primary care. It allows people to access the service who wouldn't otherwise have done so, or who do so only when extremely ill.

Whilst this can seem like additional time, in reality many people access GP appointments multiple times, and others not at all. This is a result of the design of the appointment system not a reflection of need. Not providing access for a specific population, whilst providing multiple access for others is discriminatory. It points to the need to be proactive in designing the appointment system (see [Chapter 1.1](#)).

But it is also important to note that, to be successful, **the adaptations have to relate to the barriers that people face.** Information about the COVID-19 vaccine was all over the news, and the vaccine centres were open long hours. Opening them longer does not fix someone's anxieties that the vaccine will render them infertile. That's why it's important to understand our communities by reaching out, building trust, and listening empathetically to them. The goal is, where possible, to transition people into mainstream NHS provision.



1.3 Make your own luck with the VCSE sector

The first two chapters explained that primary care services must meet social need (see Chapter 1.1) and must reach out and build trust to be accessible to their communities (see Chapter 1.2). The voluntary, community, and social enterprise (VCSE) sector is well placed to help with this thanks to active and trusting communities, and their strong partnerships. Relationships between the NHS and VCSE sector should recognise the needs of both partners. In particular the VCSE sector needs sustainable funding, clear roles, and to share data effectively. Partnerships can be created in many ways, including through informal gatherings, door knocking and co-location.

VCSE: A diverse sector with a scale of formality

The voluntary, community, and social enterprise (VCSE) sector is diverse, with different organisations varying in their approach and connections. Tracey Cabache, Director of Torbay Communities, explained three levels on a scale of increasing formality (see also Boyle, Crilly and Malby, 2017).

The most informal level is community-led groups like 'knit and natter' gatherings in cafes, driven by genuine good neighbourliness and friendship. These groups don't require referral forms or processes. People who are naturally aware of these groups and bring people together are known as 'community connectors'.

The next level is time banking, which adds structure to exchanges. People earn credits for helping others, and they can use those credits to receive help in return. For example if I do your shopping, I get one hour credit. I could spend that hour on someone doing my ironing. Tracey noted however, that once people have made friends, they often don't need the time bank structure anymore.

The top level is formal volunteering, where individuals have DBS checks and formal training, providing specific services, such as helping people transition from hospitals back to their homes.

Above the previous levels, one might distinguish another level of professionalism where charities and social enterprises deliver services mainly with trained and employed staff, like local counselling services with trained counsellors. These organisations typically have referral forms and processes, functioning similar to other NHS services.

As we move up the scale, there is not only an increase in the formality, training, and bureaucracy, but there also is a movement from the community doing things themselves (e.g. 'knit and natter' groups) to services working with the community (e.g. time banking) to doing for the community or doing to the community. Each type of organisation has its own value, with its own advantages and disadvantages.

Asset-Based Community Development (ABCD)

Asset-Based Community Development (ABCD) focuses on growing those informal community-led groups. ABCD approaches are led by community builders who focus on what gifts, skills, and talents that the community possesses; and on growing and use these resources well.

Instead of always looking at what a community needs or *what is wrong*, ABCD **focuses on what is strong within communities** and what its members can give. It believes that everyone has something valuable to offer, and when people help each other, they feel a sense of purpose and build friendships.

ABCD is about **recognising and working with the assets in the community rather than outsiders taking control.** Community builders create an environment where the community can decide what's important to them and take charge of their own growth and flourishing.

When people feel that they are genuinely listened to, it actually creates some energy within those people to start to be motivated to be the people that do the doing. [...] So, so long before social prescribing became the 'in' thing the residents wanted various groups to happen: table tennis, singing, dancing. And rather than just bring somebody in to run those groups, what's really important within Healthier Fleetwood is residents run those things themselves.

**Dr Mark Spencer, GP Partner,
Mount View Practice**

What the VCSE sector offers

Reaching out and building trust

VCSE organisations, particularly those that take an ABCD approach, are the experts in reaching out and building trust in a community. They have years of experience in physically reaching out to people, meeting them where they are, listening empathetically to identify their needs (see [Chapter 1.1](#)), and they adjust their services accordingly (see [Chapter 1.2](#)). What distinguishes them is their **focus on specific neighbourhoods, deep integration within the local community, and equitable communication with the people they serve**. For illustration, this will focus on HKP (the Hangleton and Knoll Project, see [Chapter 2.5](#)), but the principles discussed apply to many other VCSE organisations.

HKP is an organisation that has been developing the community on its namesake estate for over 40 years. They focus on **deep, concentrated work within a neighbourhood** instead of spreading efforts thinly over a larger region. This is because community identities and needs can differ significantly even within the same town or city. A deeper approach fosters trust and empowerment within communities, which a shallow approach cannot achieve.

A large 'community involvement' programme based in the city centre may not effectively reach communities on the outskirts of the city who need to travel by bus to participate. These outlying communities may have different experiences compared to those living in the city centre.

Prototype: Doorstep Wellbeing

In this prototype, primary care was delivered at a neighbourhood level using an ABCD approach to address social needs and reduce pressure on GP surgeries.

By creating a welcoming space with food and activities, people were initially attracted, and as they engaged, positive relationships formed, fostering trust in familiar faces. Consequently, people used their services more and benefited greatly from them.

Read more in section [3.3.1](#)

Given HKP's 40 year history it is deeply **integrated into its community**.

HKP has deep roots in the community, grandparents living on the estate who were with the project as young people, volunteers who are now staff and loads of people who have benefited from support getting a job, getting online for the first time now helping others do the same.

**Joanna Martindale, Chief Executive,
The Hangleton and Knoll Project**

This integration is enhanced by their ABCD approach. HKP works by finding community connectors, and people with passions and interests, and encouraging them to bring people together. They facilitate a whole selection of community-led groups. This ABCD approach works alongside their youth outreach, their involvement in health and social care and other community projects.

Their policy is to make sure that a board member with lived experience in a particular community leads the corresponding area of work. For instance, an older person leads the over 50s work, and an Arabic person leads the multicultural efforts. This approach helps them to be **representative of the various communities they serve**.

They also understand that they cannot fully represent those people who are not on the board so they conduct an annual consultation on a pertinent local issue. This gives them an excuse to **knock on people's doors on the estate**, and have a conversation about what people need, what they can contribute to the local community, and what HKP can offer to them.

By focusing on people's interests, empowering them, and respecting their agency. **HKP form equal relationships with people**. This makes it easier for people to discuss the issues they face.

We [VCSE employees] are more equal to the person who's come in. The minute somebody sees somebody in their lanyard, they already feel oh, right, that person knows best. And they're going to tell me what to do. [...] We don't present like that. We don't wear lanyards, we wear normal clothes, we look like normal people. When we're out in the community, you know, we'll talk to you at a bus stop [...] So I think it feels like we're similar people. And I think people open up more.

**Tracey Cabache, Director,
Torbay Communities**

In a more general sense, it is true that people tend to trust people who are more like them – that 'birds of a feather flock together', as the saying goes.

HKP prioritises cultural sensitivity and language familiarity to build trust. They advocate that health messaging for specific communities, like the Bengali community, should come from members of that community. This approach is based on the idea that Bengali people are familiar with cultural barriers, such as men's involvement in women's healthcare, and they can effectively communicate in Bengali.

If you're talking about something that's sensitive, it really does help if that person has a choice to be spoken to in their home language.

**Joanna Martindale, Chief Executive,
The Hangleton and Knoll Project**

The trusting relationship that VCSE organisations build makes it **easier for them to identify needs and for people to access and benefit from their services.**

Prototype: Cervical screening for Asian Women

GP surgeries worked with Asian VCSE organisations in Bradford to encourage Asian women to take-up cervical screening. They held events in community venues which were led by a local GP and covered what to expect in bowel, breast, and cervical screening; as well as giving space to discuss any worries.

VCSE organisations were fully involved in helping to put the events together, and they helped consider cultural sensitivities as well as translating and promoting the events.

Read more in section [3.3.2](#)

Tackle social causes of symptoms

Instead of treating poverty like an illness with drugs or treatment programs (see [Chapter 1.1](#)). After having created trusting relationships, VCSE organisations have the **flexibility to focus on addressing the social causes of the symptoms of poverty proactively.**

Torbay Communities's **community helpline serves as a 'front door' to adult social care services, addressing social needs in the community** (see [Chapter 2.6](#)). As of June 2023, the helpline handled around 1 in 4 of adult social care's calls. It successfully resolved 83% of these calls, with only 12% needing a referral back to adult social care, while the rest received joint support. This approach has reduced the workload for adult social care and has better met people's needs.

The helpline works well because it was **designed by the community.** Instead of providing a predetermined list of services, the helpline encourages people to call in with their specific needs or skills they can

offer. Initially, a small group of health and wellbeing organisations manned the helpline. When they couldn't directly assist, they would **reach out to other VCSE organisations** for support. This approach embodies their strapline: 'one call – that's all.' With over 100 organisations accessible through the helpline, they strive to ensure comprehensive assistance for every caller. Calls are handled by both VCSE sector employees and volunteers, and their **strong partnerships** allow them to bring in additional handlers when demand is high.

We didn't design it this way. And I'm wondering, actually, if that's why it works so well, is because actually, the community designed it, you know, we didn't sit there in an office three years ago and go 'right, what does the community helpline look like?' We didn't, we just embraced it.

**Tracey Cabache; Director;
Torbay Communities**

Emma Drew, Programme Director of the Healing, Expressive, and Recovery Arts Project (HERA), explained how their charity's freedom enables them to provide a similarly **holistic and person-centred** support programme for refugees and asylum-seekers (see [Chapter 2.7](#)).

We do have the freedom to make decisions outside the NHS, and I don't think we could do our jobs without it to be honest

Emma Drew; Programme Director; Healing, Expressive, and Recovery Arts Project

Since the NHS offers limited free services to refugees, **HERA collaborates with various agencies to address all their needs** including mental health, dental care, and education. They also **adapt their services to meet people's needs and their experience**. Some people simply appreciate the help they receive, others, however, have had poor experiences with health services, leading to a complete lack of trust.

HERA builds trust by being flexible and supportive. **They don't set a strict limit on sessions and respect each person's pace**. For some, a phone call with guidance is enough, while others may need ongoing support and prefer meeting in a comfortable place like a café if they are too scared to meet in the GP surgery.

What the VCSE sector needs

VCSE organisations are eager to collaborate with the NHS but desire a mutually beneficial and supportive partnership. **The NHS can help them by providing sustainable funding, clarifying roles, and sharing data.**

Providing sustainable funding

VCSE organisations need at least **medium-term funding that covers all service-related costs**, including overheads to enable them to deliver a consistent service with dedicated staff. Given that VCSE sector pay is already low, also having insecure contracts makes it harder to attract and retain good staff, and persistent bidding processes detract the VCSE effort from supporting the NHS.

If you're employing staff or if you're making a big spend then you need to know that money is going to come through the same time next year [...] Six month rolling contracts are not how you get good people.

**Joanna Martindale, Chief Executive,
The Hangleton and Knoll Project**

System Change: Securing a sustainable funding model for VCSEs and helping the VCSE be a full partner

The VCSE sector needs NHS Funding to provide coordination and the 'front door' for the NHS to access the VCSE organisations.

The VCSE sector needs funding that enables it to secure and retain staff, focus on the real work, and create services that last.

To do this you need:

- Political and Senior Leadership Support
- Understanding by Statutory Sector of Breadth/Depth/Role of Third Sector
- Strong Third Sector Infrastructure
- Effective Partnerships in Place
- Strong engagement with, and involvement of the third sector across commissioning and use of appropriate processes
- Support for the development of a culture of collaboration within the VCSE sector

Read more in section [3.3.3](#)

The NHS needs to **consider the accessibility of its commissioning and contract monitoring processes to VCSEs**. NHS commissioning processes are seen by some as highly competitive, and resistant to smaller services, using qualitative approaches to evaluating their impact.

[NHS commissioning is a] highly competitive process where big organisations have an advantage because they have development departments and contract bids and all that. So it is not a level playing field in the NHS. And there [...] has been traditionally cultural resistance to things that aren't covered by randomised control trials.

Emma Drew; Programme Director; Healing, Expressive, and Recovery Arts Project

Independent evaluations have gathered ample quantitative and qualitative evidence. For instance, HERA was evaluated by Dr Urika Tse at Brighton and Sussex Medical School (see [Chapter 2.7](#)), Healthier Fleetwood was evaluated by a team of researchers at Imagination Lancaster (see [Chapter 2.1](#) and Moreno-Rangel et al., 2022a, 2022b), and Torbay's community helpline received praise for their data.

We managed to have better data and better statistics than our statutory sector partners

Tracey Cabache; Director; Torbay Communities

Evidence collection often centres around capturing people's stories of impact, complemented by quantitative data from tools like the Warwick-Edinburgh Wellbeing Scale (Tennant et al., 2007) and the outcomes star (MacKeith, 2011). Nevertheless, it's important to note that many VCSEs think **it's more important to prioritise meeting people's needs than meeting specific targets.**

If I had a magic wand, I would do something about [... commissioners' willingness to] listen to what patients are saying. And it's not that people don't want to do that. I just think the structure has forces that push people away from that and to think in terms of numbers and documents and reporting measurables, all of which have their place. But at the moment, I think we've got a tail wagging the dog situation.

Emma Drew; Programme Director; Healing, Expressive, and Recovery Arts Project

Clarifying roles

Asset-Based Community Development (ABCD) does not support asset stripping, which involves public bodies disposing of public resources. Instead, it acknowledges that certain tasks are best suited for the community when the state should have never got involved, whilst others are more effectively handled by governments.

The idea that you solve loneliness in older people by putting them on a special bus, driving them six miles for sitting for three hours with a bunch of strangers, with some activity organisers funded to entertain them, instead of chatting to their neighbours, or the neighbours coming round and stuff like that.

**Mick Ward; Senior Associate;
Nurture Development**

VCSE organisations can effectively address social needs within the community, but **they shouldn't be asked to meet complex needs they are not equipped for**. Emma shared her experience in social prescribing work.

There are just huge gaps in strategy services so the complexity of our workload is significant. Much more so I think that was originally envisaged when social prescribing became a thing in the NHS. [...] if you're spending a lot of time dealing with people when don't really have the skill, so complex mental health stuff, that's going to take time, and we're probably not the right people to be doing that.

Emma Drew; Programme Director; Healing, Expressive, and Recovery Arts Project

Sharing data

Tracey shared how the Torbay Community Helpline (see [Chapter 2.6](#)) **faced difficulty in sharing data** on callers with Adult Social Care. This led to manual workarounds and extra administration increasing the risk of human errors and the possibility of failing to meet someone's needs or providing them with a negative experience.

Prototype: "No wrong door" for service users

Inspired by the Torbay Community Helpline, this prototype shifts the 'front door' for health and wellbeing support to community organisations, who will triage people.

To facilitate this they have created a data sharing system which sends data securely between organisations. This supports people as they move between services and means they do not have to repeat their needs each and every time.

Read more in section [3.3.4](#)

Creating the partnership

Bringing all of those folks together, got something up and running within a matter of weeks. That was driven from within the community itself. So those organisations didn't get together and say 'Oh, look at poor Fleetwood, you know, what are we going to do to help them?' This was listening to our residents. And those partners, being in the room listening to residents, they will have heard that.

**Dr Mark Spencer, GP Partner,
Mount View Practice**

Partnerships should be driven by the community.

Both professionals and community members must invest time in getting to know, understand, and trust each other. **As well as formal relationships, it's important to have time away from meetings and agendas:** walking, chatting, and having picnics. Make it fun! These strong relationships mean that things can **move quickly and flexibly to adapt to emerging community needs.**

It's not simply a matter of two organisations agreeing to work together. What's important is that human beings in those organisations choose to work together and spend time building those relationships.

**Dr Mark Spencer, GP Partner,
Mount View Practice**

Sheinaz Stansfield, a GP practice manager would meet VCSE organisations by **literally knocking on their doors.**

I started to knock on people's doors of the third sector organisations, I met some amazing people [...] we can't expect people to come to us as leaders

**Sheinaz Stansfield, Practice Manager,
Oxford Terrace and Rawling Road Practice**

Co-locating can also lead to chance encounters and opportunities to work together. HERA is co-located within a GP Practice, and Fleetwood Youth Hub involves a wide collaboration (see [Chapter 2.1](#)).

From there, it's about starting working together on something small that matters to everyone, then growing and iteratively making improvements.

The NHS needs strong VCSE partners. This interdependence is recognised by West Yorkshire ICS, which supports and funds the coordination of the VCSE organisations that work in the health and care field, so that the NHS can access the VCSE sector efficiently and effectively.



1.4 Invest in children and young people

Children and young people are one of the least well served groups in primary care. They access primary care significantly less, A&E more frequently, and are locked out of digital services due to their age. Meeting the needs of children and young people is vital to a lifetime of health benefits and in securing an NHS fair for all. We recommend that services are co-produced with young people to better meet their needs. We highlight the need for more investment in mental health support for children and young people at every level of the healthcare system, especially primary care, as demand for these services vastly outstrips capacity. We also highlight the need to intervene early and prevent illness. We see caring for the young as an investment in our future healthcare workforce and future society.

Design primary care to meet young people's needs

Young people are underserved

Young people are one of the least well served groups in primary care. We know that young people need and want to use primary care, but the way that primary care is set up discriminates against their age and isn't easy for them to access. Their voice is underrepresented in NHS decision making (see [section 3](#))

As a result, young people don't access as much primary care as they need. Figure 1.4.1 shows that despite the fact that 5-25 year olds make up 16% of the population, they use only 10% of primary care

Your time how GPs spend their time in appointments (units = hours/age group). 2021

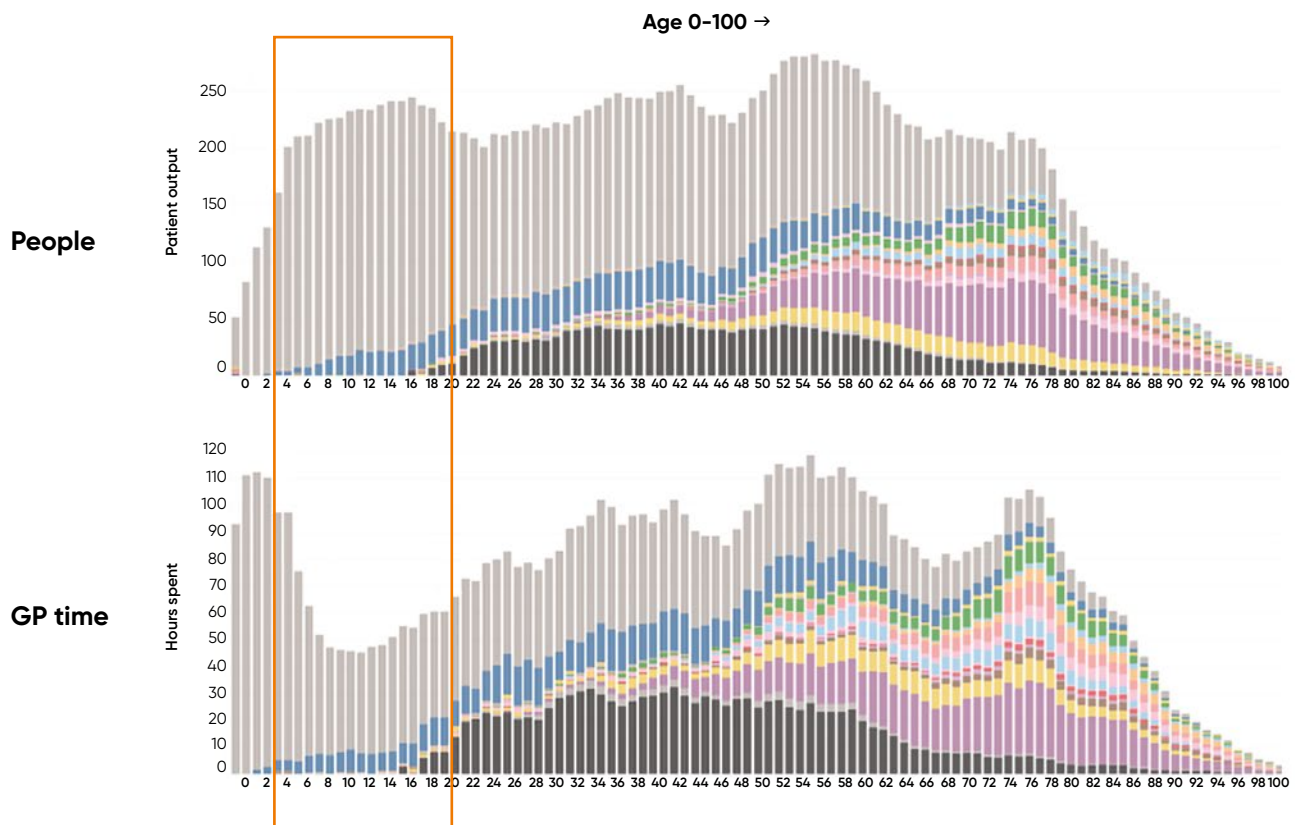
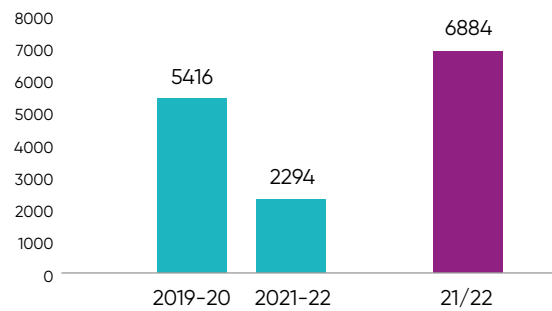


Figure 1.4.1: Young people use primary care to a much lower degree than we would expect.

Data example 1: Bradford 0-18 A&E respiratory attendances +30%

All paediatric (Aged 0 to 18 Inclusive) Respiratory A&E Attendances



Data example 2: East Sussex 0-18 A&E respiratory attendances +40%

All Paediatric (Ages 0 to 18 Inclusive) Respiratory A&E Attendances - ESHT

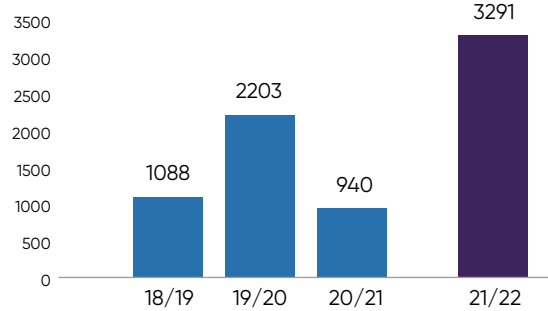


Figure 1.4.2: Young people access A&E more frequently. Note this data was taken across the COVID pandemic.

time. That is, young people make fewer, shorter appointments in primary care. The GP Patient Survey measures the satisfaction of young adults aged 16-25 years (previously, 18-25 years), and **these young people are some of the least satisfied users with primary care** (Davey *et al.*, 2013). They are two to three times more likely than other patients not to turn up for an appointment and their use of A&E services is on the rise, as shown in Figure 1.4.2.

The NHS also locks young people out of digital systems by default. Until the age of 16, young people will not automatically be granted access to their records – instead, 11-16 year olds must apply to the GP practice for access, and it is not guaranteed. (NHS Transformation Directorate, 2022).

These results are because primary care is predominantly designed around adults, rather than young people. Young people’s rising A&E use indicates that they need care but that they aren’t able to access existing primary care. For example, as available appointments are often during school and college hours, and there is pressure from schools and

colleges to have high attendance, young people are pressured not to make an appointment in primary care. Instead they wait, become more unwell, and end up going to A&E.

It is important to stress that young people are aware of the pressures that the NHS is under. In some cases, young people don’t want to get an appointment precisely because they don’t want to become a burden on the NHS.

Young people themselves, when you talk to them, will say: ‘No I won’t do that. I won’t phone up and try to get an appointment, because I think they’re [the NHS is] too busy’

Emma Rigby, Chief Executive, Association for Young People’s Health

Co-produce services with young people

Young people are the experts in their needs, and should be partners in the design, delivery, and review of services, as well as in their own care.

Adults, including healthcare professionals and parents, play a significant role in determining whether children's efforts to participate are facilitated and supported in healthcare settings. Primary Care Networks (PCNs) play an important role in bringing primary care, children and young people and wider stakeholders (e.g. schools) together to re-think services.

This principle of co-producing services with young people is **highlighted in the refresh of the "You're Welcome" standards** for young people friendly health and care services. (Office for Health Improvement & Disparities, 2023)

The 'You're Welcome' standards, co-developed with young people, highlight how **young people simply want to be respected and supported appropriately for their level of maturity**. The standards discuss how staff working with young people should receive training to make sure that they can:

- respect young people's rights regarding consent, confidentiality, and complaints;
- communicate well with young people and support them to make informed choices;
- respect young people and treat their issues thoroughly and holistically.

Just as we would not expect a youth worker to communicate well with elderly people, or a care home employee to communicate well with school children', we should not expect every primary care professional to work well with young people. **Primary care professionals should be supported to offer a good level of service to all of their young patients.**

The 'You're Welcome' standards also highlight how services should:

- be provided in appropriate locations;
- be integrated with local communities, schools, colleges and universities;

- use digital approaches as a means of increasing access, rather than replacing face-to-face interaction;
- support young people as their needs change, and during any service transition.

The review approach for 'You're Welcome' recognises the expertise of young people, and involves **working with a youth group or project to assess how friendly and welcoming your service is to children and young people**. It is similar to the process of undertaking a Fifteen Steps Challenge in an inpatient ward (NHS England Public Participation Team, 2017).

Prototype: Children and young people friendly GP practices

The prototype found that weekend clinics are difficult for young people to attend due to school and college schedules. As a result, they are organising Saturday clinics tailored to young people's needs. They are collaborating with Young Healthwatch to have young individuals visit five local GP surgeries, including those hosting the clinics, to listen to their feedback and make improvements based on it.

Read more in section [3.4.1](#)

The greatest benefits can be obtained by creating a youth forum, a representative group of local young people, who work with the practice over a longer period of time. By having this longevity of involvement you can create a shared understanding of what specific needs young people have in your area, what barriers they are facing, and how you can navigate these together.

The young people will be able to see the health and care system from a different perspective to primary care professionals. As a result they will be able to **identify systematic successes and challenges and suggest creative improvements** to them. Discussion of their experiences, both positive and negative, will **help primary care professionals to empathise** and understand them, and ultimately to see how primary care is part of the young people's lives, rather than separate from them.

By having services that are better adapted to their needs, young people will be able to access primary care before they become too unwell. They might have longer appointments that fully resolve their issues. As a result, they will be more satisfied and have less need of A&E services.

There is a network of local NHS Youth Forums, as well as Young Healthwatch groups. The British Youth Council have run the NHS England Youth Forum since its inception in 2013. They have lots of helpful resources on starting a youth forum in your local practice. (British Youth Council, 2023)

Invest in mental health

Demand for mental health support for children and young people vastly outstrips capacity. Figure 1.4.3 shows how the number of people being treated in the secondary-care Child and Adolescent Mental Health Services (CAMHS) in East Sussex doubled between April 2019 and March 2022. Mental health services in the Bradford area have seen a 70% increase in

referrals in the last two years, and a doubling in children and young people being treated in the CAMHS with no change in staffing.

CAMHS waiting lists are also extreme. Figure 1.4.4 depicts how in East Sussex, in March 2022, over 500 people were waiting over six months for their first 'assessment' appointment, and over 500 people were also waiting more than six months between assessment and receiving treatment. In West Yorkshire the expected wait for a first 'assessment' appointment was over eight months, as shown in Figure 1.4.5.

Neurodiversity services are even worse. There were more than 4,500 young people waiting for an autism or ADHD diagnosis in West Yorkshire recently and some services have seen up to an 80% increase in referrals over the last two years. As a result, the wait for neurodiversity assessment in West Yorkshire can be just short of two years. **To a young person, this isn't a wait, it's a 'life on hold'.**

Data example 1: Open CAHMS cases 2019–2022

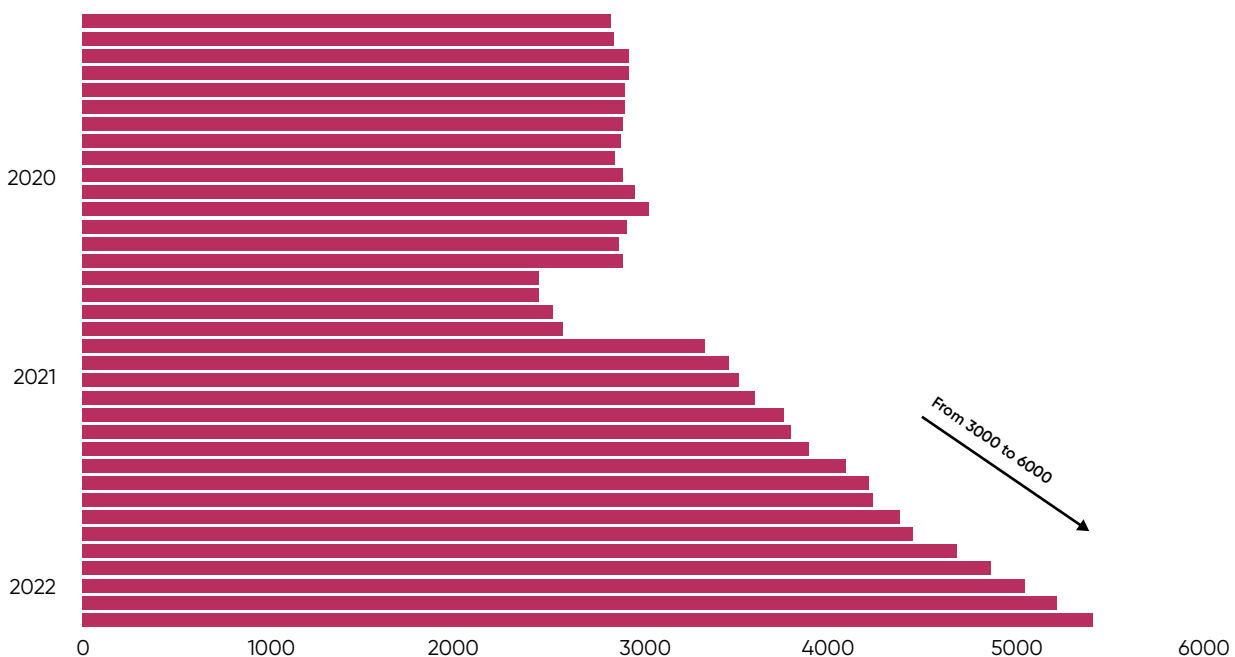
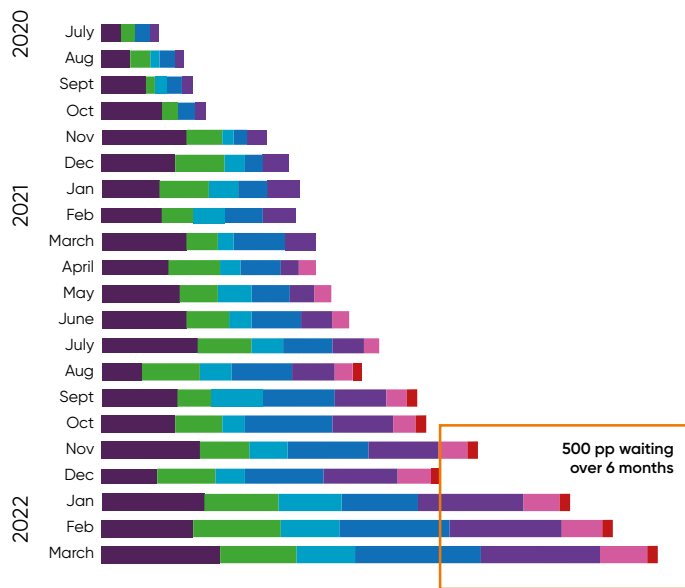
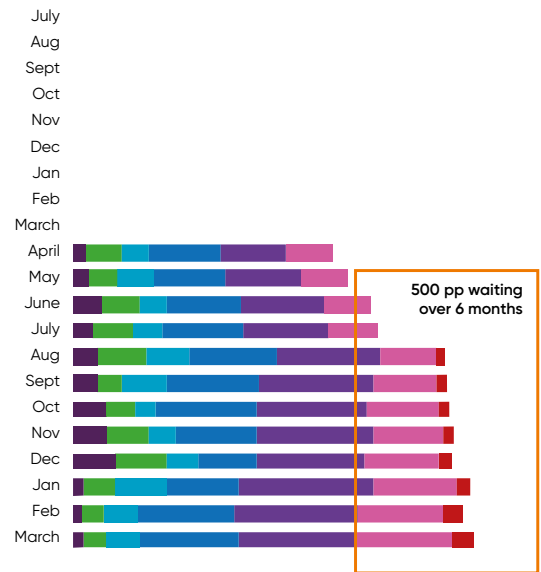


Figure 1.4.3: Demand for mental health support outstrips capacity

Length of wait for assessment



Length of wait for assessment



2022 position: 4 month average wait, over 500 people waiting more than 6 months for initial assessment and a similar number for treatment.

Figure 1.4.4: CAHMS cases 2020-22

Average waiting time for CYPMH in days (referral to 1st appt)

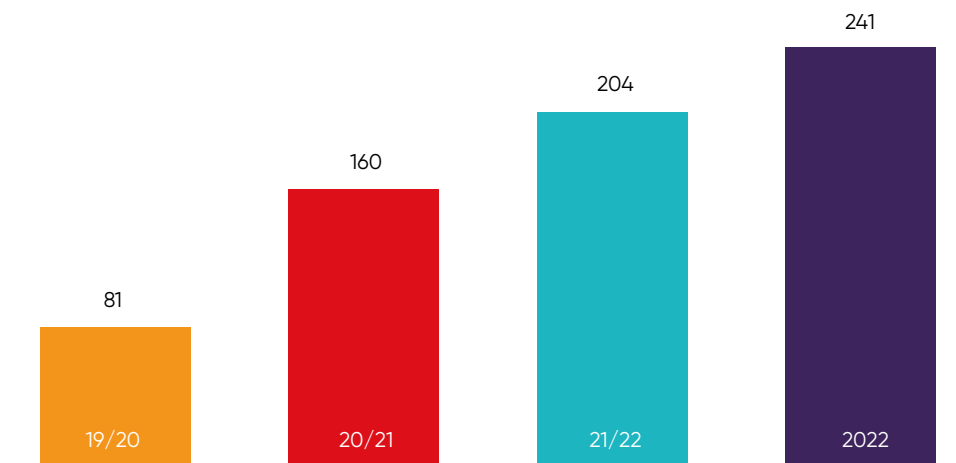


Figure 1.4.5: CYPMH waiting to 1st appt – Bradford

Prototype: Mental health crisis support for young people

This prototype aimed to increase use of mental health safe spaces, where a young person can receive same-day support within the community. The safe space would work with the young person to identify what they need and want, and facilitate a transfer to A&E as needed.

This was achieved by offering a three hour training session for A&E staff on the safe spaces and other mental health support available in the VCSE sector, and by reviewing the standard operation procedures of the local A&E departments and police force.

Read more in section [3.4.2](#)

Historically, children and young people's mental health has been underserved by commissioners, both because of the NHS' focus on adults, as previously discussed, but also because there still fails to be parity between physical and mental health.

[...] as a country, we haven't prioritised mental health services for children. It certainly seems to have less staff than other areas. [...] It's much easier to get people seen for routine physical things than it is for routine mental health stuff.

**Dr Caroline Rayment, GP Partner,
Grange Park Surgery**

The problem has now reached the extent where **we need to take a whole system approach to find ways to meet needs.**

We're not going to solve the crisis by shoring up CAMHS. And neither are we going to do it by mental health support teams in primary schools or by any other one thing. It has to be something which is a whole system looking at this.

**Emma Rigby, Chief Executive,
Association for Young People's Health**

Dr Caroline Rayment is a West Yorkshire based GP. She started her GR8 Minds children and young people's mental health social prescribing service because **there were no services available in her area for young people with low-level mental health difficulties** (see [Chapter 2.7](#)).

Previously, school nurses could provide some mental health support and refer students to CAMHS if needed. Unfortunately, these services were largely removed because of austerity measures. Caroline noticed that more young people were coming to the GP surgery simply because they were unhappy, but there were no suitable services to refer them to. To address this gap, Caroline established a social prescribing service.

From my personal point of view, austerity was a disaster for the NHS and children's mental health services really suffered with that, because of the lack of resources given to things like school nurses, the lack of funding into mental health services, and that's created this crisis [...] we can't expect services to be there if we don't invest in them.

Dr Caroline Rayment, GP Partner,
Grange Park Surgery

Social prescribing requires sufficient funding for its successful implementation. It's not useful to prescribe a service socially if it lacks proper funding to carry out its work effectively. **Sending more people to a service while cutting its funding leads to overworked staff and poor outcomes.**

If we're trying to socially prescribe to youth services, for example, [...] there is an issue of funding flow to those services, And these are services [...] that have been hugely cut. So we have to recognise that we can't just solve it by socially prescribing to a service without any financial incentive to that service. [...] If we had good youth services, and we had enough investment in young people's development, the spaces and the places [...] that is I guess feeding into that medicalisation issue.

Emma Rigby, Chief Executive,
Association for Young People's Health

Emma Rigby also questioned whether, **if we actually had good investment in public services, whether there would be as great a social need to tackle** (see [Chapter 1.1](#), where this issue is also mentioned).

In Bradford the whole system has developed The Thrive Framework (i-THRIVE, no date) for system change. As shown in Figure 1.4.6, this is an integrated, person centred and needs-led approach to delivering mental health services for children, young people and families. From prevention to proving help, across Bradford there are collaborations between the NHS, schools, local authority, children and young people and their families to test out ways to support children and young people in the community.

Intervene early and prevent illness in young people

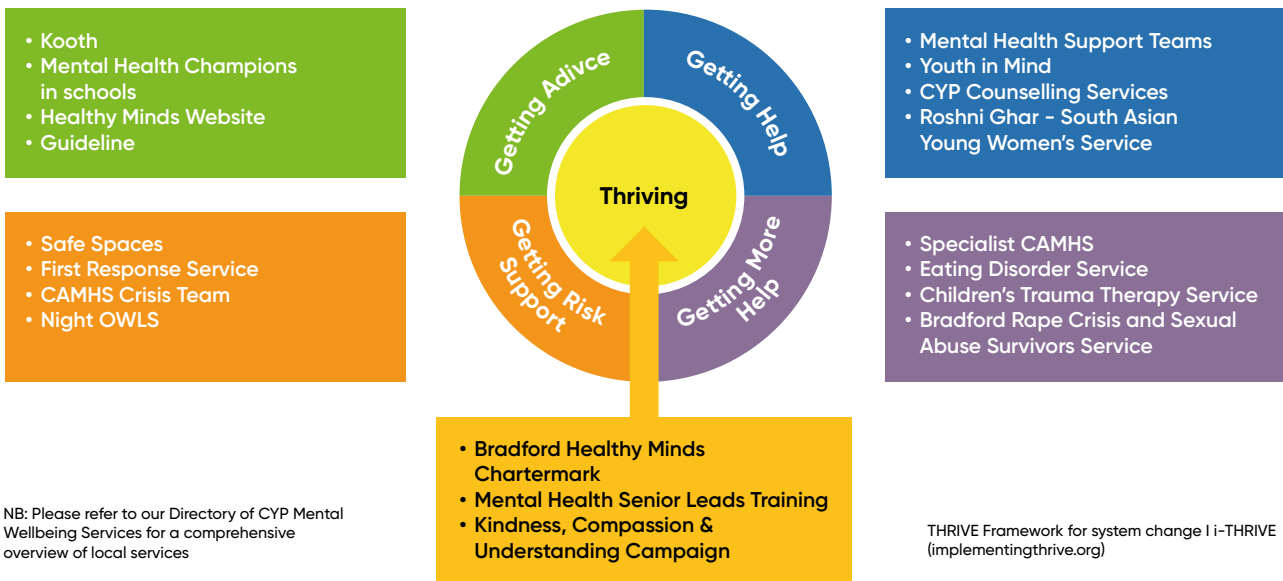
Dr Olesya Atkinson, Clinical Lead for Cheltenham Central PCN (primary care network, a group of GP practices) saw that, as previously mentioned, children

and young people are some of the least well served groups in primary care, and they are facing extreme challenges in getting support with their mental health issues. She saw that **young people who had been unable to seek mental health support during their early years returned repeatedly to her surgery now aged in their 20s and 30s, with serious issues.** Olesya realised the importance of taking proactive steps to prevent issues from arising in young people and to intervene early if problems have already emerged (see Chapter 2.9).

It is now well known that many long-term health issues start in the first 25 years of life. Half of adult mental health problems starting before the age of 14, and obese children are much more likely to become obese adults (RCPCH, 2020).

THRIVE Framework - Access

The Thrive Framework for system change is an integrated, person centred and needs led approach to delivering mental health services for children, young people and families. In Bradford District and Craven we are working with partners to implement Thrive and develop a One Trusted Referral Pathway, the below provides some examples of our services within each element of Thrive.



NB: Please refer to our Directory of CYP Mental Wellbeing Services for a comprehensive overview of local services

THRIVE Framework for system change | i-THRIVE (implementingthrive.org)

Figure 1.4.6: Thrive model in Bradford

[We] need to focus on prevention and early intervention, and that is not only in early childhood [...] but there is also a really important opportunity within the first and second decade of life [...] and securing the gains that may have been made in the early years.

**Emma Rigby, Chief Executive,
Association for Young People's Health**

Olesya's plan was for her PCN to **proactively reach out to young people who might be most at risk of developing long term serious health conditions**, and offer them support from a specialist children and young people's social prescriber.

Cheltenham Central PCN were targeting young people who were known to have had ACEs (adverse childhood experiences) but who were not currently receiving support. They offered them an appointment to see a social prescriber. At the appointment, they discussed the young person's needs, and, if it was appropriate, the young person was offered a six-week bespoke resilience programme.

Additionally to this, Cheltenham Central PCN collaborated with a local school within the Core20 area (in the the most deprived 20% of the national population as identified by the national index of multiple deprivation) on a pilot project of having mental health support workers based at the schools to support young people on the CAMHS (child and adolescent mental health service) waiting list. While resilience programs are exclusive to Cheltenham Central PCN's patients, these support workers assist any school student. They offer a level of support that is an intermediate step between what GPs and CAMHS offer. This pilot was triggered by observation that social prescribers were helping some young

people to recover without needing CAMHS, and were preparing others to make the most of the CAMHS support.

Olesya elaborated on the benefits of a specialised social prescribing approach focused on children and young people's prevention. She highlighted the diverse backgrounds of these specialists, who possess a unique ability to address social challenges without medicalising them. Additionally, they offer extended appointment times beyond GPs and can engage with entire families. These specialists, employed through a local family support charity, collaborate within the PCN and are frequently situated in schools. This strategic positioning allows them to effectively partner with GPs, schools, and the broader VCSE sector to comprehensively address the needs of children and young people.

We echo the call of Davies (2013) to **invest in services which prevent young people from becoming ill**, and offering these proportionately to those who are most disadvantaged (see [Chapter 1.5](#)).

Early interventions and preventive measures such as immunisation, health checks and education do make a difference to outcomes. If we act early we can prevent harm. To address these issues, we need to take a population health perspective – to think about what benefits the most. [...] This means 'proportionate universalism' – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged groups.

**Prof Dame Sally C Davies,
then Chief Medical Officer (Davies, 2013)**

Invest in our future workforce

We have a very academic education system that focuses on attainment being really important. And I think this is maybe often a focus when we talk about workforce on doctors and certain parts of the workforce. And I think we should be thinking really, really broad, and enabling people to see how many different opportunities and ways there are [to start a career in health and social care]. [...] I'm sure that for some young people it just feels unattainable either academically or indeed, in relation to cost.

**Emma Rigby, Chief Executive,
Association for Young People's Health**

In deprived areas, people may have limited exposure to health and social care professionals, fewer opportunities to join the sector, and lower levels of aspiration and self-confidence. As a result, **people in deprived areas might find it harder to see careers in health and social care as realistic options**, in comparison to people from less deprived areas. This feeling may be worsened by concerns about academic abilities and financial barriers.

In Chapters 1.2 and 1.3, we highlighted the importance of primary health professionals being **representative of the communities they serve** to build trust and understand community needs. In Chapter 1.5, we discussed the **shortage of primary care professionals in poorer communities**. Consequently, we argue that **engaging with young people in poorer areas should form a key part of investing in our future workforce**.

Prototype: Growing our own primary care professionals

This prototype aim to run a series of events in primary schools in deprived areas to promote health and social care careers.

A group of four health and social care professionals hope to present an introductory assembly, followed by a series of sessions to explore different career options, as well as a session for parents. They hope to continue to work with the young people that they meet over the long term to continue to raise their aspirations and address structural barriers to entering the health and social care professions.

Read more in section [3.4.3](#)

It is also important to remember that all young people have the potential to become future members of the health and social care workforce. Therefore, when you are designing primary care to meet young people's needs, investing in their mental health services, or in preventing their illness, then this also counts as investing in the future health and social care workforce.



1.5 Fund primary care based on need

Primary care in poorer communities is unequal compared to that in wealthier areas, leading to people with the greatest healthcare needs receiving inferior service. To address this, we propose that local ICBs (Integrated Care Boards, people who buy NHS services locally) take action by funding primary care based on need.

Our approach involves collaboratively designing a funding model that is fairer. Once a model of need has been developed, it can be used to create an entire primary care system tailored to meet the needs of the population. We specifically advocate for funding preventative services in deprived areas, to address social needs, provided by the VCSE sector.

Care is unequal and different in poorer areas

The availability of good medical care tends to vary inversely with the need of the population served

Tudor Hart, 1971

Despite being 50 years old, Tudor Hart's (1971) inverse care law still seems to be appropriate to summarise our findings from the Sussex and West Yorkshire data mining.

We found that **in more deprived areas there tend to be fewer primary care professionals per person**, as demonstrated in Figure 1.5.1. This relationship is due, at least in part, to the 2004 Global Sum formula (also known as the Carr-Hill formula), which forms the basis of the money most GP practices are paid.¹

The formula focuses more on the age and gender of patients at a GP practice than the needs of patients at that practice. This means that richer (less deprived) areas of older people could receive more funding than poorer (more deprived) areas of younger people, even where the need is the same level.

Practices serving more deprived populations receive around 7% less funding per need adjusted* registered patients than those serving less deprived populations

Fisher *et al.*, 2020

The unfair funding, and the fewer primary care professionals in more deprived areas means that services provided are also different. **Services are harder to access, and less preventative.** Care is harder to access because there tend to be fewer appointments available (per 1,000 people) to people in areas of higher deprivation, as shown in Figure 1.5.2. We also found that patients in the most deprived group are almost three times more likely to not attend an outpatient appointment than those in the least deprived group.

There are also lower screening levels, fewer planned hospital admissions and more emergency admissions, as depicted in Figure 1.5.3. This means that care is less preventative in these areas too.

Our data mining exercise has demonstrated that **people in more deprived areas have greater health needs** than people in less deprived areas. Specifically we found that the life expectancy gap has not

1. The global sum allocation income is paid to each practice under the GMS contract (70% of practices in 2018/19), and typically accounts for over half of each practice's income. Practices under the PMS contract (26% of practices in 2018/19) negotiate payments locally, but are usually based on the Global Sum formula. Practices under the APMS contract (2.5% of practices in 2018/19) also negotiate their contracts locally, and may not be based on the Global Sum formula. (Fisher *et al.*, 2020)

narrowed between people living in the most and least deprived areas of the UK. Figure 1.5.4 shows that people in the most deprived areas of the UK live shorter lives by 5-10 years, and enjoy approximately 10 less years of good health, in comparison to the least deprived areas of the UK.

We also find that people have more complex needs in more deprived areas, along with the earlier onset of people having multiple related health problems (comorbidities). **It is illogical and unfair to provide a worse healthcare service to people who need healthcare more.**

Number of full-time GPs per 1,000 patients

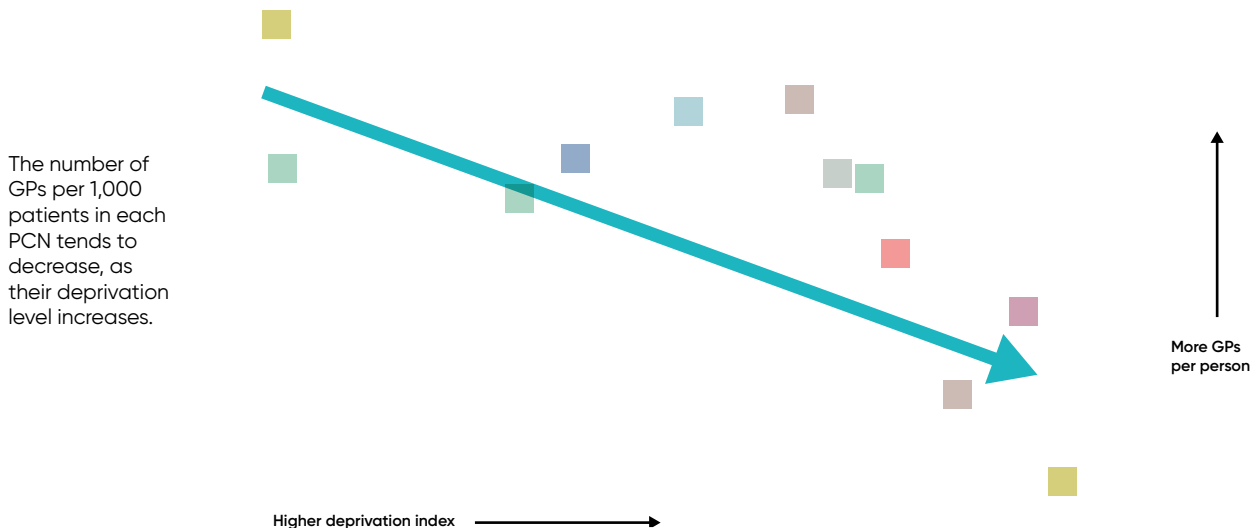


Figure 1.5.1: Full-time equivalent number of GPs per 1,000 patients in each PCN (primary care network, meaning groups of practices) plotted against the PCN's deprivation index.

Number of appointments per person by PCN (groups of practices)

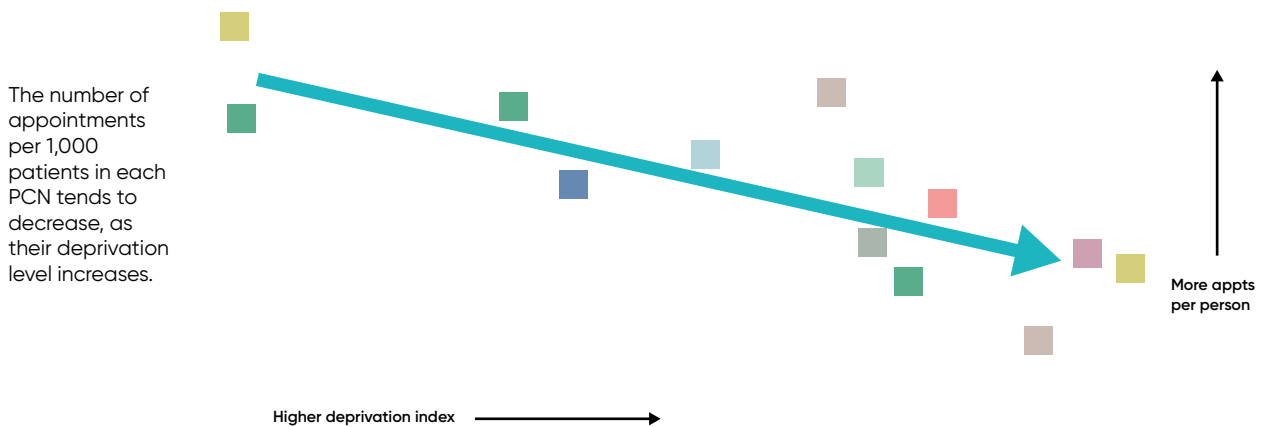


Figure 1.5.2: Number of appointments per 1,000 patients in each PCN (primary care network, meaning groups of practices) plotted against the PCN's deprivation index.

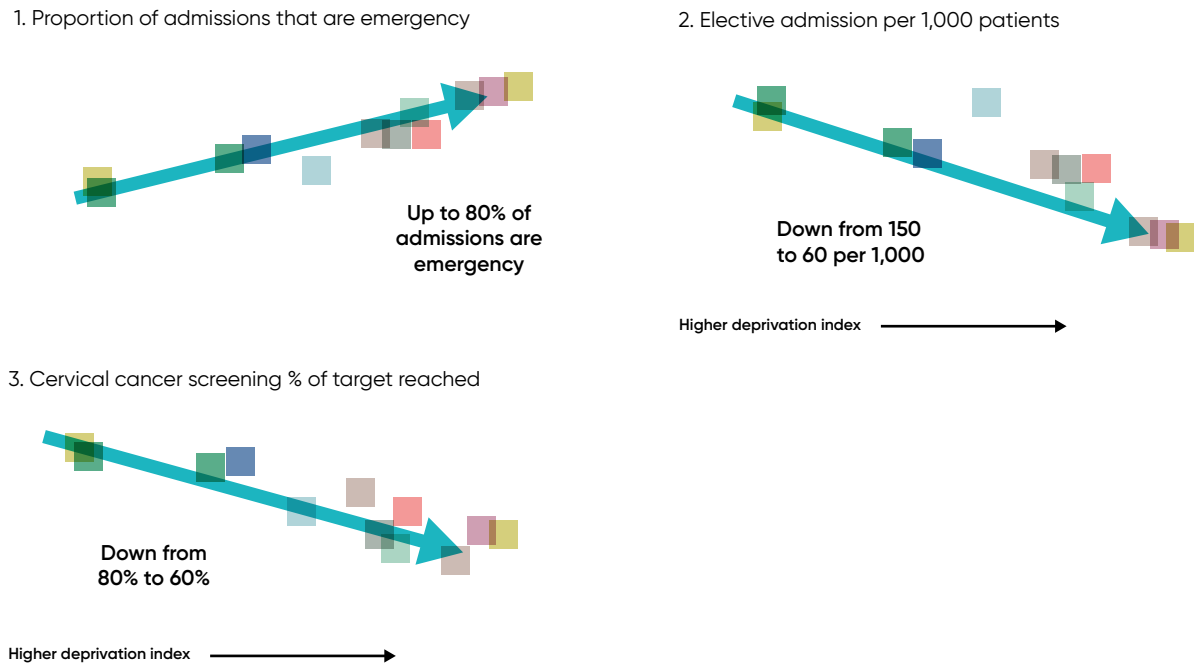


Figure 1.5.3: Number of appointments per 1,000 patients in each PCN (primary care network, meaning groups of practices) plotted against the PCN's deprivation index.

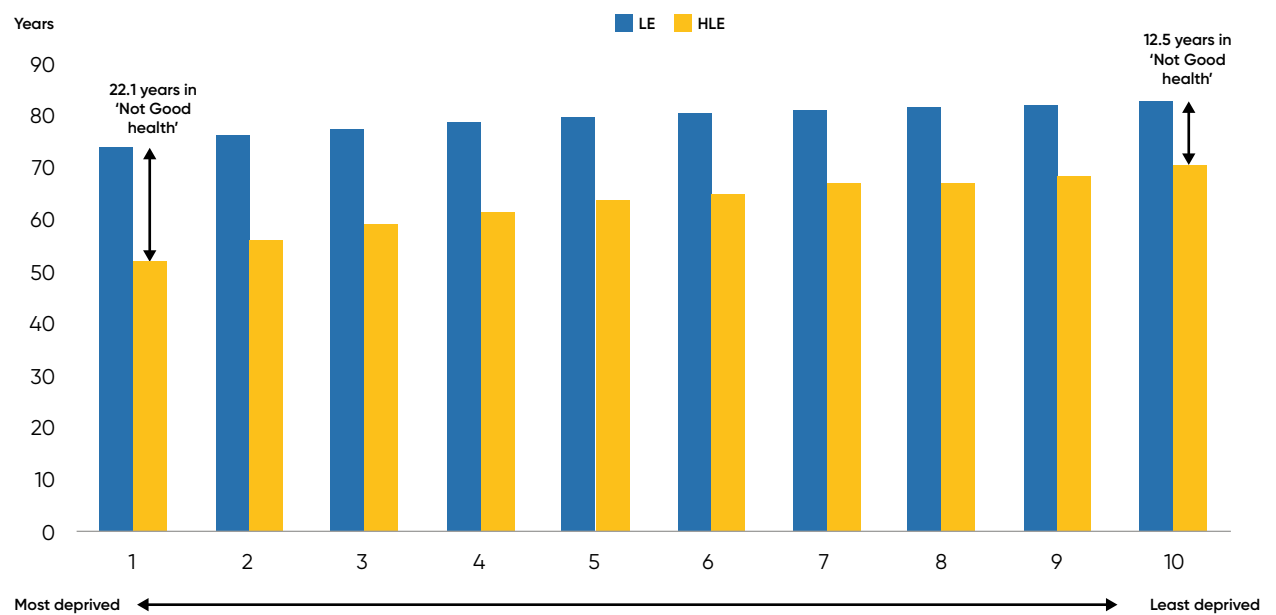


Figure 1.5.4: Life expectancy (LE) and healthy life expectancy (HLE) gaps for Males at Birth 2012 - 2014 (Office for National Statistics)

There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.

Marmot et al., 2010

Create a local needs-based primary care funding model

[...] the more I've thought about the government's agenda with the NHS and funding, all of the cost challenges that we've got in the NHS, I think the rationing is the elephant in the room, about 'How do we intend to fund the NHS?'. How we as professionals feel it shouldn't be funded or it needs to be funded and therefore feels like that's the bit that has to give.

Design team member, Bradford

The national funding model is not changing fast enough to address this challenge of unfairness. We are aware that some ICBs (Integrated Care Boards, people who buy NHS services locally) have directed discretionary funding to deprived areas. Yet inspired by the approach of NHS Leicester, Leicestershire & Rutland ICB, we encourage them to go further.

We want **local ICBs to take action** by making sure practices in poorer communities are not at a financial disadvantage as a result of national funding formula, and basing their funding on the level of need in the communities they serve.

There are lots of benefits to a locally controlled funding model. Local models can flex to fit the need of the local population now, and as these needs change in the future. They can also be adapted to fit an ICB's financial strategy and priorities, perhaps creating a whole needs-based model of provision and funding of care. Finally, a local model also simplifies payment and contracting, as it removes the administrative burden of making multiple different payments to service providers.

Create a model of need

To build a need-based primary care funding model, it is crucial that we measure the need in each area. Currently, there is limited national data available on primary care need, with existing data focusing on appointment access and patient satisfaction, providing only a partial view of demand. Instead, ICBs should adopt a population health management approach by **establishing patient-level data and metrics to assess need accurately**. This will enable them to demonstrate how the Global Sum formula unfairly affects care provision in their area.

We recommend a **collaborative approach to develop the data, metrics, and overall model for assessing need**. This collaboration should involve NHS commissioners, primary care professionals, academics, and members of the local community. Each participant will bring their unique perspective, understanding, and interpretation of the data. By synthesising these diverse perspectives, a shared understanding and interpretation can be achieved, leading to the creation of an accurate model of need. Collaboration also facilitates wider and more effective consultation, testing of the model, and communication of the results to various stakeholders.

One particular data interpretation challenge is that **people can categorise, or 'code', the same thing, differently**. For example, a patient presenting with anxiety and depression may have their condition categorised by either of these diagnoses, both, or simply "mental health". These different categorisations and definitions of similar phrases make it more difficult to understand the actual need in a given area. Recognizing this difficulty, NHS Leicester, Leicestershire & Rutland ICB advocates for the use of a locally designed terminology instead of relying solely on the national NHS terminology. This shift aims to reduce confusion and ensure consistent understanding of the data.

As we are dealing with over 130 practices in LLR it is vital that the labels for each element are the same as confusion can lead to practices questioning the process and the requirements

NHS Leicester, Leicestershire and Rutland ICB, 2023

To effectively address this and other complexities, NHS Leicester, Leicestershire & Rutland ICB understood the importance of a clear vision at the executive level and acknowledged that developing the funding model would require sufficient time. To secure progress, they established a small, skilled team comprising of a senior finance lead, a commissioner with population health expertise, and a retired GP with primary care data expertise. (NHS Leicester, Leicestershire and Rutland ICB, 2023)

Their approach also involved close collaboration with Johns Hopkins Medicine. They built their model of need on Johns Hopkins' AGC weighting system, which is used by other European health systems,

and customised it to accurately reflect the unique characteristics of the local population (Johns Hopkins Medicine, 2023). In their commitment to comprehensiveness, they emphasised the inclusion of all available data related to need, going beyond relying solely on secondary care data (NHS Leicester, Leicestershire and Rutland ICB, 2023).

System Change: Fair funding for primary care services

The Carr Hill formula is not fair. Practices in poor communities struggle to provide the same access as practices in wealthier communities. The funding model for general practice is increasing inequalities. The answer is not to shuffle money around in primary care. General Practice has increased its productivity without adjustments in funding. A whole system model is needed to secure a robust front door to the NHS, with funding based on need.

Develop a funding model

It is important that developing a funding model is an open and transparent process with all practices. We advocate a 'no loss' approach which means that **no practice should lose money under the new funding system**, compared to the Global Sum allocation. The fact that primary care in more deprived areas is underfunded, does not imply that primary care in less deprived areas is over-funded. Therefore, **any redistribution of income has to come from across the whole local healthcare system, not just from primary care**.

This approach of cross-system income redistribution should drive the choice of which funds to pool together and include within the model. **Start with the principle that all ICB funding sources are included, then exclude any specific or designated funds.** (See the Leicester, Leicestershire and Rutland ICB approach in Briggs, 2021)

To incorporate the no-loss approach explicitly, ICBs can **pay a practice a set sum to cover core costs that are unrelated to need** (like staffing costs), equivalent to that it would have received under the Global Sum formula.

Then think about how the remaining income should be distributed based on need. ICBs can **use their needs model to determine the majority of the payment, but should consider adjusting this** based on how often a practice takes on new patients and recognising where there might be communication issues. **New patients generally use more of a practice's services** than older patients, for their first year of registration whilst **people who do not have English as their first language – or who have additional communication needs – also require extra funding** for interpretation: this means that it often takes longer to deliver care to them, in comparison to people who do not have these difficulties. ICBs could also consider a small proportion of the payment being solely related to the level of deprivation a practice serves (John Hopkins Medicine, 2023), in order to meet additional needs associated with a higher deprivation score, as discussed earlier in this chapter (1.5).

Finally, the funding model should also take into account any issues in how people categorise or 'code' conditions, as previously discussed. **No practice should be adversely impacted by having poor data quality.**

Consider a whole primary care model based on need

If there is a robust model of need that is being used as part of a needs-based funding model then this can also help to drive the design and provision of primary care services, as described in Chapter 1.1. The resulting system could **combine the design and provision of primary care services, payment for this provision, and the monitoring of this provision all based on the need in a given area.**

Any statistical model will always be imperfect, and should be continually tested against qualitative data from **visiting the community and listening to local people** (see Chapter 1.1). This process also builds trust in a community, which helps people to access and benefit from your services (see Chapter 1.2), as well as to identify assets within the community that may be useful to you (see Chapter 1.3).

Invest in prevention

In Chapter 1.1, we mentioned that austerity led to cuts in preventative services, which has created additional social need. Earlier in this chapter (1.5), we explained how services are less preventative in deprived areas, despite having greater need. We also mentioned in Chapter 1.4 the particular need for prevention for children and young people.

In Chapter 1.3, we explained **how VCSE organisations are uniquely placed to address the social causes of the symptoms of poverty proactively**. They focus

on specific neighbourhoods, deeply integrate within the community, and have equitable communication between the people that they serve. As a result they have strong trusting relationships with people in the community. These trusting relationships enable them to understand community needs intimately, and for people to access and benefit from their services. The voluntary sector also has strong partnerships which give them the flexibility to address almost any need.

As a result of these arguments, **we recommend ICBs invest in preventative services in deprived areas, to address social needs provided by the VCSE sector.**

There is a recognition that we (the system) need to shift investment more into community prevention and away from crisis provision, but this is so much easier said than done, especially while crisis services are so stretched.

In the meantime, investment in programmes of small grants support would build skills and knowledge in the health issues that communities prioritise while also building capacity for people to find their own solutions.

**Joanna Martindale, Chief Executive,
Hangleton and Knoll Project**



1.6 Involve the community from the outset

A major element of the Innovation and Change Lab process is helping the healthcare system to see itself from different perspectives, and helping the system to see itself as a part of the community that it serves. The community members and the stories that they share are instrumental in this. The biggest gains are made when the community is involved from the outset, at the design process, where they can make sure that the whole system is represented during the workshops. Their continued involvement as partners in the inquiry and solution finding is the one thing that keeps the system in the mindset to innovate and to change for the better.

Helping the system see itself

The first workshop of the Innovation and Change Lab process, 'sense', brings together members of the local community with healthcare system professionals: NHS commissioners, primary care professionals, the local authority, voluntary and community sector organisations. **Each of these people have a valuable understanding of how the healthcare system works from a different perspective.** No single perspective is 'right' and no one has all the answers.

The Labs are designed to encourage discussion between different types of people, so that **each person can learn to see things from other people's perspective.** In doing so, participants build a shared understanding of how the healthcare system works, with its patterns and implicit assumptions. Participants also better understand the part that they play within the system, and the impact (intended and unintended) that their actions have on other people. In this way, they learn that the system is not something external to them, a nebulous ball of bureaucracy that is "out there", but rather it is something that they work within, with people, faces and names. **And that they, working together, have the power to make the system function better.**

Healthcare system professionals "become" the community

[It is] helpful to understand the community better by speaking to people who live in the community

Community-based lab participant, Hastings

In our work, we have found that **members of the community have a particularly powerful perspective.** The presence of the community enables those employed in the healthcare system to mentally step out of their roles, breaking down hierarchies, and helping them to see themselves simply as fellow community members.

The Observe workshop leads to community members **openly and honestly discussing their healthcare experiences, and their experiences of living locally.** These honest and open discussions sometimes shock and surprise healthcare system professionals, who did not see the system from the same perspective. Other healthcare system professionals are reminded of experiences where they were patients too, and are invited to reflect on this, and consider what changes might be made to improve the system for everyone.

The 'learning journeys' intensify the effect by **immersing participants in new contexts that are important, but unfamiliar to them.** Often these learning journeys take place within voluntary sector organisations, community projects, or general practice itself. The aim of the learning journeys is to speak to the people there and understand their perspective, to 'put oneself in their shoes'. At the

same time, community members can also gain a new appreciation for the work of the system's healthcare professionals – though often learning about the local community, to which everyone belongs, is even more powerful.

These experiences **help the system to see and sense itself: it helps participants to see themselves as a part of the communities they serve**, rather than being separated from them.

Co-design with the community

The benefits of community involvement can be multiplied further by having community members as part of the design team. The amount of support available from community resources is explained in detail in [Chapter 1.3](#), and is often not known about until community members are involved. Some of our design team were surprised to discover the amount of useful skills and help that was available in the community. In order to make the most of these skills, it is best to **involve the community from the design stage**, and in doing so, make this true co-production.

The design team creates the agenda for the Labs and sets the tone for the entire change process, so having the community here means that the **Labs are better adapted to the needs of other community members**. This improves the ability of the Labs to engage with the community, and multiplies all of the benefits that follow.

I think quite often in the past, people have said, yes, we're co producing. But then what they do is they actually go to partners with a preconceived idea of what they want to achieve, or at least some kind of goal that they would like, be the work to be focused on. Whereas with this, we basically went to the community with a clean slate and said, Look, here's what the data is telling us. What does that mean to you? What you want to do with it, and where should we go from here? And so having that kind of authentic coproduction built in right from the start, just made it so different and was really great

Design team member, Hastings

The design team also maps the system initially. Whilst employees within the system often work within silos or close-knit teams, the local community experiences a breadth of the system's offer. That's why community members may know about services offered by voluntary sector organisations or community groups that are overlooked by system professionals. The community involvement **improves the quality of the system mapping, and makes sure that the whole system is represented in the room for the first workshop**, which saves time inducting people into the process later.

The community keeps the system innovative

[Community involvement ensures that the] right changes are made in the right way

Community-based lab participant

The impact of community involvement in the design team, Observe workshop, and learning journeys has been discussed previously in this chapter. Even so, continued community involvement through the final two workshops and the Check and Challenge process is essential to keep the NHS in the mode to innovate.

The Retreat workshop is all about reflecting upon participants' shared awareness of how the system works now, and the shared intention of how everyone wants it to work in the future. In this workshop, community members were able to **bring abstract ideas and concepts into the realm of real life experiences**, by sharing what matters to them.

This clear awareness and intention helps everyone to imagine what needs to change in order to get from where we are now to where we want to be. The community's stories often evoke a range of emotions, from laughter and joy to tears and anger. These emotional responses **prompt healthcare system professionals to see their roles in a new light, and to think about how they might be part of the change.**

The Act workshop is where prototypes are created to test new approaches that are in line with the shared intention for the system. Without community members, it can be tempting for healthcare system professionals to fall into the same patterns of creating new reactive care services. Community members are less likely to fall into this trap. Rather **they ask insightful questions, and tend to be innovative, pragmatic and solution-focused.** For example, it was the community members in Hastings who realised that open access English classes were the solution to empowering people who

do not have English as their first language to take control of their care, and their wider lives. They knew that they could secure a venue from the Imam, and knew how to get in touch with him to support them. Healthcare system professionals are unlikely to have started this initiative alone.

Also, rather than basing the prototype design around assumptions of what the community needs, involving the community themselves means they can clarify and explain their needs and goals. Therefore, **the prototypes better fit the needs and goals of the community**, which is likely to make them more effective and satisfactory. Community members are also able to spot issues that others might miss, particularly in terms of cultural sensitivities. Catching issues early means they are quicker and easier to rectify.

Finally, community involvement is also important in the Check and Challenge process. This process is where the learning from the prototypes is reviewed by system leaders. The prototypes are each reviewed to understand what resources they will need to grow and to be sustained over the long-term. **Community members make sure that as the prototypes grow and develop, they don't lose their focus of meeting the needs in the community** and creating the change in the system that everyone wants to see.

The Innovation and Change Labs built upon the existing community involvement processes used within Sussex and West Yorkshire ICSs (Integrated Care Systems). The Labs contributed to the continuous improvement of these processes, and participants seemed keen to build on this learning in the future.

[The programme and its facilitation] really does allow for equality of everyone around the table and to pull out the voices of those least heard. [...] We've heard from communities, families, households, [and] individuals in Hastings that you would never usually hear from.

Lab participant, Hastings



1.7 Support from systems leaders

Innovation and Change Labs involve a move from a hierarchical way of working to a more egalitarian way of working together that unlocks the knowledge, skills and creativity of all members of the system. System leaders need to support the programme throughout in order to give rank-and-file healthcare system professionals and members from the wider community the permission, space, and support to lead system change. This support is particularly important in the early stages of the process, where people need resources, and at the end of the process, where learning from the Lab process and the prototypes is applied to the whole system.

Hierarchical to egalitarian

Innovation and Change Labs value the diversity of perspectives, knowledge, and skills that different members of the system bring to the table, and encourage them to work together, through the workshops. Feedback suggests that participants were able to build cohesive communication and an egalitarian working structure.

[The labs were an] exciting project where everyone feels equal. A real opportunity to join the dots

Community-based lab participant, Hastings

Still, this new egalitarian approach is not without its challenges. **For people who are used to leading, it can be difficult to balance giving people enough space to co-create a solution with providing enough support and overall direction.** It is advisable for system leaders to be visible in their commitment to the work, making space in their diaries to join the workshops to pay attention to the emerging ideas and solutions, and to actively support people to test these out.

Lab participants were more confident in leading change where the system leaders were visibly present. System leaders' involvement differed both between the two sites, and over the course of the labs, and this tended to be noticed by participants.

I feel there was not enough support from the strategic people of positions as there were none of them who attended the workshops. I feel their input would have highlighted their own barriers and could have helped shape these events and contributed in developing this service further.

Lab participant

Supporting people to lead change

People who are not used to leading change can be anxious about taking charge of something new. It seemed that, at times, people did not realise their agency in being able to co-create the process of their involvement.

For example, several prototype teams mentioned that they were struggling without having a nominated leader. It seemed not to have occurred to them that they could nominate their own leaders.

In Bradford's design team, concern was expressed in the evaluation about how the project was initially focussed on one area of Bradford, and then the project grew in scope. The scope of the project was the responsibility of the system leaders.

Clear communication regarding roles, responsibilities, and their alignment with the broader process is essential. It is important to have mutual trust to negotiate over a support level that gets the best out of everyone. System leaders can support this

by giving people permission, time, and resources to innovate. We observed that this approach instilled confidence in our participants, enabling them to embrace experimentation and new ideas.

I think just having the opportunity to test innovations really rapidly and without having so much scrutiny that you just, you become overwhelmed with what you need to try and illustrate that you've tested rather than just giving it a bash to doing the innovation testing at a very small scale... [This] meant that there wasn't any pressure for people, that they could test all or part of their prototype. And I think that resulted in lots of people doing some quite good stuff that they might not have had the confidence to do if we were doing it in a much bigger scale.

Design team member, Hastings

The strategic perspective can also help people connect with everything that is available within their community. In doing so, this can **'unlock' knowledge, skills and creative energy** that people did not have the ability or agency to use.

[The labs] gave me permission to find my time. It gave me the people to work with, people I've never met before who were really powerful plus also people I had met before, but...

so it kind of took a few conversations that say, 'I can do that', 'I can help you with that', 'that sits with our aims and objectives.' And that was something that wouldn't have happened [otherwise]

Lab participant, Hastings

Support at the start: Create the environment

The first part of the Innovation and Change Lab is the design team stage. This first stage lays the foundation for the later process and its impact. It involves **listening to the whole system, uncovering common intentions, and providing resources for the way forward.**

By listening, the design team is there to help uncover the common intentions for the process. We listen to ourselves, and what we're doing now; we listen to others in the system and their perspectives; we listen to what we are collectively called to do through this process.

It's important to have an understanding of the Innovation and Change Lab process, in order to provide the appropriate people, place and budget. The lab in Bradford struggled initially to get the resources and staffing that they needed to support the project. They compared themselves to the lab in Hastings, which had more staff support. We advise that at least one dedicated staff member coordinates the work locally supported by some administrative capacity.

I think we needed probably in the first three or four months, a programme manager, There were a lot of meetings, a lot of admin. [...] Every time at joint meetings with Hastings, it became quite apparent they have people that were working full time on universal health care, we just didn't have anyone like that.

Design team member, Bradford

Support at the end: sustainability & learning

It is important for system leaders alongside those leading change to be able to **share the learning from the Innovation and Change Lab process and from the prototypes to the wider system**. In doing so, they synthesise the learning in all of the different elements of the Labs, so that the whole system then acts from this synthesised shared awareness.

I think the fundamental learning from UH is in the strapline that underpins the three hypothesis [sic.] of medicalising poverty, unequal service provision and rationing, that the way we plan, design, and deliver services exacerbate inequalities. Now these three things constitute the commissioning cycle and so UH is telling us that [...] we need to improve the way we plan, design and deliver services. We had a discussion [...] this morning and reflected on the UH journey and we agreed to review our processes of commissioning, governance and assurance and incorporate UH learning themes into mainstream thinking so that we all start to see what usually only a few in any system can see at this moment.

System leader, Bradford

In particular, as participants are often very focused on their own prototype, they might lose sight of what is being achieved by other prototypes. Ongoing sharing between prototypes in a community of practice is critical to sustainability and spread. The Innovation and Change Lab in Hastings held a celebration event in June 2023 specifically to share learning between the prototypes.

I must say, because, like the prototypes that have come out, I haven't been involved with all of them. So I haven't seen any evidence of what's been achieved and I think maybe at the next event it we've got one in June, where maybe we hear about that all of them.

Design team member, Hastings

Practical examples of learning

The learning from the process is about people having experienced **a whole new way of working** – it's not merely about the measurable medical impact of the prototypes. Learning might include, for example, the **importance of openly and honestly questioning patterns in the system.**

[... The] universal healthcare proposition that raises very, very direct questions clearly statements around rationing, inequalities and poverty and medicalizing a lot of those issues. They're really powerful statements and I don't think we ever got too close to question it...

Lab participant, Hastings

The Lab approach initially gives people more time to perceive, reflect on, and discuss a situation before taking action. The subsequent prototypes are created quickly and involve lots of experimentation. This **different structure and pace of working** can be a learning in itself.

[It's a] Very different programme to the sorts of things we've been involved with previously. And I think... there's been lots of, sort of, sitting back, waiting, reflecting, you know, rather than jumping in trying to get things done, which I must say I did struggle with initially

Design team member, Hastings

Learning might also include **improved community engagement, or links with other partners and areas of the system.**

There's definitely a change in terms of the way we're working across organisations in a way that traditional barriers would normally get in the way. So definitely an improvement in a way of working. Definitely an improvement in the way that we engage our interaction with our communities

Design team member, Hastings

Learning at every step

The programme is designed to build participants' knowledge and skills at every stage. In the Observe workshop, participants learn factual and empathic listening skills (more detail in [Chapter 1.8](#)), and they develop empathy and understanding of the perspectives of different people within the system. They develop the ability to collaborate and form a shared understanding of the system and its problems. The subsequent learning journeys reinforce this by immersing the participants in contexts that are important but unfamiliar to them. Throughout this process, participants also learn how to overcome judgement and cynicism and practise honest and open inquiry.

The second workshop, Retreat, builds the ability of participants to reflect and to generatively listen (more detail in [Chapter 1.8](#)). They move from considering how the system is now, to how everyone might want the system to work in the future. This activity develops people's sense of self, connection to their role, and creative thinking skills.

The third workshop, Act, further develops people's collaboration by working with others to develop their rapid prototypes. This develops participants' abilities to design 'mock ups' and models of their concepts,

and rapidly test these using weekly 'plan, do, study, act' cycles.

Finally, the Check and Challenge process brings together all of the learning from the Innovation and Change Lab process and from the prototypes to the wider system.

There **may be some measurable improvements.** For example, the fuel poverty prototype resulted in 64 referrals from a GP surgery to Citizens Advice, where people received advice on how to reduce energy costs, financial support to help with heating costs, and help with home improvement measures to reduce their energy bills (more detail in [Chapter 3.1.2](#)). Alongside these measurable improvements, there also emerged a **new understanding of the system and new ways of working within it.**

[...] we have got both material but a legacy experience in Sussex now, which I think we can use for blueprints for all kinds of things.

Design Team member, Hastings



1.8 Support open, honest, non-judgemental inquiry

The Innovation and Change Labs involve a process of open and honest inquiry into how the healthcare system works, and why it works in this way. The process follows three stages: challenging assumptions, empathising with others, and letting go of the old ways of working. We work to overcome judgement, cynicism, and fear at each stage respectively. The workshops should reflect the diversity of the local community, and everyone should be given the support they need to get involved as equals. This means that workshops need to be well structured, use a variety of communication methods, and that extra support should be given to anyone who needs it.

A process of opening

Whilst **participants can easily look back and see how far they've come**, it can be more difficult, at the start, for people to envision how far they've got to go.

The workshops enable all statutory and voluntary organisations to come together and look at different ways that they could work to improve engagement and provide a vital service to the community. Looking at gaps in the existing services and how to bridge these gaps together to considering the inequalities that are apparent in the services currently.

Lab participant

At the end of the process, **participants are happy to honestly acknowledge** the gaps and inequalities that exist within services, and they can see the benefit of working with people from across the system, and the value of their different perspectives.

I think there's been a really good opportunity to meet with people that you would never normally meet with in your day to day work.

Lab participant, Bradford

At the start, several participants compared the Innovation and Change Lab approach to previous change projects that they had experienced. This reflects their attachment to old mental habits and past experience. The theory behind the Labs recognises that how people 'see' the system and its problems determines what they choose to do about it. It's important to help people open their minds, hearts, and will, so that they can see the system differently.

I think one thing that that maybe there could have been a little bit more sensitivity was that we that we have sort of tried things before...we've got a big schools programme, let's go and talk to them. And it felt a little bit like it was no fixes that fail, we don't need to go down the same things we've done before this needs to be new.

Design team member, Bradford

This process of opening involves three stages: challenging assumptions, empathising with others, and letting go of the old ways of working. These stages can be difficult and participants may encounter barriers of judgement, cynicism, and fear at each of these stages respectively. (Scharmer 2018)

Overcoming judgement: challenging our assumptions

The state of ‘downloading’ refers to when we listen from our assumptions and prejudices and reaffirm what we already know, without learning anything new. We can **open our minds by suspending our judgements and cultivating curiosity**. (Scharmer 2018)

Everyone’s view of the system is based on certain assumptions – judgements about what certain people might need or think. But these assumptions aren’t always right. **We should test our assumptions** against qualitative and quantitative data, and ask critical questions. Qualitative data can be collected by engaging with new people and understanding their perspectives and experiences. Quantitative data can be obtained through data mining and presented during the Observe workshop.

Because people have such well-reinforced assumptions and prejudices, we often think our perspective is the only correct one. **Confronting one’s own ignorance head on can be difficult**. Even so, in reality, no one possesses all the knowledge, and everyone has valuable insights to offer. By asking meaningful questions and actively listening, we can develop a genuine understanding of the system’s current state. This lays a solid foundation for driving positive change later in the process.

Overcoming cynicism: empathising with others

Through curiosity, we achieve ‘factual listening’ where we actively listen to others, even when their perspectives challenge our own. This enables us to broaden our understanding. To further develop our listening, **we redirect our attention, opening our hearts and cultivating compassion for others**. (Scharmer 2018)

Factual listening recognises other people, and what goes on with them as external and separate to ourselves. **When we disagree with people whom we perceive as separate, it’s common to develop cynicism**, especially if they feel that we are to blame. We can create a narrative of division, perceiving an “us versus them” mentality and even nurturing hatred towards those who hold different viewpoints to us.

Often people put on a professional front at work, and like to be seen as invincible. But compassion involves a state of true openness and vulnerability, reflecting on our own, sometimes difficult experiences, in order to **put ourselves in another person’s situation** and to feel what they feel. It’s important to listen actively to the other person, pay attention to their non-verbal cues, and try to sense their thoughts, emotions, sensations, and urges. Even if you still don’t agree, you can understand how they perceive the situation and why they might feel that way.

Overcoming fear: letting go of old ways

Compassion helps us achieve ‘empathic listening’ which involves listening with all of our senses, and helping us to see the system through the eyes of someone else.

The final step, ‘generative listening’, involves **letting go of our old ways, and creating the space for something new to emerge**.

Our familiar patterns of behaviour and established ways of working provide us with comfort, a sense of identity, and predictability. **Letting go of the past, opening our will, and stepping into the new can provoke immense fear of what we stand to lose**.

Even so, our previous work challenging our assumptions and empathising with others has created a shared awareness of what happens in our system and why. The fundamental question that an open will poses is **‘What do I feel moved to change in the system?’** By having the courage to let go of what has gone before, and to make changes, we open a world of limitless creative potential.

Supporting involvement

The Innovation and Change Lab process involves lots of collaborative working in a flat egalitarian structure. There is often no clear leader, and there is lots for everyone to learn at each stage. This gives everyone the opportunity to start from a clean slate and effect system change.

It also comes with an amount of uncertainty, which as previously noted, can provoke fear. As such, it's important to support people sufficiently to make the most of the opportunity. This can be done by structuring workshops well, and adapting facilitation to make sure everyone can gain equal benefit.

Well structured workshops

The **workshops should be welcoming and well structured**, especially in the initial stages. In the Observe workshop we made sure that activities involved lots of **meeting and mixing between participants as equals**, whether they be community members, staff from the NHS, the local authority, or the voluntary sector. These discussions were designed to encourage empathy and understanding between people. Community members told us that these activities allowed for honest and open discussions about their own experience and the experience of others, although those with social anxiety may need additional support with this. Community members also reminded us that the workshops should not feel too professionalised in their structure.

To make learning enjoyable and engaging for everyone, it's crucial to **use a variety of communication methods**. We incorporated verbal stories, PowerPoint presentations, and videos, along with a touch of humour. During discussions and feedback sessions, we provided moments for reflection to accommodate both introverts and extroverts.

I think it was accessible. I think, there was a lot of reflection. There was a lot of reminding us why we were there. A lot of you know, the videos that were shown the way that we had like an illustrator there as well, that was all really, really helpful

Lab participant, Hastings

We found that **worksheets were an effective way to guide people through the process**, particularly to help people plan their prototypes and to prepare people for the discussions during their Check and Challenge meeting. To **capture the results of other discussions, we enlisted a live graphic illustrator**, who created an engaging and accessible record of our work.

Providing facilitation to suit people's needs

It is important that, from the start, the workshops involve the full diversity of the community. Anyone should be able to take part, and **everyone should be supported to enable them to have equal involvement**. This will result in some people needing more support than others. During our work in Hastings, there were two (overlapping) groups of people we provided extra support to. There was a large group of people for whom English was not their first language, and there were also a number of parents of young children.

For people who did not have English as their first language, we engaged extra translators, as well as providing translations of some of our presentations and worksheets. We also adapted our session delivery to help the translators who were repeating what we were saying to the participants.

For the parents of young children, we made sure that there was a free crèche provided during some of the workshops, so that their parents could fully engage. We also responded to issues of background noise in the room, by offering breakout spaces where appropriate, and did what we could to make everyone comfortable. It was **appreciated that lunch was provided at all of our half-day or longer events.**

We've brought together groups of people and mainly the patients who don't speak English in a sort of a very wonderful way which I've never seen before and that was something quite special. And I think, for me personally,.. it was the priority. We could do that again. So I think we've kind of learned how to engage the public much, much better.

Lab participant, Hastings

1.9 What this means for NHS organisations

A message to general practice

You are spending thousands of pounds on people who turn up frequently, and we find mostly you are offering little continuity. If you found out more about these people – it might surprise you who they are! – and proactively booked them in, providing continuity and longer appointments, you have a better chance of meeting their needs. In turn, this will free up appointments and reduce the load on the morning phone line.

Have a look at the needs of these people, and ask yourself if you have the capability in your practice to meet their needs. If not, then take steps to design MDTs at neighbourhood or PCN level to bring services together to meet those needs.

If your patient satisfaction is low, it's probably because you are not meeting your patients needs, even if you are offering a lot of appointments. Be humble, trust the data, and look at how you can differentiate your list to organise around need, not demand.

Take a look at who is coming to your practices, and see if you are providing services for children and young people. If not, reach out to schools, VCSE sectors and young people themselves and work out together how you can support them.

If there are people in your practice population who are not accessing your practices, find out why not. You may need to provide something nearer their home, at least to start with. Make the most of the relationships you built up in the pandemic with your community leaders to help you.

A message to ICBs and strategic leaders

This report is not a call for more funding, but for using funding based on need and data rather than demand and assumptions.

Start with need, moving beyond the very broad population measures of ill health, to more focused understanding of need as it presents at the front door of the NHS.

Make sure you are 'counting' fairly. Check your metrics to make sure they represent the whole of your community's needs for universal healthcare. Develop a dashboard that reflects your values and the values of the NHS constitution.

Question your funding model to make sure it is based on current need, not historic patterns.

Provide business intelligence support to PCNs so that it is possible to know who accesses primary care and who doesn't; who the persistent attenders are; who gets continuity or not. Understanding who accesses and why enables the design of primary care to meet need.

Primary care needs support to design a proactive differentiated model (which is needs based) that also meets 'Directed Enhanced Service' requirements on access. This includes building confidence in the 'easy to ignore' communities to transition back into the NHS; meetings needs where they show up; providing continuity where it works; designing MDTs to meet actual need rather than assumptions about need; building relationships with local government and politicians to meet the needs of people struggling with life.

The VCSE sector needs support to be a good partner, which means the NHS investing in the conduit between the NHS and the VCSE sector. Fund VCSEs for years, not short-term, so they can focus on service provision.

Children and young people do not access primary care as much as we think they could and should. Primary care as provided is not always meeting their needs; they need to be partners in the design of their services. The primary focus on adults in NHS policy and performance measures is disadvantageous to children and young people.

A message for community members

Get active. It's your NHS. Check what is happening and hold politicians and agencies to account to make sure you are getting fair funding and fair access to services.

SECTION 2:

CASE STUDIES



2.1 Fleetwood Youth Hub – Fleetwood

Dr Mark Spencer, a GP partner at Mount View Practice, explained how he was creating a healthier Fleetwood by listening to residents and encouraging organisations to work together, in true and equal partnership with the community. Resident empowerment through Healthier Fleetwood, the use of Integrated Neighbourhood Teams to address the community's health priorities, and Future Fleetwood's community development to tackle the social determinants of health, all play a part. The Fleetwood Youth Hub exemplifies this approach as it supports young people into education and work.

Listening and the Youth Hub

The Youth Hub was established to help young people overcome poverty through long-term education, training, or employment. It was clear that young people's poor mental health would hinder their progress.

To address this issue, volunteers in the youth hub listened to young people in order to identify things that supported or challenged their mental health and well-being in Fleetwood. This listening revealed that many young people struggled to access necessary support, including difficulties in accessing their GP. In response, by working in partnership with the PCN, the Youth Hub introduced mental health practitioners for group sessions, with one-to-one counselling services delivered by a local charity. Young people will continue to be involved in developing and designing the spaces in the hub as it continues to expand.

In the past 12 months, over 220 young people have been supported by the hub with 80 entering into full time education and a further 40 gaining full time employment.

Partnership working

Many organisations are involved with the Youth Hub. It's run by local volunteers, funded by the Department for Work and Pensions. They also house Primary Care Network employed mental health staff, and counsellors from 'Counselling in the community', a local charity.

The key to this partnership approach was people in these organisations choosing to work together and spend time building relationships. Their trust and understanding is such that they can work quickly and flexibly with one another.

Listening, giving up control, and building relationships

Healthier Fleetwood started when Mark and Fleetwood residents asked the question 'What matters to you?'. People being genuinely listened to and encouraged, led to the founding of 68 community groups. The group emphasises action and avoids excessive paperwork and planning. They develop deep relationships through casual walks, chats, and lunches, and take action based on shared abilities and motivations.

Lessons Learned: Listen to the community and provide for their needs (see [Chapter 1.1](#)). Work with charities and community to treat the social causes of need (see [Chapter 1.3](#)).

See more: [Healthier Fleetwood Website](#); (Moreno-Rangel et al., 2022a, 2022b)

2.2 Oxford Terrace and Rawling Road Practice – Gateshead



Sheinaz Stansfield, Practice Manager at the Oxford Terrace and Rawling Road Practice, shared her bold and 'disruptive' approach to delivering the GP contract. She analysed demand and capacity, introduced social prescribing before it became mainstream, and now focuses on green prescribing with a GP practice allotment. She sees her practice as a 'community anchor', providing access to various services and community projects for patients. Sheinaz believes that making these connections with her local community and being innovative positively impacts her own mental health.

Analysing demand, and fitting capacity to this

Sheinaz's approach to the GP contract is unique. Instead of delivering it as is, she reads it and asks herself, 'What's best for my patients?' This led her to conduct a demand analysis. The analysis revealed that she had a number of elderly patients, who didn't meet the thresholds for adult social care but still needed support. To address this need, she created a Frailty Nurse post, and later introduced the 'Care Navigator' role, similar to what is now called a 'Social Prescribing Link Worker'.

Making connections

Sheinaz enjoys meeting people and has found a great way to connect with the local Muslim community by taking walks on Fridays and speaking to them after prayer. She has also found fruitful collaborations by literally knocking on the doors of voluntary sector organisations. For instance, she knows that she can visit Gateshead Clubhouse for a snack when needed, since she has helped them, they return the favour.

The allotment: 'Plot 42'

The practice's alliances with the voluntary sector help the practice to establish itself as a 'community anchor'. Given that many patients were born within its walls, the practice serves as a focal point that connects individuals to a variety of services to improve their health and wellbeing.

Sheinaz's interest in gardening, the GP contract's new focus on sustainability, and a chance conversation with Gateshead Carers led to the practice collaborating with the community on an allotment, named 'Plot 42'. Seed money donated by practice staff started a community garden, getting patients active, meeting new people and learning lots about their environment.

With donations of equipment and allotment space from local people and organisations, 'Plot 42' has expanded. They're working with Bensham Grove to start a new allotment at Bensham Court; have been working with the Comfrey Project who have beehives; and have been working with a local artist who has set up a walking group and is teaching them how to make use of their beeswax. The beeswax products will be sold to raise money for the practice.

Lessons Learned: Primary care can proactively provide for social need (see [Chapter 1.1](#)). Work with charities and community to treat the social causes of need ([Chapter 1.3](#)).

See more: [Practice Website](#)

2.3 COVID-19 Vaccine Programme – Bradford District and Craven



Rukeya Miah BEM, at the time of interview, the Health Equalities Lead for the Bradford District and Craven Vaccination Programme, actively promoted the COVID-19 vaccine. With her team, she reached out to diverse communities, identifying their barriers to vaccine access. They attended locations where communities gather, built relationships with community leaders, and educated them on vaccine side effects and safety. Rukeya recognised the power of humour in motivating action, adopting creative roles like a pop singer, a 'vaccine fairy', and using a tannoy machine in the town centre.

Listening to South Asian communities

Vaccine uptake was particularly low among South Asian women. To address this, Rukeya collaborated with a trusted community centre, a respected local councillor, a chief pharmacist, and a respiratory physician. Together, they organised tailored events.

The first event focused on older women, who were influential in relaying information to the younger women in the community. They actively listened, addressed concerns seriously, and provided education. The team's ability to speak Urdu and Punjabi proved advantageous. They discovered that women had heard that the vaccine had caused menstrual cycle disruptions and so they worried about infertility. The team reassured them that the disruptions were temporary.

Many attendees of these clinics were happy to share their vaccine experiences in local media. One young father even shared his positive experience on BBC Look North, after having his concerns alleviated.

Shopping centre vaccinations worked well for young people

Young people were found to experience needle phobia. To address this, the team decided to provide vaccinations in a familiar and convenient setting: the shopping centre. By offering walk-up vaccinations, they eliminated the need for appointments, which can be intimidating and exacerbate the fear of clinical buildings. This approach proved highly successful, prompting the team to expand their operations.

Upskilling colleagues

Some colleagues couldn't understand why people weren't coming to the vaccine centres. There were lots of centres, open long hours, and COVID-19 was all over the news.

Rukeya was able to help her colleagues to see, from the perspective of the people, all of the barriers that they faced. She was able to encourage her colleagues to challenge their assumptions and biases and to try new approaches that were outside of their comfort zone.

Lessons Learned: A one size approach to services does not fit all; Reach out, listen to people's barriers and build trust to help communities access services (see Chapter 1.2).

See more: [Universal Healthcare Toolkit](#)



2.4 Homelessness Vape Project – Crawley

Julie Clare, Senior Wellbeing Advisor at Crawley Wellbeing, a partnership between West Sussex County Council and Crawley Borough Council, told me about how they had started providing vapes to homeless people to help them stop smoking. Each borough worked with a local charity to reach out to homeless people and to build trust. Homeless people sharing their positive experiences with the service increased uptake. The wellbeing officers learnt more about how the challenges of homelessness made it more difficult to stop smoking and adapted their service to meet homeless people's needs.

Working with a charity to reach out and build trust

The vape project began when homeless people were moved to non-smoking hotel rooms during COVID-19 for their safety. As a result they needed help to stop smoking. Each borough council worked with a local homelessness charity to build connections and gain trust. Crawley Borough Council worked with Crawley Open House.

Homeless people often have negative experiences with public services, leading to a lack of trust. But since they already trust Open House, when Open House suggests speaking with the Council's wellbeing team, it helps bridge this gap. This makes it easier for wellbeing advisors to build rapport with them.

They also provided such a good service to the first person that they met through open house, that he became an advocate for the service, and recommended it to his friends. Between August 2020 and June 2023 they had 129 people try a vape, of whom 58 successfully stopped smoking. The quit rate is similar to the rate of the people on their other stop smoking programmes.

Challenges of homelessness make it more difficult to stop

Working with the homeless community is tough due to their constant movement, and they often deal with other health problems. Julie shared a story about one person who had parents struggling with drug addiction. They recently broke up with their partner, received a diagnosis of a debilitating long-term health condition, and had to give up their career. These challenges led to financial and mental health issues. The council also lost contact with them when they spent time in prison.

The council offer extra support

In comparison to standard stop smoking services, they offer more regular contact to homeless people, and enlist the help of Open House if people aren't contactable.

The person I mentioned above, said that the weekly conversations help him to keep going. He also appreciated the help of wellbeing officers to arrange free gym membership and for him to join a local men's mental health group. He swims regularly, is more accepting of his disability, and is keen to make the most of life.

Lessons Learned: Work with individuals who are already trusted by the local community, and make changes to services to make them more accessible (see [section 1.2](#)).

See more: [West Sussex Wellbeing Website](#)

2.5 Hangleton & Knoll Project (HKP) – Brighton and Hove



Joanna Martindale, Chief Executive of HKP, explained how the charity, in its 40th year, continues to deliver asset-based community development. Their vision is for the community to be part of the answer to their own healthcare needs. Built in the 1930s, the Hangleton and Knoll estate made little provision for recreation. Now HKP run a wide range of projects on the estate, from ageing well services to youth work, arts, and community learning. Their cancer screening programme is a great example of how a community-based organisation can reach out and take hyper-local action.

Embedded in the community

HKP, over its 40 year history, has built deep roots in the community. They focus on deep, concentrated work on their estate to create trust and empowerment.

HKP facilitates the community-led “West Area Health Forum,” where locals actively contribute solutions to health issues. This forum attracts significant attendance from public and community sector bodies. Notably, a suggestion from the Health Forum inspired HKP’s menopause project, complementing their ongoing initiatives focused on cancer screening, diabetes and hypertension, and health-related digital inclusion.

Hyper-local and asset-based

Joanna emphasised adopting a hyper-local approach by going directly to the estates instead of expecting people to travel to the town centre.

Local community organisations with established networks and trusted relationships can help health services in recognising and using the local community as a valuable asset.

Reaching out, building trust

HKP are representative of the community that they serve. Their policy is to ensure that a board member with lived experience in a particular community leads the corresponding area of work.

To widen their understanding of people’s needs, they engage directly with people by knocking on doors and conducting an annual consultation on a local issue. They also connect with people over shared interests and activities; they address immediate needs and foster equal relationships with people. This leads to natural conversations about other issues in people’s lives, and how HKP can help.

HKP also prioritises cultural sensitivity and language familiarity to build trust. They advocate that, health messaging for specific communities, like the Bengali community, should come from members of that community. This approach is based on the idea that Bengali people are familiar with cultural barriers, such as men’s involvement in women’s healthcare, and they can effectively communicate in Bengali.

Lessons Learned: Build trust through focusing on specific neighbourhoods, integrating with the local community, and fostering equal relationships (see [section 1.3](#)).

See more: [Hangleton & Knoll Project Website](#)



2.6 Community Helpline – Torbay

Tracey Cabache, Director of Torbay Communities manages the community helpline that provides a front door to all of the services available in the community in Torbay to meet people's social needs. It was set up by a VCSE (voluntary, community and social enterprise) network during the pandemic, and was designed because the community often meets people's social needs better than adult social care. The helpline is able to enlist the help of partners and volunteers to support their services and adapt quickly to changing needs in Torbay.

A VCSE 'front door' to meet social needs in the community

A massive social care bill prompted Torbay Council to consider what services they were providing that could be better provided by the community. The adult social care team were good at assessing people's needs and responding to crises and safeguarding issues. Yet, in terms of long-term care they would be unable to keep track of what the community might be able to offer.

At first, the helpline focused on practical matters like food and prescription deliveries during the initial COVID-19 lockdown. Then, as the lockdown progressed, people began calling about various issues, such as mental health, financial concerns, and domestic abuse. The helpline has also experienced increased demand for its services during the cost-of-living crisis, mainly for food bank referrals.

As of June 2023, the helpline were taking approximately a quarter of adult social care's calls. 83% of these were resolved by the helpline, and only 12% were referred back to adult social care, with the remainder receiving joint support.

Process of calling

When people call, they are connected with a volunteer call handler whose job is to have a friendly chat and figure out what support someone is offering or seeking. The call handler will then decide if it's better for the person to access community-led support, working with an asset-based community builder (see [Chapter 1.3](#)) or if they should speak to a specialised charity for their specific needs. In case of urgent needs or crises, staff members called shift leaders are available to respond promptly.

Flexibly responding to need with partners and volunteers

The helpline's approach is to adapt to the callers' needs rather than dictating a fixed offer. Originally, a small group of health and wellbeing organisations manned the helpline, and when they couldn't assist, they would contact others for support. Their motto is 'one call – that's all'. Now they have over 100 organisations over 11 specialisms. Callers to each specialism are triaged by a charity familiar with the capacity of others in that field, helping people to quickly and easily get access to the support they need.

Lessons Learned: VCSE organisations have the flexibility to focus on addressing the social causes of the symptoms of poverty proactively (see [section 1.3](#)).

See more: [Torbay Communities Website](#)

2.7 The Healing, Expressive, and Recovery Arts Project (HERA) – Brighton and Hove



Emma Drew, HERA's Programme Director, aims to treat social health needs in their community through diverse creative programmes led by professional artists. Their programmes include music, art, and creative writing; and are available on social prescription, with the aim of reducing demand on GP services. Recently, HERA has expanded its scope to support refugees too, capitalising on their community integration and flexibility. Emma emphasises the importance of building relationships through effective communication in this work.

NHS & voluntary partnership

The Robin Hood Foundation – the charity who run the HERA project – was set up 10 years ago by one of the WellBN practice partners. They continue to work closely with the practice: their office is in the practice building, and HERA employs the social prescribing link workers for the local primary care network.

HERA supports over a thousand people per year with artistic and creative programmes and have consequently seen a drop in demand for GP appointments between 27% and 41%.

Relationship driven work

For both colleagues and patients, how people communicate and spend time together is what matters most for Emma. There are more forms of evidence than randomised controlled trials, and they show that the success of a project is about working with skilled and compassionate professional artists.

She takes care of them too, and makes sure that they are briefed on the health service and how to care for themselves and others. She explained how her work requires patience with the public, resilience with partners, and flexibility.

Supporting refugees

HERA provides group and one-to-one support to refugees and asylum seekers. Since the NHS offers limited free services to refugees, HERA collaborates with various agencies to address all their needs. For instance, they work with a local charity to provide trauma-focused CBT, find dental practices offering free treatment, and work with the local education authority to secure school places for refugee children.

HERA understands that people's needs and experiences are diverse, so they adapt their services accordingly. Some people appreciate the support they receive, while others have experienced health services as an extension of an oppressive state, leading to a complete lack of trust.

To build trust, HERA takes things at each person's pace, providing support without a strict limit on the number of sessions. For some, a simple telephone conversation and guidance may be sufficient if they have good English. Others may require ongoing support and may feel too afraid to visit a GP practice, in which case HERA can meet them in a café or a comfortable place of their choice.

Lessons Learned: VCSE organisations have the flexibility to focus on addressing the social causes of the symptoms of poverty proactively (see section 1.3).

See more: [WellBN Website Page](#)

2.8 GR8 Minds – Wharfedale, Airedale, and Craven



Dr Caroline Rayment, a GP Partner at Grange Park Surgery, noticed a concerning rise in the number of children and young people struggling with low-level mental health issues. With no suitable treatment options available, she conducted a consultation with schools, parents, and teenagers, and produced some basic mental health first aid leaflets. Funded by the Primary Care Network and working with others, she set up a social prescribing service that met young people where they were and helped them access appropriate care. Her success came from open inquiry, protecting her time, and building coalitions.

Understanding the issue

Cuts to youth services and school nurses, left inadequate support for young people with low-level mental health issues. As a result, more of them visited the GP surgery. Concerned about this trend, Caroline contacted local schools to gather their experiences. One school agreed to distribute a questionnaire to parents, and Caroline enlisted a local radio journalist to interview opinionated teenagers.

During this process, Caroline met Dr. Natalie Jewett, a local psychologist. They both wanted to promote mental health awareness and resources. Together, they created two leaflets: one for teenagers and another for parents of 5-11 year olds, providing information on how to protect mental health and where to seek help.

Meeting children and young people wherever they are

Recognising the impact of social prescribing for adults, they successfully applied for funding to their PCN (primary care network, a group of GP practices) for a similar service for children.

Their first social prescriber, David, built trust and rapport with young people through activities they enjoyed, like boxing and football classes. He also introduced them to other local youth services. He also found it valuable to make himself available as a drop-in resource at the school, for both students and staff, while organising parent information evenings.

Post-pandemic, young people struggled to reconnect with their previous interests. GR8 Minds witnessed a surge in demand, and hired two additional social prescribers and a resilience counsellor. Working closely with the voluntary sector, they remain committed to providing support for young people.

Open inquiry, protecting your time, building relationships

Caroline recommended a form of open and honest inquiry into what people in your area need, as it may not always be obvious. Being a busy GP, she has found it helpful to reserve 4-5 hours a month to 'take herself out of the system' and focus on GR8 minds, along with working closely with people like Natalie, the schools, and the PCN.

Lessons Learned: Reaching out and building trust is a good way to address social needs (see [section 1.2](#)). We need to invest in young people's mental health (see [section 1.4](#)).

See more: [PCN Website Page](#)

2.9 Social Prescribing for Children and Young People – Cheltenham



Dr. Olesya Atkinson, Clinical Director of Cheltenham Central PCN (primary care network, a group of GP practices), observed two main problems: limited healthcare access for 5-15 year olds and increasing mental health issues among them. She adopted a population health management strategy to prevent long-term health problems and provide early assistance. Social prescribers were hired to proactively reach out to the young people who were most at risk, and offer them support. The social prescribers were employed by a local family support charity, and partnered with GPs, schools, and VCSE organisations.

Prompted by prevention

Very few young people aged 5-18 years old visit Olesya's practice, despite many being registered. She does, however, see many adults in their 20s and 30s with serious issues that began in childhood or adolescence, but they didn't seek support for at that time. Olesya also learned from schools that many young people were facing mental health challenges due to the COVID-19 pandemic.

Olesya realised the importance of taking proactive steps to prevent issues from arising in young people and to intervene early if problems have already emerged.

Targeting and reaching out

Olesya's PCN reached out to young people who were known to have had ACEs (adverse childhood experiences), since these experiences often lead to future health issues. She searched through the practice's records, communicated with schools, and collaborated with the local authority to identify those who had ACEs but were not currently getting support.

Social prescribers link GPs, schools, and VCSE sector

Olesya's PCN collaborated with young people to co-create a letter inviting their targets to see a social prescriber. They discussed their needs and, if suitable, were offered a customised six-week resilience programme. So far, they've engaged with 24 out of 78 identified young individuals and observed significant enhancements in their well-being and resilience based on their SDQ surveys.

The social prescribers have driven the partnerships between the schools and GPs. Social prescribers are also employed by a local family support charity, so can leverage their connections across the VCSE sector (voluntary, community, & social enterprise).

More school collaboration resulted in a pilot of mental health support workers for young people on the CAMHS (child and adolescent mental health service) waiting list. While resilience programs are exclusive to Olesya's PCN patients, these support workers assist any school student. This pilot was triggered by observation that social prescribers were helping some young people to recover without needing CAMHS and were preparing others to make the most of the CAMHS support.

Lessons Learned: Listen to the community and provide for their needs (see [Chapter 1.1](#)). We need to intervene early and prevent illness among young people (see [section 1.4](#)).

See more: [Email Dr Olesya Atkinson](#)

SECTION 3:

**PROTOTYPES
AND SYSTEM
CHANGES**



3.1 Referenced in 1.1 'Start with need'

3.1.1 Prototype: Identifying persistent attenders (Hastings)

This prototype aims to identify and understand particular cohorts of persistent attenders by using searches on practices' patient lists, and starting open conversations.

Driven by an understanding that persistent attenders' needs were not being met, and that patients may be experiencing harm through their symptoms being medicalised, this prototype sought to better understand their persistent attenders.

They developed a search on practices' patient lists to identify persistent attenders. They found that there were a number of women aged 18–24 who persistently attended. They contacted these patients to better understand their medical and social needs, and offered them an appointment with a health coach to explore their environment, community and family, career and education, and health.

They learnt that this group of people were often neurodiverse, had dysfunctional relationships, were in secondary care, had poor mental health, and adopted unhelpful lifestyle behaviours.

They are continuing to investigate how they can understand this need collaboratively and how they can offer support for these patients, with increased continuity where appropriate. They aim to spread their learning to the rest of Hastings and beyond.

Lessons Learned: Investigate GP surgery records to support persistent attenders. Look for patterns in persistent attenders and provide for their needs.

3.1.2 Prototype: Fuel Poverty Referrals (Hastings)

This prototype aims to tackle health issues caused or exacerbated by fuel poverty, by inviting GP practices to refer to VCSE fuel poverty services.

Patients in fuel poverty may experience symptoms such as depression and asthma. Rather than prescribing antidepressants and inhalers to treat the symptoms, this prototype aims to tackle the issue at cause.

Citizens Advice officers worked with a respiratory nurse at the Station Practice, Hastings to develop criteria to filter the practice's patient list to find people with the conditions most likely to be exacerbated by living in a cold home. These target patients were then sent a text message to make them aware of the impact of the cold on their health, and to invite them to contact Citizens Advice for support.

Sent in batches of 100, the texts generated 25–40 referrals per batch, enabling Citizens Advice to assist those in greatest need, and GP practices to prevent health issues. From a batch of 200 texts and five additional referrals from GP staff, 64 clients were offered support. Support included, advice on how to reduce energy cost, financial support to help with heating costs, and help with home improvement measures to reduce their energy bills.

However, this success can also strain a fuel poverty service already operating at full capacity. To address this, the prototype team is developing a gradual expansion plan to ensure sustainability. They emphasised the crucial role of a motivated lead clinician collaborating with the fuel poverty team in achieving their success.

Lessons Learned: Provide services depending on what people need, specifically, work proactively with the VCSE sector to treat the social causes of the symptoms.

3.1.3 Prototype: Managing persistent attenders (Bradford)

This prototype aims to support persistent attenders by exploring alternatives to multidisciplinary team intervention, as well as improving continuity and care navigation.

This prototype wants to improve patients' experience of care and their outcomes, along with making GP appointment access more equitable and improving staff morale and wellbeing.

Having identified persistent attenders at two GP surgeries, firstly, they are going to bring these patient cases to a multidisciplinary team (MDT). However, they also recognise that the MDT approach will not suit all patients, and are exploring alternative options including involving community matrons, social prescribers or care co-ordinators.

Secondly, we found that the practices that took part did not offer as much continuity as people needed. They are identifying which patients may benefit from increased continuity, that is, having a single primary care professional or team, who they see each time. They are putting in the booking systems to make continuity sustainable.

Finally, the prototype are supporting their teams to offer better care navigation and coordination to meet social need, where a GP appointment is unnecessary.

The prototype are keen to share the learning from their work across West Yorkshire, and are working on resolving practical issues such as differing boundaries between PCNs and District Nurses.

Lessons Learned: Offer continuity where appropriate and form multidisciplinary teams, only where needed, and around the needs of individuals.

3.1.4 Prototype: Increasing uptake of sports and activities (Hastings)

This prototype aims to reduce demand on primary care services by enhancing council-operated sports and activity programs with a specific emphasis on health.

This prototype recognised that physical activity sessions could meet social need and reduce demand on GP appointments. The local council already runs physical activity sessions through Active Hastings, and so it was decided to build on this offer, with a specific emphasis on health.

In conjunction with Active Hastings, the prototype explored the need in the area, and found that developing sessions for men's mental health, and for menopausal women would be particularly beneficial. Additionally, they developed yoga sessions for people with long term health conditions and lower back pain.

They found that whilst almost everyone who engages with the sessions increases their level of physical activity, and a majority feel more optimistic, and can deal with their problems better, the challenge is getting people to start coming to the sessions.

They have tried working with individuals to resolve practical issues, as well as offering the sessions at little to no cost, in places accessible to the community. They now recognise that the principal barrier is psychological, and are hoping to explore this with potential attendees to increase the uptake of their sessions.

Lessons Learned: It's important to keep rare attenders satisfied, and to prevent complex health needs from developing, particularly amongst young people.

3.2 Referenced in 1.2 'Reach out, build trust, and transition communities into accessing services'



3.2.1 Prototype: Health and wellbeing festival (Hastings)

This prototype aims to raise awareness of available services and healthy lifestyle choices by holding health and wellbeing events in Hastings town centre.

Following the lessons from the COVID-19 vaccine of physically locating health services within the community, this prototype wanted to promote the wide array of activities available to help people live healthy lifestyles. They believe that greater visibility and awareness of services would improve their uptake.

They held an event at the town's shopping centre, inviting a variety of NHS, local council, and voluntary sector organisations. Lots of people over the age of 50 attended, but very few younger people. They learnt that offering the same thing to everyone will work for some people, but not for others.

They are going to conduct a focus group with young people at a local college, to see how it might be best to communicate this information about health services and healthy lifestyles. In particular they think that health and beauty students may be interested in helping to deliver this information whilst practising elements of their course. They hope to hold more health and wellbeing events, with more of a targeted audience

Lessons Learned: A 'one-size' service does not fit all. Instead, reach out to specific groups and understand their barriers to accessing services.

3.2.2 Prototype: Translation services in primary care (Hastings)

This prototype aims to resolve issues surrounding access to interpreting and translation services in primary care by creating a more streamlined way to contact general practice.

In the Innovation and Change Labs, people who couldn't speak English and their translators shared difficulties in communicating with their GP and booking appointments.

One major challenge faced by people who do not have English as their first language, was the absence of a booked interpreter for their appointments, which made it impossible for them to understand the GP. Translators also faced limitations in making appointments, as they could only contact one surgery at 8 am and book for only one person per day. Online booking systems required translators to hold too much personal information about clients.

To address these challenges, the prototype group proposed making available advance appointments specifically for patients needing translation services. They stressed the importance of improving knowledge about interpreter booking processes.

Although it was not possible to test any potential solutions during the prototyping period, the matter of interpreting and translation services has been raised within the Sussex Integrated Care Board (ICB). The ICB is actively working to address the challenges faced by people who do not have English as their first language and their translators.

Lessons Learned: Non-English speakers cannot access primary care without a translator. This adjustment needs to be provided for them to have equal access.

3.2.3 Prototype: Prompt delivery of prescriptions (Hastings)

This prototype aims to help people who do not have English as their first language to obtain their prescriptions in a timely manner by working with local pharmacies.

During our Innovation and Change Labs, local people who do not have English as their first language spoke about how they received very different levels of service from different pharmacies. When there were problems filling a prescription, or when a prescription was ready, pharmacies would attempt to contact people. However, some of these communications were not understandable to people who do not have English as their first language. Other pharmacies, meanwhile, were able to translate messages to patients.

Discussions with the local pharmaceutical committee identified two particular issues. Firstly, often the pharmacy is not informed about the language needs of the patient. Secondly, different pharmacies use different systems to communicate to patients. The systems that can translate messages are more expensive, and often are unaffordable to pharmacies.

This prototype are currently working with both the members of the local pharmaceutical committee and people who do not have English as their first language who have lived experience of these issues to find a solution to them.

Lessons Learned: It is possible to adjust pharmacy services for people who do not have English as their first language, and this should be required in future service contracts.

3.2.4 Prototype: Open access English classes for all (Hastings)

This prototype aims to empower people who do not have English as their first language to take control of their health by offering informal, flexible English classes that meet their needs. It recognises the findings that this group of people are not getting fair access.

Having to rely on translators or family members to help when using health and care services can be disempowering, and present a barrier to people using services. In particular women expressed embarrassment in accurately articulating their symptoms when their son or husband was serving as their translator. This prototype saw open access English classes as a solution.

They established informal, flexible classes, in a community hall, that are led by the community and their needs. This means that they are developing english language skills on issues that matter to the community. These classes have been championed by faith and community leaders, and some local translators are also recommending the classes to their clients. The venue and the structure of the classes is working well, but attendance remains low. They aim to increase attendance by with more promotion, supported by faith leaders.

This prototype has high hopes for the future, they see the opportunity for trainee GPs to roleplay appointments with the students, which will help students to understand how appointments work, as well as helping GPs to understand this groups' additional needs.

They hope to make the programme sustainable through 'pay-back' efforts of students returning to support new learners, and is to be fully led by the community themselves.

Lessons Learned: Take an asset-based approach to reaching out to 'easy to ignore' groups (also see Chapter 1.3). Support language learning for better healthcare access.

3.2.5 Prototype: Primary care for people with drug and alcohol dependency (Hastings)

This prototype aims to enable people with drug and alcohol dependency to access primary care. It did this by holding specialist clinics with a charity in order to build patients' trust.

People with drug and alcohol issues struggle to access general practice due to difficulties in scheduling appointments, fear of stigma, and lack of trust in healthcare professionals. Consequently, they delay seeking help, resulting in poor health outcomes for this group.

This prototype, developed with the East Sussex Recovery Alliance (ESRA), aims to address these challenges. They established a clinic at ESRA where a GP practice care coordinator provides individual meetings. Appointments are scheduled for 30 minutes from 10am to accommodate clients' lifestyles. Booking is facilitated by community organisations where the client has existing relationships.

The prototype has successfully helped individuals build trust, leading to a transition to mainstream GP services with just one or two appointments. However, some individuals still require more stability before benefiting from this approach. There are also challenges in accessing notes and GP support from practices outside the care coordinator's primary care network (PCN).

There were concerns by general practice that this was an additional service on top of a full list. It is not fair that people who can access the appointment system are the ones who get GP services. People who turn up frequently in general practice often have much more than the 30mins allocated in this prototype, but they take it in 10 minute slots. This requires a change in how general practice allocates its appointment time.

The prototype team is actively working on solutions and plans to expand their efforts to serve the entire Hastings area.

Lessons Learned: We often need to reach out to build a relationship in order to transition vulnerable people back into mainstream services.

3.3 Referenced in 1.3

'Make your own luck with the VCSE sector'



3.3.1 Prototype: Cervical Screening for Asian Ladies (Bradford)

This prototype aims to address inequalities in the uptake of cervical screening by GP practices through working with local VCSE organisations.

GP practices in Airedale and Keighley, Bradford noticed that Asian women were less likely to take-up cervical screening appointments than women of other ethnicities. They thought that local VCSE organisations, being more embedded in the community, may be able to help to explore the barriers to screening.

Modality Primary Care Network contacted Keighley Asian Women and Childrens Centre (KAWACC) and Highfields Community Association and arranged 20 community events around the local area, at various community and religious centres, a shopping centre, and a school. The events were led by a local GP and covered what to expect during bowel, breast, and cervical screening, and discussion of any worries.

KAWACC staff offered to translate both the sessions themselves, and the promotional material, into Bangala and Urdu. The VCSE organisations joined the GP practices in promoting the events.

In the sessions they learnt about cultural barriers facing their patients, and were able to debunk some myths. They are motivated to continue listening and learning, to offer more flexible access to screening, and invite people in ways that suit them.

Lessons Learned: Much of this was learning in the vaccine programme. Primary Care needs to work with community leaders to ensure everyone can access health screening, and health services. A one size fits all model of accessing primary care is discriminatory.

3.3.2 Prototype: Doorstep Wellbeing (Bradford)

This prototype aims to meet social and emotional needs of individuals by providing community activities and support at neighbourhood level.

After seeing the data about social need driving primary care use (see [Chapter 1.1](#)), this prototype wondered how they could meet need locally to reduce pressure on primary care. They specifically targeted two communities in more deprived areas, where residents have to travel longer to visit a GP or A&E.

Through surveys, they identified key reasons for visiting GPs, including: a need for basic medication (e.g. calpol), services that could be provided closer to home (e.g. blood pressure checks, pain management) and particularly for mental health support.

They trialled activities such as yoga, pain management and a 'zen den' programme for children. Creating a warm space with food and activities initially attracts people, and as they get involved, they build positive relationships, feel secure, and trust familiar faces, leading to people using services more, and benefitting from them more too.

They are working towards setting up a community centre as a central hub for services, but they also understand the significance of outreach, telephone support, and flexible service hours to meet the needs of the local community.

Lessons Learned: Some demand for general practice can be met by the community itself with support from the VCSE sector and the NHS. Primary Care needs to collaborate locally to move basic health checks into communities, and help communities help themselves self-manage where they can. We must not over medicalise health needs.

3.3.3 System Change: Securing a sustainable funding model for VCSEs (Hastings)

This system change explored the importance of a strong and resilient VCSE sector for the NHS. It explored how the NHS could support the VCSE sector to be sustainable.

West Yorkshire ICS and in particular Leeds health system have been working on a model of developing a resilient VCSE sector for some years. Seminars were provided by Leeds to share their learning and you can find a video of this [here](#).

There are two things that make a real difference:

1. The NHS Funds a coordinating post to be the interface between the VCSE organisations that offer services related to meeting health needs
2. The NHS provides longer term contracts taking the risk within the NHS rather than within the small VCSE organisations.

We also investigated the Torbay experience using the VCSE sector as the front door of the NHS, which has real potential for better meeting needs. If you read the examples in the prototypes, many of them are testing the VCSE can meet needs before people get to a GP. The Torbay model of 'One call, that's all' is a step towards bringing this approach into the organisational design of healthcare (see [Chapter 2.6](#)).

Lessons Learned: VCSEs need at least medium-term funding that covers all service-related costs. This needs strong political support and effective partnerships between the public and VCSE sectors, to foster a culture of collaboration.

3.3.4 Prototype: "No wrong door" for service users (Hastings)

This prototype aims to enable patients to get the support they need no matter which organisation they first approach. It does this by improving data sharing processes.

This prototype builds on two central ideas: firstly, that the community are better placed than primary care to deal with people's social needs (see [Chapter 1.3](#)); and secondly, that 'signposting' – recommending that people contact another organisation – does not work well. Signposting means that people often have to repeat their needs to each organisation, and there is little support for people moving between services.

This prototype seeks to shift the 'front door' for health and wellbeing support to community organisations, who will triage people. Their new digital data sharing 'referral' system means people's data can be securely sent between organisations, avoiding the issues with signposting.

They have tested a simplified version of the referral system with members of the Hastings Community Network. They learnt that in particular with the local Citizens Advice service, it was very effective for triaging and allocating clients to the right teams to get the help they need, and it helped them to meet GDPR requirements.

They are recruiting more organisations: local charities, a food bank, 1 primary care network, and the local authority to test more elements, and are setting up focus groups to ensure that feedback from residents, service users, public sector, and community organisations is built into the solution.

Lessons Learned: Sort data sharing so that your community can help you.

3.4 Referenced in 1.4 'Invest in children and young people'



3.4.1 Children and young people friendly GP practices (Hastings)

This prototype aims to improve access to GP practices for children and young people by setting up a weekend clinic, and gathering feedback from young people themselves.

Young people are accessing primary care less than other age groups, and attend A&E more frequently. This prototype understood that this is because the primary care system, as it is currently set-up does not meet the needs of young people.

To overcome this issue, the prototype team worked with Hastings and Rother Healthcare primary care network and Harold Road GP Surgery to set up children and young people focussed clinics on a Saturday, as young people may find weekdays challenging to attend. They did this using money from the additional roles reimbursement scheme.

They are working with Young Healthwatch so that young people can undertake Fifteen Steps Challenge visits (NHS England Public Participation Team, 2017) to five local GP surgeries (including those offering young people's clinics) and gather their feedback on how accessible they feel accessing GP practices are, and to give recommendations on any changes that would make them more accessible for children and young people. They will then arrange to revisit the practices to see the impact of the feedback.

Lessons Learned: Investigate who gets access to general practice specifically checking out children and young people. Ask the question – is this fair? Collaborate with young people and schools to design primary care services to meet needs.

3.4.2 Mental health crisis support for young people (Bradford)

This prototype aims to improve the experience of young people in mental health crises by building links between A&E staff, mental health safe spaces, and the VCSE sector.

With demand for mental health support for children and young people vastly exceeding capacity, they were noticing more young people coming to A&E in a mental health crisis. This prototype aimed to increase use of mental health safe spaces, where a young person can receive same-day support within the community. The safe space would work with the young person to identify what they need and want, and facilitate a transfer to A&E as needed.

This was achieved by offering a three hour training session for A&E staff on the safe spaces and other mental health support available in the VCSE sector. They worked with the trust to arrange cover for the staff whilst they were doing the training.

They also worked with local A&E departments and the police to review their standard operating procedures to bring them in line with the prototype approach.

Lessons Learned: We need to take a whole system approach to find ways to meet children and young people's mental health needs.

3.4.3 Growing our own Health Professionals (Hastings)

This prototype aims to inspire young people from deprived communities to pursue health and social care careers by running an events series in primary schools.

Fewer people from deprived communities are employed in health and social care. They hope that speaking to children and their families at primary school age, and that exposure to health and care professionals informally, and providing ongoing support and mentoring can raise aspirations.

They will start by working with two schools, The Baird and Hollington in Hastings. They will hold an introductory assembly where four health and social care professionals will present. A following series of 5–6 sessions will explore an array of different career options. Finally, there will also be a session for parents, and the opportunity to share the findings with health professionals and school staff.

They have spoken with school headteachers and confirmed that their prototype is expected to be viable and impactful. They have also spoken to junior doctors to confirm their assumptions on what the barriers are for people from deprived backgrounds joining the sector. They hope to continue to work with the students that they meet, in the longer term to continue raising aspirations and addressing structural barriers to entering health and social care professions.

Lessons Learned: In a workforce crisis, where communities are in poverty, the NHS as an anchor organisation can provide a route to better health.



3.5 Referenced in 1.5 'Fund primary care based on need'

3.5.1 System Inquiry: Fair Funding for Primary Care

This inquiry aimed to understand how best to secure fair funding for primary care, given the bias in the national funding model, and our intelligence that showed GP practices in poorer communities provide less access.

The 2004 Carr Hill formula – which allocates funding for practices – emphasises age of the patient population rather than the practice's deprivation levels. There are fewer primary care professionals working in poorer communities. There is less access. Those practices get less money.

There are less GPs and less appointments in practices in poorer communities

Whilst places had used discretionary funding to 'level up' this was an opportunity to review how to ensure primary care is fair for all. Sussex and West Yorkshire worked with the NHS Leicester team to better understand how to address this issue, given the national funding model is not changing to address these inequalities.

The inquiry lead us to these conclusions:

1. Primary care funding should be based on need. At the moment there is little understanding of need in primary care, all we have is data on access to appointments (this is a partial view of demand) and patient satisfaction with general practices. We need a data model to understand need and build the primary care model from that, including funding. People who do not have English as their first language require significantly more funding to meet their needs and any formula needs to address this.

2. Primary Care funding should not be redistributed between primary care allocations. It is likely that poorer communities are significantly underfunded, but wealthier communities are not therefore over funded. Any redistribution has to come from across the whole system, not from within primary care only. Fairness should be the starting point.
3. Any solution needs to be owned by all members of the primary care system, and should develop trust between members.
4. Coding is critical and general practice at the moment is not coding accurately enough, this means any formula needs a coding adjustment.

There are other ICS exploring the same issue.

Our next step is to investigate appetite nationally to support the development of a needs based model for understanding primary care needs, the design and funding of a primary care model that meets needs

Lessons Learned: Start with need. Adjust clinical need for social context, and for the impact of inequalities. Don't shuffle money around in primary care, but take a whole place/whole system approach to securing a robust front door to the NHS

SECTION 4:**LITERATURE
REVIEW**

Overview

A rapid synthesis of the literature was carried out. This did not include literature already utilised to develop the Universal Healthcare Propositions. Key themes from the literature are explored here, namely addressing social factors in primary care, involving communities, children and young people, resourcing mental health services, along with the rationale and features of a national universal healthcare inquiry. The rationale and approach to the literature review are outlined, followed by key thematic findings and discussion with implications for practice. The literature review concludes that there is a strong rationale for open and transparent co-production approaches to tackling universal healthcare challenges, and that a national inquiry could play a key role in improving the fairness in health provision in England.

Rationale

This literature review was undertaken to provide a context and a rationale for undertaking a national inquiry into universal healthcare challenges. It serves to provide an evidence-base for creating momentum in bringing current research into the discussion exploring innovative approaches in reimagining services. The aim of the review was not to duplicate comprehensive literature reviews into universal healthcare opportunities and challenges written elsewhere (e.g. Rashford, 2007; Abihiro & De Allegri, 2015; Endamalaw, 2022), but rather to identify the peer-reviewed evidence towards challenging entrenched ideas surrounding universal healthcare provision, as well as to capture mechanisms for change-making. Literature reviews are valid methods for creating new knowledge as they can give a general overview of a body of research and can highlight what has already been achieved within scholarship and practice, in order to prevent duplication (Cooper, 1988). Further, a literature review can enable one to place the research theme in a larger context in this case within the context of a national inquiry into universal healthcare.

Approach

A non-systematic rapid literature review method was applied, sourcing thematically-relevant peer-reviewed literature. Rapid reviews are often used by policymakers and recognised as providing opportunities for building an evidence-base within the time-constraints of health service delivery (Khangura et al., 2012). The aim of the rapid literature review was to locate peer-reviewed literature, editorials and reports and identify themes related to constraints, opportunities, and innovation in addressing universal healthcare challenges. The rapid literature review covered literature published since 2000 until June 2023. The author also drew on seminal and established literature in the field. Though the national inquiry takes an England focus, international sources in the English language, including comparative examples of practice, were included in the review to widen the pool of transferable learning to the present programme of work.

The literature was sourced electronically. An electronic literature search is a process identifying in specific terms what information is needed, selecting appropriate databases, and retrieving the literature sources related to the area of interest (Kilby & McAlindon, 1992). An electronic academic literature database search of MEDLINE, Scopus, Web of Science and Google Scholar was conducted utilising various groupings of the following search terms:

- Health
- NHS
- Primary care
- Determinants of health
- Inequalities
- Community involvement
- Syndemics
- Universal healthcare
- National inquiry
- Co-production
- Community assets

- Quality improvement
- Mental health
- NHS reform
- General practice
- Deprivation
- Social
- Movement
- Transformation
- Integration
- England
- Healthcare coverage
- Innovation
- Sustainability
- Access
- Workforce

Papers were selected on the basis of their thematic relevance to the universal healthcare networks programme. The key concerns of the papers selected are synthesised thematically in the present rapid literature review, drawing on the similarities and differences between and across the selected sources in line with key concerns of the universal healthcare networks programme. Thematic analysis is seen to offer an accessible and flexible approach to analysing data (e.g. Braun & Clarke, 2006), in this case a framework was used to search for patterns and overarching themes.

Findings

The literature reviewed is synthesised within thematic categories, pertaining to key topics and areas of concern in addressing universal healthcare challenges.

The thematic categories are as follows:

- Addressing social need in primary care
- Recognising assets in the community
- Children and young people as partners
- Resourcing mental health services
- The role of a national inquiry

Addressing social need in primary care

Overwhelmingly, the literature indicates that primary care cannot adequately meet community needs without attending to social determinants and aspects of health. Evidence from the literature has demonstrated that social determinants, such as socioeconomic factors, play a fundamental role in shaping health outcomes (e.g., Taylor et al., 2016). These determinants include factors such as income, wealth, education, and neighbourhood characteristics (Braveman & Gottlieb, 2014). Addressing social determinants of health is crucial for achieving health equity. The Commission on Social Determinants of Health, a global collaboration of policymakers, researchers, and civil society, was established to promote health equity and foster a global movement to achieve it and their final report underlined the importance of addressing social determinants in order to close the gap in health disparities (Marmot et al., 2008). By considering social aspects of health, primary care can contribute to reducing health inequities and improving overall population health.

Kordowicz & Hack-Polay (2020) echoed the need to recognise social determinants of health and explored how syndemics^[1] frameworks examine the interaction of diseases with the social, environmental and economic factors that mitigate disease. A syndemics lens to understanding health and health disparities can help reduce health inequalities (The Lancet, 2017). For instance, there is evidence that minorities and socio-economically disadvantaged groups have multiple coexisting underlying conditions which place them in the high-risk categories with regards to mortality. Adler and Newman (2002), document how individuals with lower socioeconomic status are more likely to experience higher rates of chronic diseases, such as cardiovascular disease and diabetes.

Further, they argued that socioeconomic disparities in health can be attributed to various pathways, including limited access to healthcare, environmental exposure, and health behaviours. As it is well-known that health inequalities are linked to the unequal encounter with socio-economic determinants,

the syndemics approach supports action on such determinants in the form of public health education, community engagement and early intervention (Bambra et al., 2020). Therefore, primary care must attend to social aspects of health to address the underlying causes of health disparities and provide holistic and effective care.

There are a number of well-documented challenges facing NHS primary care, affecting its capacity to address social determinants of health. GPs face heavy workloads and high demand for their services, alongside a policy focus on 10 minute appointments, leading to difficulties in providing comprehensive care. Furthermore, GPs in the NHS are reported as having a low morale and low job satisfaction (e.g., Owen et al., 2019). A cross-sectional study of GP workload in 33 countries by Schäfer and colleagues (2020), found that patients of GPs who are happier with their work were found to experience better communication, continuity, access, and comprehensiveness of care. A longer GP consultation was associated with less stress from the GP and was more likely to lead to the patient experiencing more comprehensive care. However, the average GP appointment time in England pre COVID-19 pandemic was 9.2 minutes, with a Royal College of General Practitioners recognising that 15-minute appointments would be more advantageous to both GP and patient (Salisbury, 2019). Length of consultation is shorter in practices in poorer areas (Stirling et al 2001). Increased consultation time for complex needs is associated with higher patient enablement and quality (Mercer 2007, (There is also a shortage of GPs across England, with ongoing workforce planning issues of poor recruitment and retention (Marchand & Peckham, 2017). In this vein, Friebe and colleagues (2018) in their reflections on the NHS at identified the need to develop a 'coherent strategy to improve quality, to boost public health as a measure to reduce disease burden, to adopt evidence-based priority setting methods that ensure efficient spending of financial resources (...) and to allow for task-shifting, specifically in regions where staff retention is low.' The latter is part of the rationale that underpins the Additional Roles Reimbursement

Scheme (ARRS) bringing a wide range of professionals and skills into general practice.

Notably, challenges of providing general practice in poorer communities in England are evident from the literature review. Access to healthcare is a complex issue influenced by multiple factors, including socioeconomic status, geography, and social vulnerability according to a study of healthcare access during the COVID-19 pandemic (Roy & Kar, 2022). Poorer communities often face barriers to accessing healthcare services, leading to health inequities and disparities (Heaslip et al., 2022). These challenges are no doubt further exacerbated by limited resources and funding in these communities. Individuals from poorer communities may face financial constraints, lack of transportation, and limited health literacy, which can hinder their ability to access and utilise general practice services, and variation in prescribing (Heaslip et al., 2022; Wang et al., 2009). These barriers can contribute to delayed or inadequate healthcare, leading to poorer health outcomes (Heaslip et al., 2022; Parsons et al., 2018).

Geographical factors also pose challenges in providing general practice in poorer communities. In rural, coastal or remote areas, there may be limited availability of healthcare services and trained specialist professionals, resulting in reduced access to primary care services (Roy & Kar, 2022). This geographic disparity in healthcare access further exacerbates health inequalities, as individuals in these communities may have to travel long distances to access general practice services (Roy & Kar, 2022).

Moreover, social vulnerability plays a significant role in healthcare access. Vulnerable populations, such as individuals with intellectual disabilities or those in the care system, may face additional barriers to accessing general practice services (Parsons et al., 2018; Alexander et al., 2020). These populations, such as looked after children, are more likely to require tailored and specialised care, which may not always be readily available or adequately resourced in poorer communities (Parsons et al., 2018; Alexander et al., 2020).

The literature suggests that limited resources and service variation in poorer communities present a significant challenge in providing general practice services. Practices in these areas may struggle to attract and retain healthcare professionals, resulting in workforce shortages (Saghy & Ozieranski, 2021). Additionally, limited financial resources may hinder the implementation of necessary infrastructure, technology, and support systems in general practice settings. Therefore, addressing these challenges requires targeted and tailored (rather than 'one-size-fits-all' interventions), such as increasing access to healthcare services, improving transportation options, enhancing health literacy, and allocating adequate resources to support general practice in socio-economically deprived communities.

With the move to increased integration between health and social care services and providers in England, issues with data-sharing may further exacerbate problems with the delivery of holistic, quality care. Patients often speak of the burden of having to retell their stories to multiple healthcare professionals working within the same system (e.g. Healthwatch Surrey, 2017). Indeed, it is widely reported that the implementation of nationwide electronic health records in primary care has been time-consuming and challenging, with limited discernible benefits for clinicians and patients according to Sheikh and others (2011). Delays, unrealistic expectations, and changing NHS policies had hampered progress in 12 early adopter sites studied longitudinally by Sheikh and colleagues over a 2.5-year period. In addition, patients have expressed concerns about the lack of transparency and awareness regarding the use of their data, making it difficult to secure public trust in shared records systems, though they generally voice support for sharing their records for research purposes in particular (Spencer et al., 2016).

However, implementing electronic systems for data sharing poses technological, operational and infrastructural challenges, including supporting patients with limited access to technology and tackling digital poverty (Holmes & Burgess, 2022).

Therefore, data sharing in primary care in England faces challenges related to implementation, trust, transparency, patient perspectives, and technological considerations. Patient involvement, clear communication, and the use of user-friendly systems are important for successful implementation and engagement in data sharing efforts with the move to integrated care and more joined-up, holistic care.

Recognising assets in the community

Within a rapid ethnographic study by Kordowicz & Hack-Polay (2021) conducted in Lambeth and Southwark in South East London, community assets were discussed by community interview participants as providing rich opportunities to deliver a more holistic approach in terms of addressing socio-psychological factors, outside of, or even beyond the biomedical model, driven by bottom-up needs and motivations. Furthermore, it was felt by the interviewees that community assets have an important part to play in providing holistic physical and mental health support.

It is well documented that recognising and leveraging the resources and assets within communities is important for promoting health and well-being (Munford et al., 2020). Community and voluntary organisations play a significant role in tackling universal healthcare challenges. These organisations often work in collaboration with statutory services and healthcare providers to improve holistic and coordinated healthcare, reduce inequalities, and address specific healthcare needs within communities (Bell et al., 2022). A study of mass anti-malarial administrations, for example, found that community engagement activities, when involving government and local community structures, can lead to high population healthcare coverage rates (Adhikari et al., 2016). Community-based health promotion activities can help spread fact-based awareness, understanding, and acceptance of healthcare interventions, promoting increased participation and adherence.

One key aspect of community and voluntary organisations' role is community engagement. Community engagement involves actively involving community members, including service users, their families, and community organisations, in decision-making processes related to healthcare planning, delivery, and evaluation. This engagement helps ensure that healthcare services are responsive to the needs and preferences of the local population. Community engagement activities can include employing community members, providing health education, and collaborating with local community structures (Adhikari et al., 2016). However, community sector engagement needs to be mutually beneficial, ensuring that it does not place an undue resource strain on voluntary organisations (Kordowicz & Hack-Polay, 2021).

Furthermore, community and voluntary organisations often provide more flexible and tailored approaches to healthcare compared to statutory healthcare services. They can offer opportunities for developing specialised healthcare services that address the unique needs of specific populations, such as the homeless community (Bell et al., 2022). Community assets can therefore bridge gaps by providing services that are accessible, culturally sensitive, and responsive to the specific challenges faced by marginalised groups, including social challenges.

The literature therefore suggests that it is vital to strengthen the collaboration and partnership between community and voluntary organisations and statutory services. This can involve establishing multi-agency partnerships that promote information sharing, resource allocation, and joint planning and decision-making processes (Bell et al., 2022) and thus leveraging the strengths of each of the partner organisations and their users. For instance, several papers identified in the present review explored the utility of integrated community support around a specific chronic condition, in particular addiction and mental illness (White, 2009). Wilson and colleagues (2005) made a compelling case for the role of community resources in the management of multimorbidity, stating that 'communities and

voluntary organisations often contain the necessary energy and enthusiasm to make a difference. This can have dramatic effects on a whole community, improving a range of measures, including the care of long-term conditions'. In line with this, DeHaven (2017) argued for community-embedded resources which address the needs of the patient within the context of their multimorbidity experience.

Community engagement and action can also take the form of social movements, which can play a significant role in making change in health services. It has been well documented that social movements and the pressure of civil society have been instrumental in advocating for health equity and addressing social determinants of health (Baum & Fisher, 2014). They draw attention to the structural factors that contribute to health disparities and work towards creating more equitable healthcare systems. From their qualitative study of the adoption of social movement strategies in the implementation of a quality improvement campaign, Waring and Crompton (2017) concluded that social movements have the power to shape health policies and practices by raising awareness, mobilising public support, and advocating for change. They have been successful in driving reforms, such as campaigns for universal healthcare and the promotion of services for marginalised groups.

Social movements can empower communities by giving them a collective voice and platform to advocate for their health needs. Lehrner and Allen (2009) identified that they provide opportunities for affected and often disadvantaged individuals and communities to come together, share experiences, and collectively work towards improving health outcomes. Social movements can therefore challenge dominant narratives and power structures and asymmetries within the healthcare system. They can bring attention to marginalised voices and perspectives, challenging existing norms and advocating for more inclusive and patient-centred approaches to healthcare (Waring & Crompton, 2017).

In the vein of a national universal healthcare inquiry, it is worth noting that social movements can mobilise resources, both human and financial, to support their advocacy efforts. This is achieved by engaging volunteers, activists, and organisations to contribute their time, expertise, and resources to advance their cause and emotional aspects are core to this (Mackenzie, 2022). The social movement approach to making the most of community assets as part of a universal healthcare inquiry can help collaboration and co-production with key professionalised stakeholders within the system, including healthcare professionals, researchers, and policymakers, to drive change (Waring & Crompton, 2017). This can help build new networked alliances and partnerships to amplify their impact and create a collective force for transformation in the health system.

However, it is important to note that social movements may face challenges in sustaining momentum, maintaining inclusivity, and navigating power dynamics and processes within the healthcare system (Waring & Crompton, 2017). The translation of community co-production and social movement strategies into healthcare improvement initiatives can therefore be complex and may require careful consideration of varying and at times competing stakeholder agendas.

Children and young people as partners

The literature reviewed underlines how children and young people can play a crucial role in health service planning as their perspectives and experiences are essential for developing effective and responsive healthcare services. Involving children and young people in the planning and development of health services ensures that their unique needs, preferences, and concerns are taken into account, leading to more tailored and appropriate healthcare interventions (e.g. Hall et al., 2013; Green et al., 2013).

Research has demonstrated that children and young people possess valuable insights and perspectives on their own health and healthcare experiences. For instance, a study on cleft lip and/or palate

found that involving children and adolescents in the planning, delivery, and evaluation of services is advocated by policies such as the U.K.'s National Service Framework for Children, Young People, and Maternity Services (Hall et al., 2013). By actively involving children and young people, healthcare services can be designed to meet their specific needs and preferences, resulting in improved outcomes and patient satisfaction.

Involving children and young people in health service planning can be achieved through various strategies. One approach is to create opportunities for children and young people to participate in decision-making processes, such as involving them in advisory groups, focus groups, or consultations (Day, 2008). This allows them to share their experiences, voice their opinions, and contribute to the development of healthcare policies and services. Additionally, utilising child-centred research methods can help ensure that children and young people are active participants in the research process. This involves recognising children as experts on their own lives and involving them in research activities, such as interviews, surveys, or participatory workshops (Hall et al., 2013).

However, it is important to acknowledge that involving children and young people in health service planning requires careful consideration of ethical and practical considerations. Researchers and healthcare professionals must ensure that the involvement of children and young people is done in a safe and supportive manner, respecting their rights and privacy (Jansen et al., 2019). Additionally, appropriate methods and tools should be used to facilitate meaningful participation and ensure that the voices of children and young people are heard and valued (Oliver et al., 2019).

Based on the sourced references, it is evident that children's voices are underrepresented in the NHS. For instance, children's voices are often excluded or marginalised in healthcare decision-making processes and they are not adequately involved in discussions and planning related to their own

healthcare experiences and needs. It is important to note that adults, including healthcare professionals and parents, play a significant role in determining whether children's efforts to participate are facilitated and supported in healthcare settings (Coyne & Gallagher, 2011). It may be that some adults could have reservations or concerns about children's participation, leading to their exclusion from decision-making processes. Further compounding the problem of the lack of representation of children and young people in health planning efforts, there is an absence of clear guidelines in how to involve them. Coyne and Gallagher (2011) further argue that establishing guidelines that support and encourage children's participation is crucial for ensuring their inclusion.

Resourcing mental health services

Mental health services in England face several key and entrenched problems which highlight the need for better resourcing. Firstly, there is a significant disparity in access to mental health services, with certain groups facing greater barriers. The "Ten Years On" Marmot Review highlighted the increase of health inequalities in England, indicating that the situation has become worse over the past decade (Marmot, 2020). The Review indicated that marginalised populations, such as those from lower socio-economic backgrounds, often have limited access to mental health services, exacerbating existing health disparities.

Language barriers and cultural interpretations of mental health also pose challenges to accessing and utilising mental health services, particularly for immigrants and refugees. Indeed, a study on access and utilisation of mental health services for immigrants and refugees identified language barriers, cultural interpretations of mental health, stigma around mental illness, and fear of negative repercussions as significant barriers (Salami et al., 2018). These factors can prevent individuals from seeking help and receiving appropriate care, and build mistrust between service users and healthcare professionals.

Additionally, the COVID-19 pandemic has exacerbated mental health issues globally, including in England. The pandemic has led to an increase in depression, loneliness, and distress, which has placed additional strain on mental health services (Anindyajati et al., 2022). The increased demand for mental health support highlights the need for appropriate resourcing to meet the growing needs of the population in the pandemic recovery landscape.

Quality improvement and community engagement, as well as service user involvement, are crucial aspects of mental health services. Involving patients in the planning and development of healthcare has been recognised as an effective strategy to improve the quality and accessibility of services (Crawford et al., 2002). Research has shown that involving patients and service users in the planning and development of healthcare leads to positive outcomes. A systematic review by Crawford et al. (2002) found that involving patients in healthcare decision-making resulted in improved patient satisfaction, increased adherence to treatment plans, and better health outcomes (Crawford et al., 2002). Community engagement therefore plays a vital role in mental health services as it helps to ensure that services are responsive to the needs and preferences of the local population. By actively involving community members, including service users, their families, and community organisations, mental health services can gain valuable insights and perspectives that can inform service planning, delivery, and evaluation. Arguably, this can lead to the development of more culturally sensitive and tailored services that better meet the needs of the community.

The role of a national inquiry

A national inquiry into universal healthcare in England can be deemed necessary for several reasons. An inquiry can identify the gaps in healthcare access resources and help develop strategies to address these challenges. This can include improving healthcare infrastructure in socio-economically deprived areas and increasing the number of

trained primary care healthcare professionals. It could therefore be argued that by examining the existing healthcare system and its impact on different population groups, a national inquiry can identify and implement measures to ensure equitable access to healthcare for all. No literature directly exploring the rationale for, and potential impact of a national inquiry was identified in the present review. However, suggested high level elements for an inquiry are rooted in relevant sources discovered as part of the electronic search.

The steps of a national inquiry into universal healthcare should include a comprehensive assessment of the current healthcare system, including the availability and accessibility of healthcare services, the quality of care provided, and the resource burden on individuals and the system (Binyaruka et al., 2021). Additionally, the national inquiry should involve stakeholders from various sectors, including healthcare professionals, policymakers, researchers, and expert by experience advocacy groups. This will ensure that different perspectives are considered and that the recommendations and findings of the inquiry are comprehensive and representative of the needs and concerns of the population, the benefits of which are well documented (Detwiller & Petillion, 2014).

To ensure that a national inquiry has the most impact, it is important to disseminate the findings widely and engage with key decision-makers and stakeholders to translate knowledge into practice (Straus et al., 2013). The inquiry should produce a detailed report outlining its findings, recommendations, and proposed strategies for improving universal healthcare in England. This report should be shared with relevant government agencies, healthcare organisations, and policymakers to inform policy and decision-making processes. Furthermore, ongoing monitoring and evaluation should be conducted to assess the implementation of the recommendations and track progress (Reeve et al., 2015). This can involve regular reporting on key indicators, such as healthcare access, quality of care, resourcing, and making adjustments to strategies and interventions as needed.

Discussion

The key themes stemming from the synthesis of the literature are discussed in turn, pointing towards central considerations for a universal healthcare national inquiry.

Addressing social determinants of health in primary care

Primary care and general practice in England must consider social determinants of health due to their significant impact on individuals' well-being and health outcomes. Social determinants of health refer to the conditions in which people are born, live, learn, and work, including factors such as income, education, employment, housing, and social support. Indeed, a study from the field of ophthalmology found that social factors have a profound influence on health outcomes, often surpassing the impact of biological and clinical factors (Williams & Sahel, 2022). The authors argued that addressing social determinants of health in primary care is crucial for several reasons. Firstly, social determinants have been identified as major contributors to health inequities and disparities. Individuals from disadvantaged backgrounds or marginalised communities often face greater challenges in accessing healthcare services and experience poorer health outcomes. By considering social determinants, primary care can play a vital role in reducing health inequalities and promoting health equity.

Secondly, social determinants of health have a significant impact on the development and management of various health conditions. For example, socioeconomic factors such as income and education can influence individuals' ability to adopt healthy behaviours, access preventive care, and manage chronic conditions effectively. By addressing social determinants, primary care can support patients in making positive lifestyle changes, accessing appropriate healthcare services, and improving their overall health outcomes.

Furthermore, primary care is well-positioned to identify and address social determinants of health due to its continuous and comprehensive approach

to patient care. Primary care providers have ongoing relationships with patients and are often aware of their social circumstances and needs. By incorporating social determinants into their assessments and care plans through appropriate toolkits, primary care providers can provide holistic and patient-centred care which addresses the broader determinants of health (LaForge et al., 2018).

However, there are challenges in integrating social determinants of health into primary care practice. In a study of nurses' perspectives, time constraints, lack of provider self-efficacy, and unfamiliarity with available community resources have been identified as barriers to addressing social determinants (Phillips et al., 2020). Additionally, drawing on a study of social prescribing, Islam (2020) argued that the biomedical model of care, which traditionally focuses on the diagnosis and treatment of diseases, may not fully recognise the importance of social determinants in health outcomes. Overcoming these challenges requires training and support for primary care providers, collaboration with community organisations, and the development of joined up referral pathways and networks to connect patients with appropriate social support services (Williams & Sahel, 2022).

The opportunities of co-production and community involvement

A key theme resulting from the literature review highlights the importance of co-producing health service transformation in England with communities. The literature emphasises the need to move beyond traditional models of knowledge translation and engage in more creative and critical ways of researching the link between knowledge and practice (Greenhalgh & Wieringa, 2011). This includes recognising the value of practical wisdom (phronesis) and tacit knowledge built and shared among practitioners (Greenhalgh & Wieringa, 2011). It is argued that co-production with communities can facilitate the integration of diverse knowledge and perspectives, leading to more effective and sustainable health service transformation.

Drawn from a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups, the concept of candidacy, which describes how people's eligibility for healthcare is determined between themselves and health services, highlights the importance of involving communities in health service planning and decision-making (Dixon-Woods et al., 2006). Communities possess valuable insights into their own health needs, preferences, and experiences, which can inform the design and delivery of services. Co-production ensures that services are responsive to the specific needs and contexts of the communities they serve.

Furthermore, a study of vaccine hesitancy among ethnic minority groups, highlighted how involving communities in health service transformation can help address health disparities and promote health equity. Vulnerable and marginalised groups often face barriers to accessing healthcare and experience poorer health outcomes (Gardiner et al., 2021). Co-production can help identify and address these barriers, ensuring that services are accessible, culturally sensitive, and tailored to the needs of diverse populations.

The literature also highlights the importance of community organisations and harnessing community assets in understanding and tackling health disparities (Gardiner et al., 2021). These organisations have a deep understanding of the communities they serve and can provide valuable insights into the social determinants of health and the specific challenges faced by different populations. Co-production with community organisations can help identify and leverage community assets, resources, and strengths to drive health service transformation.

However, there are challenges to co-producing health service transformation with communities, as well as to harnessing the power of social movements in community engagement. Power asymmetries, unequal representation, and limited resources can hinder meaningful community engagement (Martin et al., 2017). As part of the national inquiry into universal healthcare, it is essential to ensure that community voices are heard and valued, and that power is shared in decision-making processes. It is clear from

the synthesis of the literature that building trust, fostering collaboration, and providing adequate support and resources are crucial for successful co-production as part of the universal healthcare national inquiry.

Partnering with children and young people in systems transformation

Based on the literature review, there are several reasons why children and young people should be treated as partners in health planning and design. Involving children and young people in health planning and design ensures that services are tailored to their specific needs, preferences, and experiences (Rouncefield-Swales et al., 2021). Their input can provide valuable insights into their unique perspectives, enabling the development of more relevant and effective healthcare interventions (Gaillard et al., 2018). By treating children and young people as partners, they are empowered to take an active role in decisions that affect their health and well-being (Gaillard et al., 2018). This promotes a sense of ownership and engagement, leading to increased motivation and participation in their own healthcare (Rouncefield-Swales et al., 2021). A study from the field of urban design argued that engaging children and young people in planning and design provides opportunities for learning and skill development (Rudner, 2017). According to Gaillard and colleagues (2018), involving children and young people in health research can enhance their understanding of healthcare systems, research processes, and decision-making, empowering them to become informed advocates for their own health and the health of their peers.

Notably, it has been demonstrated that co-designing healthcare services with children and young people can lead to improvements in service quality and outcomes (Brett et al., 2012). Their involvement, including in public health research, can help identify areas for improvement, highlight potential barriers to access, and contribute to the development of innovative solutions. Crucially, partnering with children and young people in health planning and design aligns with ethical principles of inclusivity and

respect for their rights. True involvement recognises the agency of children and young people and ensures that their voices are heard and valued in decision-making processes and in policymaking to promote improved health outcomes (Rouncefield-Swales et al., 2021).

However, it is important to acknowledge the challenges associated with involving children and young people in health systems planning design. Recognition of barriers and opportunities helps achieve meaningful participation, addressing power imbalances, providing appropriate support and resources, and considering the diverse needs and capacities of children and young people (Rouncefield-Swales et al., 2021). Overcoming these challenges as part of the tackling universal healthcare challenges requires a commitment to inclusive and participatory approaches, as well as ongoing collaboration and communication with children, young people, their families and carers, and relevant stakeholders.

The mental health crisis

The present literature review highlights the need for mental health services in England to be fully resourced. The literature provides evidence of the detrimental impact of waiting times on patient outcomes in mental health services, particularly in the context of early intervention in psychosis services (Reichert & Jacobs, 2018). Longer waiting times were associated with a significant deterioration in patient outcomes, emphasising the importance of timely access to care. This suggests that earmarked resources are needed to reduce waiting times and improve patient outcomes.

However, the development of care pathways and packages in mental health based on the model of human occupation screening tool highlights the complexity of decision-making in mental health services (Lee et al., 2011). Mental health diagnoses alone are not sufficient indicators of the services individuals may need, emphasising the need for comprehensive and individualised approaches to care. Undoubtedly, adequate resources are

necessary to support the development and implementation of such personalised care pathways.

Furthermore, the literature reveals critical concerns about the disinvestment in mental health services in England since the economic recession in 2008. There have been substantial reductions in resources dedicated to mental health treatment and care, including decreases in social service expenditure and direct NHS expenditure according to a review of specialist mental health services in England in 2014 (Docherty & Thornicroft, 2015). These reductions in resources ran counter to the government's policy of "parity of esteem" for mental health, which aims to ensure equal priority and resources for mental health services compared to physical health services. Radfar and colleagues (2021) identified a worldwide emergency and mental health crisis since the COVID-19 pandemic.

Implications for Practice

There are several core implications for practice when considering the evidence from the literature, namely involving the community from the outset, gaining 'buy in' from senior systems leaders, and ensuring that inquiry is transparent and open. 'Practice' here denotes applied work to tackle universal healthcare challenges in an innovative and people-centred way. Efforts to address universal healthcare challenges require a multi-pronged approach involving healthcare providers, policymakers, community organisations, and society at large.

Involving the community from the outset

It is apparent from a review of the evidence that community participation should be central to change efforts. To involve communities from the outset in health transformation, there are several strategies from the literature that can be considered. Firstly, it is important to collaborate with community leaders, organisations, and grassroots movements to understand the specific health needs and priorities of the community. In their study of large-scale IT transformation in healthcare in the US, Lynch and colleagues (2013) concluded that involving

communities from the outset in the planning and design of health transformation initiatives to ensure their perspectives are incorporated from the beginning should be central to health improvement efforts.

In addition, another key aspect of community involvement could be recognising the benefit of initially conducting comprehensive needs assessments to identify the health challenges, gaps, and opportunities within the community and to understand where community engagement is likely to have most value to the communities themselves. In a study of Medicaid at 50 in the US, Shin and colleagues (2015) provide a number of ideas and tools for meaningful community engagement is systems transformation, including creating community advisory boards with diverse and inclusive membership, maintaining open and regular communication channels (making sure that the information provided is accessible, understandable and culturally appropriate and makes good use of technology), providing educational resources in the form of workshops and training, collaborating with preexisting community centred and assets to harness pre existing networks.

Gaining 'buy-in' from systems leaders

To make a sustainable change in health at scale, gaining buy-in from senior systems leaders is crucial. Senior systems leaders play a pivotal role in setting the direction, priorities, and vision for health transformation initiatives. Their commitment and support are essential for driving change and ensuring the allocation of necessary resources according to a study of NHS transformation in the North East of England (Erskine et al., 2013). Indeed, study of health information technology large-scale transformation in Finland, argued that senior systems leaders have the authority and influence to make decisions that impact the entire system and their support is crucial for overcoming resistance, navigating bureaucratic processes, and securing the necessary approvals and resources for change initiatives (Laukka et al., 2020). A study of health governance in the Caribbean indicates that systems leaders shape the organisational culture.

They can create an environment that supports and encourages innovation, collaboration, and continuous improvement and therefore their support is vital for fostering a culture of change and ensuring that change efforts are effectively managed and implemented (Greaves, 2017).

As systems leaders control the allocation of resources, including financial, human, and technological resources, their 'buy-in' is necessary for securing the resources needed to implement and sustain health transformation initiatives (Laukka et al., 2020). Therefore, the evidence from the literature review suggests that senior systems leaders have the ability to engage and collaborate with various stakeholders, including healthcare professionals, policymakers, and community organisations, drawing on their status and pre-established networks. Thus, their support is crucial for building partnerships, fostering collaboration, and aligning efforts towards the strategic goals of a universal healthcare inquiry.

The importance of openness and transparency

The reviewed literature indicates that openness, honesty, and transparency are central to health transformation. These core values foster trust, engage stakeholders, facilitate learning and improvement, enhance patient safety and quality of care, promote accountability and ethical conduct, and build public confidence. It can therefore be argued that by embracing these principles, the universal healthcare national programme can create a culture of transparency, collaboration, and continuous improvement in health systems, leading to more effective and patient-centred healthcare. In addition, given the importance of data sharing and interoperability highlighted earlier, openness, honesty, and transparency are crucial for building trust and ensuring public confidence in data sharing initiatives (Spencer et al., 2016).

Lessons from a cross-sectional study of pandemic responses in Iran (Zarei et al., 2021), conclude that the recognition that openness, honesty, and transparency in health systems fosters trust

between healthcare providers, policymakers, and the public. When information is openly shared and communicated honestly, it enhances credibility and promotes trust in the healthcare system itself. The authors argue that trust is the underpinning of effective collaboration, engagement, and cooperation in health transformation efforts. This is in line with the work of Dixon-Woods and colleagues (2013) in England, arguing that openness and transparency create opportunities for meaningful engagement and involvement of stakeholders in health transformation processes. By providing access to information, stakeholders can actively participate in decision-making, contribute their perspectives, and hold health systems accountable. This inclusive approach ensures that diverse voices are heard and considered in shaping health policies and practices.

Additionally, openness and a non-judgemental approach enable the identification of areas for improvement and learning from mistakes and by openly acknowledging and addressing shortcomings, health systems can foster a culture of continuous improvement and innovation. Dixon-Woods and colleagues (2013) posit that transparency in reporting outcomes and performance data can also allow for benchmarking and comparison, driving quality improvement efforts as part of the universal healthcare innovation work. Therefore, openness, honesty, and transparency hold health systems accountable to the communities they serve for their actions and decisions. Transparent governance structures and processes ensure that health systems operate ethically, with integrity, and in the best interest of the public (Prasetyorini, 2023) and have the potential to build public confidence (Zarei et al., 2020).

Why a national inquiry now?

Universal healthcare is designed to provide healthcare services to all citizens. However, the literature review demonstrates that still there are inequalities in access and outcomes for certain population groups. An inquiry can highlight these disparities and recommend measures to address them, assessing the efficiency and effectiveness of

the current universal healthcare system. For instance, a national inquiry could be a powerful means of investigating the funding mechanisms, sustainability, and cost-benefit analysis of health systems to ensure that resources are used optimally and equitably. Nonetheless, healthcare innovation remains multi-faceted and multi-factorial and therefore it is important to consider that sustained innovations are influenced by a variety of complex preconditions or factors (Fleischer et al., 2015).

It is clear from the literature review that with changes in demands and health needs, the system needs to evolve accordingly, and a focus of a national inquiry could be how the healthcare system needs to be tailored to meet these new demands. No doubt, studying and comparing healthcare systems in other countries can offer valuable insights into best practices, potential improvements, and innovative approaches that could be applied to the NHS and a future literature review with a specific comparative focus could elucidate this further. There are however some limitations to radical organisational change within the public sector. McNulty and Ferlie (2004) argued that change tends to be 'sedimented' and incremental, rather than transformational, and that networked organisational forms may be the mode of tackling intractable 'wicked' problems within the NHS (Ferlie, 2011). It is apparent that a national inquiry must actively involve the public, healthcare professionals, and stakeholders in networked discussions about and actions towards the future of the health system.

Conclusion

Addressing social determinants of health in primary care is a crucial aspect of healthcare delivery. This involves recognising and responding to the social factors that impact individuals' wellbeing and access to care. Recognising and leveraging the resources and assets within communities is important for promoting health and wellbeing, as well as for meaningful change to take place. Involving children and young people as partners in healthcare planning and decision-making is essential to ensure that services meet their unique needs and preferences.

Resourcing mental health services adequately ensures that individuals have timely and appropriate support for their mental health needs.

Conducting a national inquiry into universal healthcare challenges and exploring alternative approaches is central to assessing the current state of healthcare, identifying areas for improvement, and co-producing strategies to achieve change for the better. A national inquiry into universal healthcare in England is necessary to assess the current state of the healthcare system, identify areas for improvement, and develop strategies to ensure equitable access to quality healthcare. The steps of the inquiry should involve a comprehensive assessment of the reality of the healthcare system, co-production with communities and stakeholders, and a transparent dissemination of findings and recommendations. Ongoing monitoring and evaluation are crucial to ensure the impact of the inquiry and to track progress towards achieving a fair healthcare offer.

Overall, drawing on the evidence-base from the rapid synthesis of the literature, a national inquiry into universal healthcare in the NHS can be conceptualised as essential to improve and adapt the system to ensure that it remains fit for purpose at a time of high demands and resource scarcity. A national inquiry would be best informed by the principles of community involvement and openness. Evidence-based insights from such an inquiry are likely to inform significant policy decisions and shape the future of healthcare delivery in England.

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SECTION 5:**APPENDICES**

Appendix 1: The Universal Healthcare Network

The Universal Healthcare network is working with Sussex and West Yorkshire Integrated Care Systems and has established the Universal Healthcare Innovation and Change Labs to address the three propositions that 'design in' inequality.

Our Shared Purpose

To establish a collaborative programme of work to uncover the reality of inequalities and service provision, and to work through how best to secure services that are designed around health needs.

Our Key Roles

- 1. Amplify & Make Visible:** We amplify the issue by collectively making this issue visible, through this network and from the power of our own institutions.
- 2. Community-Building:** We are growing a community of interest around this issue.
- 3. Convening:** We convene a learning community at the level of place and nationally
- 4. Resourcing:** We have collaborated to a Change Lab method which has been actioned in two ICSSs

Universal Healthcare Network Members

- Adam Doyle – Chief Executive Officer NHS Sussex
- Alice Mathers, Dir Research at the RSA
- Becky Malby, Professor, Health Systems Innovation Lab, LSBU (Convener).
- Charlotte Augst, previously Chief Executive, National Voices.
- David Somekh, Network Director, European Health Futures Forum
- Des Holden, Chief of Innovation, Surrey and Sussex Healthcare NHS Trust.
- Fatima Elguenuni, mother, grandmother, community activist, mental health specialist, Grenfell community member.
- John Bryant, Head of Integration and Development, Adult Social Care and Partnerships, Torbay Council.
- Jonathan Seargent, Associate, Health Systems Innovation Lab, LSBU.
- Kamila Hawthorne, Professor of Primary Care, Swansea University.
- Mark Spencer, Mount View Practice, Fleetwood.
- Mathew Taylor, Chief Executive, NHS Confed
- Mitch Blair, Prof Public Health, Imperial College
- Nagina Javaid, Programme Director for Children, Young People & Families, Bradford District and Craven Health and Care Partnership
- Nick Downham, Cressbrook Limited, Associate Health Systems Innovation Lab, LSBU
- Nnenna Osuji, Chief Executive, North Middlesex University Hospital NHS Trust
- Ollie Hart, GP and Clinical Director Heeley Plus Primary Care Network, Sheffield.
- Prमित Patel, Lead PCN Clinical Director at Surrey Heartlands Integrated Care System.
- Rebecca Rosen, Senior Fellow, The Nuffield Trust
- Rob Webster, Lead Chief Executive of West Yorkshire and Harrogate ICS
- Rowan Munson, Research Associate, Health Systems Innovation Lab, LSBU
- Ruth Hannan, Transform Programme Manager, RSA.
- Samira Ben Omar, Community Organiser, Advisor on Community Collaborations
- Sarbjinder Sandhu, Chief of Surgery and Planned Care, Kingston Hospital.
- Sian Knight, Executive Director, Modality Lewisham.
- Simon Sherbersky, Director SPINDL, previously Torbay Communities.
- Stephanie Hatch, Professor, King's College London.
- Tony Hufflett, Data Syrup.
- Tom Holliday, Associate Prof, LSBU; Consultant Paediatrician, London NW University Healthcare
- Victor Adobwale, Chairman Visionable, Chair NHS Confed.

Appendix 2: Innovation and Change Lab Process

The two places chosen within each ICS to be the laboratories for prototyping change were Bradford (West Yorkshire) and Hastings (Sussex). The Innovation and Change Lab Process is inspired by Theory U and IDEO prototyping processes.

Design Teams

Each place identified a Design Team to work on behalf of the place and the ICS.

A Design Team is a small group of 6-8 people from each ICS place who

- a. are committed to the concept of Universal Healthcare
- b. come from diverse experiences and are therefore, as a whole group, well connected across the place (the local system Lab)
- c. are curious about how to design systems change, and are willing to learn and facilitate new approaches
- d. are dedicated to developing the relationships necessary to support this work

These needed to reflect the system we are working with, be passionate about the work, be well connected in the place, and have the power to invite people to the workshops. Being interested in the work was not enough, design team members needed to be committed to the work of universal healthcare.

The Design Team met regularly to map the system (1-2 hours frequently over a 4 month period) to secure participation, co-design and sense-check detailed design of the process. The Design Team was also

critical to clarifying the uniqueness of this work in relation to how this is different from the multiplicity of workstreams on inequalities within each ICS.

The role of the Design Team was to:

- Map the system for the work
- Determine the invitation list for the Data Mining workshop
- Review and advise on the Innovation and Change Lab workshop design
- Design the relational invitation process for the Innovation and Change Lab workshops; Take a lead on inviting colleagues to the workshops; Review participation and support ongoing recruitment.
- Identify the 'domains' of practice for the Community of Practice for the wider ICS; and the invitation process for the CoPs.

The design teams in each place were to meet weekly in June and Bi-weekly in July and August. We achieved this in Hastings. In Bradford participation was less consistent and frequent (a function of the speed of recruitment and securing commitment in place). Design Team members are provided at Appendix 2.

The design teams developed invitation questions for the workshops:

'How can we together ensure that everyone has an equal chance of a healthy life in Bradford'

'What can we reimagine and do differently together so everyone has fair opportunity of the best possible healthy life in Hastings and St Leonards?'

The design teams mapped the system in each place and developed the invitation process, and participant list. Each design team member took responsibility for personally inviting a section of the system. The intent was to secure half of the participants from the local community and half from the NHS, VCSE and LA sectors.

The design team also secured the initial Learning Journey visit hosts.

Finally the team reviewed the design of the workshops and provided feedback. They played a key role in securing the focus of the prototypes not proposed.

Stage One: Data informed understanding of the issue

We worked with data lead in both Bradford and Hastings to secure data to inform collective understanding of the two propositions. Whilst the NHS has a lot of data, mostly presented in dashboard, this data tends to be to inform performance judgements, rather than to support inquiry. We were looking for data to understand the current situation (using the 3 propositions on

universal healthcare) and data that would be useful in informing dialogue about both what is going on but also why what's happening is happening.

Both securing data, and then cleaning that data/ ensuring it is robust enough quality to be useful, and then visualising the data in a format to be useful to the workshop inquiry process took over six weeks. The domains of inquiry were:

- 1. Medicalising Poverty:** The GP Audit data
- 2. Accessible Services:** Lessons from the Vaccine? Flat offers e.g. Health Checks/reviews, GP appointment distribution/utilisation
- 3. Rationing:** A story about Children and Young People: Access to primary care/CAMHS waiting lists
- 4. Rationing:** A story of Poverty: Differences in Primary Care GPs/appts/referrals/elective day care utilisation relative to deprivation, Waiting lists

A set of cards were developed that made visible data that showed what is happening locally. By working across Bradford and Hastings we could make the most of each place's intelligence and develop a collective data pack.

A half day Data Mining workshop was held to sense-check the data and the narrative around it, to socialise the system into the data, and to refine prior to the first workshop. The design team from each place identified a small (circa 20) cross section of stakeholders to participate. From this the final data pack was developed for the incubation and Construction workshops. Some examples from the data pack are provided here for illustration:

Example data cards



Four categories of information

- A** *Healthcare – both unequally accessed and fundamentally different for poor people*
- B** *Primary care today – are we medicalising poverty? Is this the best use of our resources and a wise way of spending the money?*
- C** *Rationing – Who is forgotten? Are we looking honestly at the reality of rationing of services? Examples from Children and Young People and the vaccine programme*
- D** *Questions to answer*



Example data cards

A1

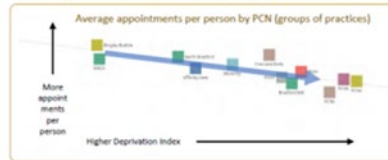
There is both unequal and different care for poorer people

The primary care we provide is fundamentally different in poorer areas.

For a poor population who may have huge challenges in their lives, primary care is:

- (a) harder to access (fewer appointments)
- (b) And less preventative (lower screening levels, less planned admissions).

Data example: fewer appts available per person in poorer areas



* Data not currently provided in Hastings



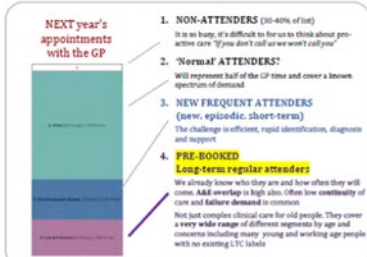
Example data cards

B1a

20% of next year's GP appointments are already booked

The people who see GPs frequently year after year are effectively 'pre-booked' next year too, taking up 20% of future GP appointments. This is just 4% of patients. That's a whole GP used up full-time for a medium-sized practice on 200-200 pp).

Data example: a year's GP appointments - 20% to long-term regular attenders



Example data cards

C1

Mental health waits for young people are extreme

CAMHS referrals are up very significantly post Covid.

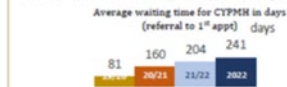
EXAMPLE

- Wait for first appointment = 8 months (one region)
- Over 500 people waiting over 6 months (another region)

The wait for neurodiversity assessment in xxxx can be just short of 2 years. This isn't a wait, it's 'life on hold'. Referrals in one area have increased over 70% in the last 2 years.

Neurodiversity: Over 4,500 young people were waiting for an Autism and/or ADHD diagnosis in xxxx recently and some services have seen up to an 80% increase in referrals over the last 2 years.

Data example: CYPMH waiting to 1st appt in one region:



In addition, the data pack provided the core material for a facilitated session at NHS Sussex ICB Board Seminar which generated positive conversation

and engagement, and which is informing the development of the ICS Integrated Care Strategy. You can find an example of the data we used [here](#).

Stage 2: Incubation and Construction Workshops September – November 2022

The workshops were provided as follows:



These workshops were followed by

a. Prototyping in small teams to test out new ideas and solutions to the three Universal Healthcare propositions.

b. A Check and Challenge Process: That people apply their learning from the prototypes to the whole system, acting from the shared awareness that they have created.

Participation at the workshops:

West Yorkshire Bradford	Workshop 1	Workshop 2	Workshop 3
Community	22	7	5
NHS	23	13	21
Local Authority	4	2	3
Voluntary/Third Sector	23	9	8
Private/Other	2	2	0
Total	74	33	37

Sussex Hastings	Workshop 1	Workshop 2	Workshop 3
Community	64	54	47
NHS	28	22	16
Local Authority	8	10	12
Voluntary/Third Sector	19	17	17
Private/Other	8	3	2
Total	117	106	94

Workshop 1: Observe

During the sensing part of the Change Lab (workshop 1 and the Learning Journeys) the goals were:

- to develop a shared picture of the problem;
- to gain system’s sight;
- to develop empathy and understanding of the perspectives of different actors within the system;
- to gain experience of best-practice and successful innovation within the system;
- to gain awareness of different actors within the system;
- to gain an awareness of an individual’s role within the system;
- to practise “disciplined observation”, suspending judgement (whilst listening or observing) and “redirecting (stepping into another person’s shoes)”.

Workshop 1 covered:

- What we know as a system about ‘what works’ using the data packs
- What we hope for
- Interpreting what is happening now using the data packs
- Inquiry into other parts of our system (learning journeys)

What we hope for in Bradford



What we hope for in Hastings



The data card work elicited this curiosity:

Bradford Data Cards

Most selected cards/resonating themes:

Young People and Poorer Care in Poorer Areas

- Fewer GPs in poorer areas (B3)
- 20% Appointments pre-booked (B1)
- Care is unequal and different in poorer areas
- YOUNG people access primary care less (A6)
- C&YP demand increase (C2, C4)
- Focus on the next generation (D2)

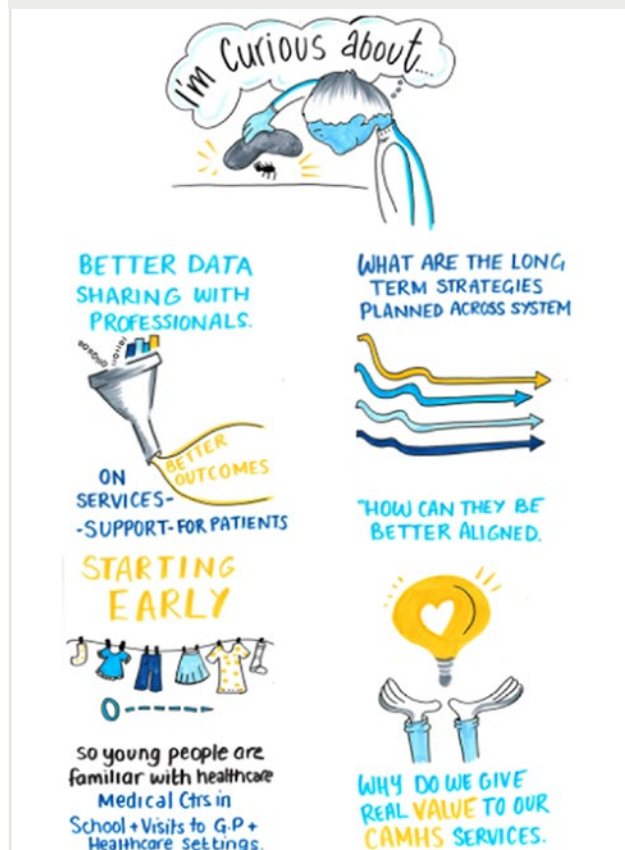


Hastings Data Cards

Most selected cards/resonating themes:

What's the GPs Role?, Connecting Families and Keeping People Out

- Do we set up to keep people out? (A7)
- What is a GP appointment really for? (D7)
- How can we connect up families better (D11)
- Flat is unequal fair is not fair (A2)
- Subtract/combine/link services don't just add (D1)



Learning Journeys

Between workshops 1 and 2 some participants (0.25%) undertook learning journeys to help understand the experience of colleagues in other services from

their own; or for citizens to understand how services work. The brief for Learning Journeys is provided at Appendix 3.

Bradford

- Horton Park Medical Practice
- Silsden Medical practice
- Project 6 and Keighley Healthy Living (next door to each other) Keighley
- Shipley Medical Centre
- Kensington (GP) Partnership
- Skipton VCSE

Hastings

- High Glades Surgery
- One You East Sussex
- Active Hastings
- Warrior Square Surgery
- ESHT Sexual Health
- Harold Rd Surgery
- Fellowship of St Nicholas
- Oasis
- Sussex Community Development Association
- Hastings Food Network
- The Common Room

Workshop 2: Retreat

This continues the 'sense' part of the Change Lab. During the sensing part of the Change Lab the goals are:

- to develop a shared picture of the problem;
- to gain system's sight;
- to develop empathy and understanding of the perspectives of different actors within the system;
- to gain experience of best-practice and successful innovation within the system;
- to gain awareness of different actors within the system;

- to gain an awareness of an individual's role within the system;
- to practise "disciplined observation", suspending judgement (whilst listening or observing) and "redirecting (stepping into another person's shoes)".

Workshop 2 covered:

- Learning Journey feedback
- How we now understand this system
- What we want to commit to personally and collectively

Learning from Learning Journeys Bradford



Learning from Learning Journeys Hastings



Workshop 2 Commitments and potential prototypes

Between workshop 1 and 2 participants identified

anyone else they needed for their potential prototype to invite to Workshop 3. They also had the chance to undertake further learning journeys

Workshop 3: Act

Workshop 3 focused on forming and focusing the potential prototypes into a set of proposals. This included exploring the proposal in terms of whether the solution was aimed at the cause or was providing a sticking plaster; and also how the proposal secured an approach that would secure universal healthcare against the 3 UH propositions.

Prototyping

Prototypes are essentially ‘mock-ups’, models, or simulations, which help to make an emerging concept visible and tangible at an early stage. This allows for generating feedback from key stakeholders

and experts, which can then be used for iterating the idea in a fast learning cycle. Through representing a system that behaves similarly to potential real world conditions, participants gain a thorough understanding of how their ideas might manifest in the real world.

The prototypes start as very quick and rough models and become increasingly sophisticated through the process of assessment and iteration.

Workshop 3 was supported by system leaders as sponsors for the working groups who contributed to the key criteria for a project success in terms of ‘how’ the prototype is delivered. These are the success criteria that are informing the prototype development.

What Works: Criteria for Success from Bradford and Hastings



Stage 3: Prototyping & Inquiry January to April 2023

Each prototype had an LSBU Universal Healthcare coach. They met between November and January to finish scoping the work, refining their prototype proposition, and mapping their stakeholders.

In January we worked with the prototype teams to develop their change approach and actions and, when ready, we coached them through a 6 week rapid change cycle. This included a community of practice across the prototypes to share learning. At the end of the cycle the groups developed their proposals, either to be embedded within a current programme of ICS work, or as a proposal for development and spread.

These proposals set out the prototype's proposition and intent, the changes that were tested, the impact of those changes, and what needs to happen next.

In addition there were two Inquiries across the two ICSs

Inquiry 1: Fair Funding for Primary Care taking advice from the Leicester team who have devised an approach to funding primary care in poor communities.

Inquiry 2: The change programme for the third sector in Hastings had support from the voluntary sector in Leeds, supporting initial dialogue within Hastings on the lessons from Leeds and how the third sector and the NHS can collaborate. Overall this will take a more significant intervention over more than the lifetime of this programme of work.

Check and Challenge

A proposal template was provided (See Appendix 4) and the propositions were reviewed using the Use the Lennox Sustainability Questions^[1] (Lennox et al 2017).

Communities of Practice

Spreading learning within and across the ICS

The Innovation and Change Labs throw up both new insight into what is causing unequal healthcare and how best to address this. The overall community of practice is designed to spread and network learning from the Labs and from experiments and innovations happening within the ICS'.

There were two CoPs

- a. CoP 1: For the Design Team and system leaders to learn about the theory and practice of leading change through Innovation and Change Labs.
- b. CoP 2: For the workshop participants, particularly those taking part in prototypes to share insights and support the development of the prototypes.

Many innovation initiatives do not pay attention to sustainability and spread. This is a very significant part of the overall proposal as it develops a community of Universal Healthcare Champions learning together and applying that learning immediately in their practice.

"Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly." Wenger-Trayner (2015) They are a learning and collaboration network.

There are three key characteristics of CoPs:

1. The Domain of Interest – where there is shared competence between peers, in relation to a specific practice. This is not about strategy or other people's work; it is about the granularity of the CoP member's work. Members are passionate about the issue, they come together because they care about it.

2. The Community – with members who help each other in service to their domain of interest, though sharing knowledge and experience. The key here is repeated interaction and supportive learning relationships. There is depth to these interactions that includes reflective skills.
3. The Practice – practice in this context means creating meaning (why we do this work together), creating coherence (how we do our work together), and for learning (what works and why – and how do new members learn about our work). Practice is the application of knowledge, and in this process this practice is shared, i.e., all members are developing their shared approach
Malby and Fischer (2006); Wenger-Trayner (2015)

Critically therefore CoP members instigate and join a CoP because:

1. They care about the domain
2. They have shared competence and practice
3. They want to learn together how to develop their practice (at a detailed competence level).

The success of CoPs is dependent on them addressing the real granular questions of practitioners as they change their practice, and the collection of data (stories, examples, evaluations) of the impact of the spread of this knowledge into practice

Community of Practice 1: Learning Together to Lead Change

The Design Team and Programme management group met in a series of Learning Together seminars.

These Learning Together sessions were to reflect on the process we have been engaged with, exploring our experience and understanding of:

- the power of context (our two places)
- how starting conditions shape outcomes
- building bridges not walls
- how the old-world bites back
- the conditions for emergent change
- how boundaries help shape the work
- the role of narrative and direction

and what we need from each other, from the wider system, in order to do this work. These are theory informed seminars, with LSBU sharing the underpinning theory for the design of this whole programme of work together.

Appendix 3: Learning Journey Visits

The point of taking part in the Learning Journey as a host or as a visitor is to 'step into each others shoes'

- For the visitors to understand how the team you are visiting goes about their work and the issues they face.
- For the hosts to experience how others see you and your work and to get new insights into their assumptions

Some of these journeys will be to local community groups, and the purpose of these is to give us the opportunity to put ourselves in the shoes of people using services, to see their community and the services they use from their own perspective. Other journeys will be to organisations, and here the purpose is to see the world from the perspective of that organisation.

Hosting a visit

You will be visited by a small group of people (half a dozen) from the workshop who will not know each other and will have very different views and experiences. You have the opportunity in 2 hours to share what you do and how you do it. The nuts and bolts of your work. You can introduce a range of people you work with to your visitors. They come to visit because they are really interested in your work. They will have lots of questions to ask you. They are trying to find out 'why what happens happens'.

At the workshop you will share a bit about your visit, and if you have sorted out a date and time, you share that too. If not you can agree with the group who have chosen to visit you the time and date of the visit.

Visiting

You will be visiting with a small group from the workshop. Make sure you all know where you are going and how to contact each other. In the workshop you have time to agree some areas that you really want to understand by asking questions. Remember that you are there for the whole groups interest as well as your own interest. Make sure everyone gets a chance to ask questions, and that the ones that matter to you as a group are the ones you start with. Please do turn up on time as agreed.

Please take some notes, and after the visit you might want to talk together about what you heard.

Preparing for Learning Journey Visits

Workshop 1 and these learning journey visits build relationships between diverse allies, multi-stakeholders. The value of this approach (it's called 'sensing') is that it allows you as a diverse group of people to reach a greater shared understanding of what the problem at stake is, before you move towards solutions and outcomes at the next workshop.

At the first workshop participants practise asking open questions which aim to understand the interviewee's perspectives. At the same time, participants will be asked to be aware of any judgements, assumptions or inner dialogue that may go through their heads as they both ask questions and listen to responses.

There are two key capacities for both the visitors and the hosts: suspending judgement and redirecting. Suspending judgement is being aware of your own conclusions and not allowing them to colour your listening and perception. Redirecting is trying to see from the other person's perspective

There are three rules of thumb for the visits:

1. Put yourself in the other person's shoes – it's not about imposing our views and ideas or seeking quick solutions
2. Less is more – have a starting question and then let things flow. The interviewee directs the interview
3. Give 30 seconds – create space to allow views and experiences to breathe

Workshop 2 Debrief: Voices from the Field

People came back with a wealth of new knowledge, and the whole group begins by hearing some of the things that had been said by their informants on the journeys.

You will meet in your visit group to discuss "What did you see, feel and think during your visits?"

After this we discuss what we have learned together across all the visits about how the health and care system works, and set out what we think we can do together.

Appendix 4: Check and Challenge Proposal

Over the past 6 months over 100 people in Hastings from across the NHS, Local Government, Third Sector with local people, have worked together to understand how the NHS could design services so that everyone has a fair chance of access and care.

Data Lab: We investigated what is happening now using data, checked what were finding in workshops and shared our collective interpretation. We found:

The old world bites back – lessons from the vaccine programme that took the NHS to people, had been partly lost. But this gave us the energy to try again, to explore how the NHS can meet need where people are.

- That primary care in poorer communities gets less funding than those in wealthier communities, and there are ways this can be adjusted to be fair.
- That children and young people are not getting as much access to services they need outside hospitals than older people.
- That a flat offer, that sounds fair, actually increased inequalities, as it favours those that can access those services.
- That there is a multiplicity of third sector solutions that can support people currently using the NHS as the front door; but the sector needs an enabling collaboration with the NHS (longer term funding, partnership that supports collaboration within the third sector), where the health professionals understand what's possible (rather than creating more dependency on the NHS).

Change Lab: Using these insights people from across Hastings/ Bradford and the ICS took time to really understand each others perspectives, to develop collaborative relationships, and to come up with ideas for what would enable Universal Healthcare. Each idea has a group working on how this will work in practice, supported by a system leader sponsor.

Prototypes: these ideas have been developed and refined and, for some proposals, aspects of the solution have been prototyped.

Learning Together: throughout this community of collaborators have been offering their experience and insights into what makes solutions work and stick, and have been learning about how to create the conditions for success.

Sustainability Check & Challenge: This next stage is to 'check and challenge' the proposals as they are developing in terms of their potential to be adopted, and to spread.

Each group working on a solution has the opportunity to pitch their idea and solutions to leaders in the health system, for advice, support and adoption.

(b) Universal healthcare proposition

Which Proposition does your idea address?:

1. Medicalising poverty and providing 'sticking plaster' approaches, with the best intentions, that make the problem of poverty invisible.
2. Providing services that are not accessible to all.
3. Not being frank and open about the reality of the rationing of services.

(c) Explain why you have chosen this proposed change?

What is your hypothesis (your views about what the problem is and why your proposed change will help).

(d) What is your proposed change?

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At what scale?

Neighbourhood/Community partnership	
Across Hastings	
Across Sussex	

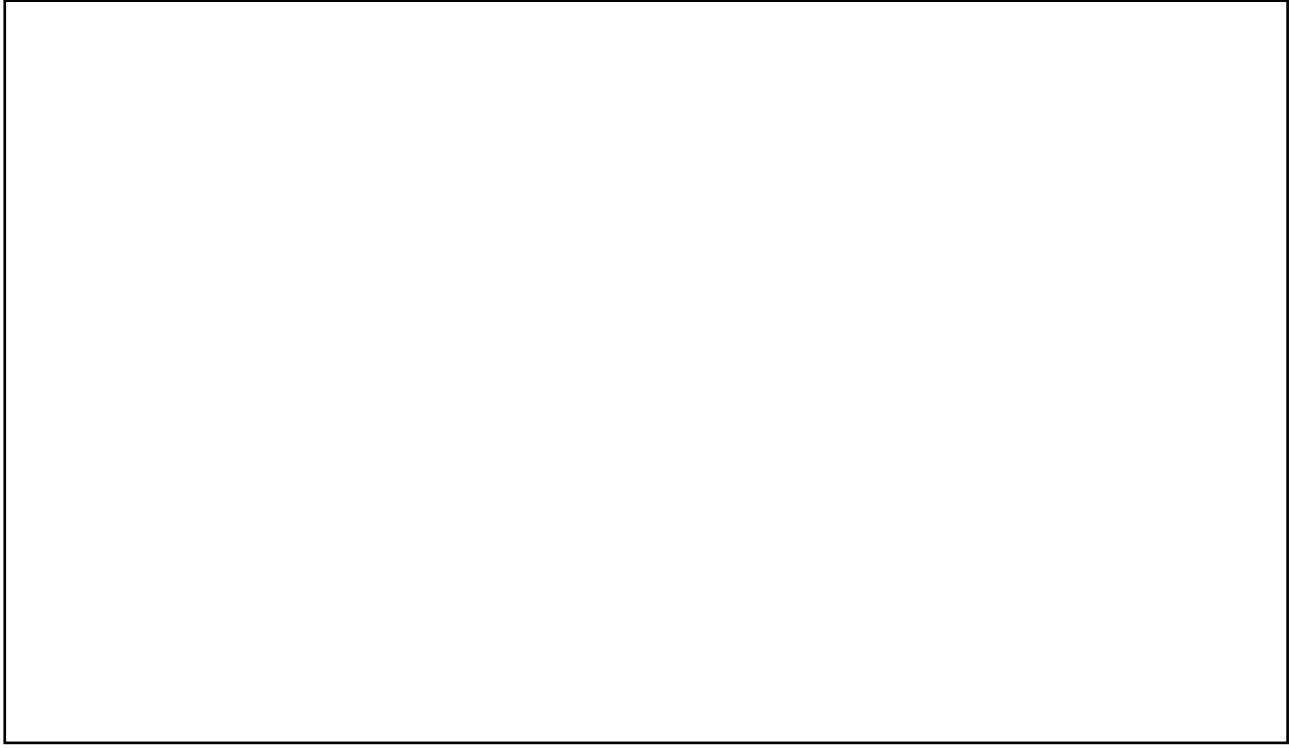
(f) Which Sussex strategic priority does this proposal address?

Digital and Data	
People and Development	
Joined up Communities	
Clinical Leadership	
Urgent and emergency care	
Planned Care	
Social Care and Discharge	
Primary Care	
Finance and Productivity	
Health Inequalities	

(g) Evaluation metrics

Have you developed any evaluation and impact measures?

Impact measures (how you would know if the change you are proposing is making a difference).



Process measures (measures that help you adapt and learn as you put the idea into practice)



(h) Do you think there any implications for resources that should be considered?

	What resource is needed to make this change / take these ideas forward	Why is it needed?
Existing:		
People		
Money		
Materials		
Other		
New:		
People		
Money		
Materials		
Other		

(i) Are there any risks you want flag?

Please put any risks you want to flag in the relevant box below

		Consequences			
		Very low	—————→		Very high
Likelihood	Very high				
	↑				
	Very low				

	High
	Medium
	Low

(j) What about governance? Do you have any views about that?

(k) Any comments from your group Sponsor?

Group lead signature: _____

Date: _____

Sponsor signature: _____

Date: _____

Check and Challenge Panel

This is for the panel and is included here for reference, and to help you prepare. Use the Lennox Sustainability Questions (Lennox et al 2017) to review the proposal.

Criteria	Explanation	Is this criteria met?
1. Commitment to the improvement	To reflect on both own personal commitment to the initiative and impression	
2. Involvement	Reflect on who has been involved and who may need to be engaged further for the initiative to achieve long-term success. Asks about personal involvement and contribution and explores the involvement of patients, carers and members of the public who are impacted by the changes being made	
3. Skills and capabilities of those involved	Explores whether the staff and other people delivering the change have the skills to do so successfully and whether training of new members of the team has been planned for	
4. Leadership	Asks if there is strong leadership in place and if the leaders are approachable, available and able to garner support for the initiative	
5. Team functioning	Explores the accountability and responsibilities for the workload involved in the initiative and ask if the team is working well together	
6. Resources in place	Explores if the necessary resources such as staff time, equipment and facilities have been dedicated to the initiative	
7. Progress monitored for feedback and learning	Encourages teams to consider what systems are in place to monitor the initiative over time and how this information will be used to inform staff of further changes needed	
8. Evidence of benefits	Asks if and how the benefits of the initiative are communicated to both staff and patients over time	

9. Robust and Adaptable Processes	Reflects on the need for initiatives to be adapted to local processes and emerging needs. It also asks about the process for recording successes and failures of changes made	
10. Alignment with Organisational Culture and Priorities	Encourages teams to consider the need to align improvement initiatives to organisational strategies to gain executive buy-in and support as well as have the initiative become part of organisational policies and procedures	
11. Support for Improvement	Explores the values and beliefs held within organisations related to continuous improvement and looks at the support given to staff and patients to be involved	
12. Alignment with External Political and Financial Environment	Looks at the need for teams to be aware of the potential political and financial changes that may impact the initiative	

¹ Lennox, L., Doyle, C., Reed, J.E. and Bell, D., (2017). What makes a sustainability tool valuable, practical and useful in real-world healthcare practice? A mixed-methods study on the development of the Long Term Success Tool in Northwest London. *BMJ open*, 7(9), p.e014417.

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