

Universal Health

2023

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Because, in these 3 areas, the NHS design is itself complicit...

1 **MEDICALISING POVERTY** with 'sticking plasters' that make poverty invisible.

2 **PROVIDING SERVICES** that are not accessible to everybody.

3 **NOT BEING FRANK** and open about the reality of the rationing of services.

These three propositions diagnose why the NHS is still driving such inequality – and it isn't about money! They mean we know...

THE ANSWER TO NHS INEQUITY!

EVERYBODY knows that the NHS is not quite living up to its name.

But now an innovative group of academics, health professionals and voluntary sector activists have worked out why, how and what to do about it.

Starting on two sites – Bradford District and Craven in West Yorkshire and Hastings in East Sussex – the team from the Universal Healthcare Network at London South Bank University have supported local people to bring about a small revolution in health services.

Following a series of big gatherings in both locations - which included individuals associated with the NHS such as patients and doctors - those in attendance began collaborating to develop at least 20 'prototypes' aimed at improving services to accommodate everyone's needs.

These range from building relationships in Bradford District and Craven between A&E nurses and local charities and voluntary sector organisations to improve the healthcare experiences of children and young

By Universal Health Reporter

people, to designing a proactive GP appointment system for long-term high intensity users in Hastings.

The idea is that the same techniques and insights will then be expanded to new sites across the country when the Universal Healthcare inquiry finishes at the end of the year.

"Then anyone can sit down where they live and use our materials to do the same," said Inquiry leader Becky Malby. "We are showing how any group of people can help their local NHS be fair for all."

Becky's team is now doing a deep review of several of these long-term patients to stimulate new thinking about how to engage differently with them, using a wider array of roles at the practice outside just GPs and providing GP continuity.

The same analysis has been run across all practices in the area to show them that they have similar numbers of long-term, high attending patients.

The Universal Healthcare team investigated what is happening now: using data, they

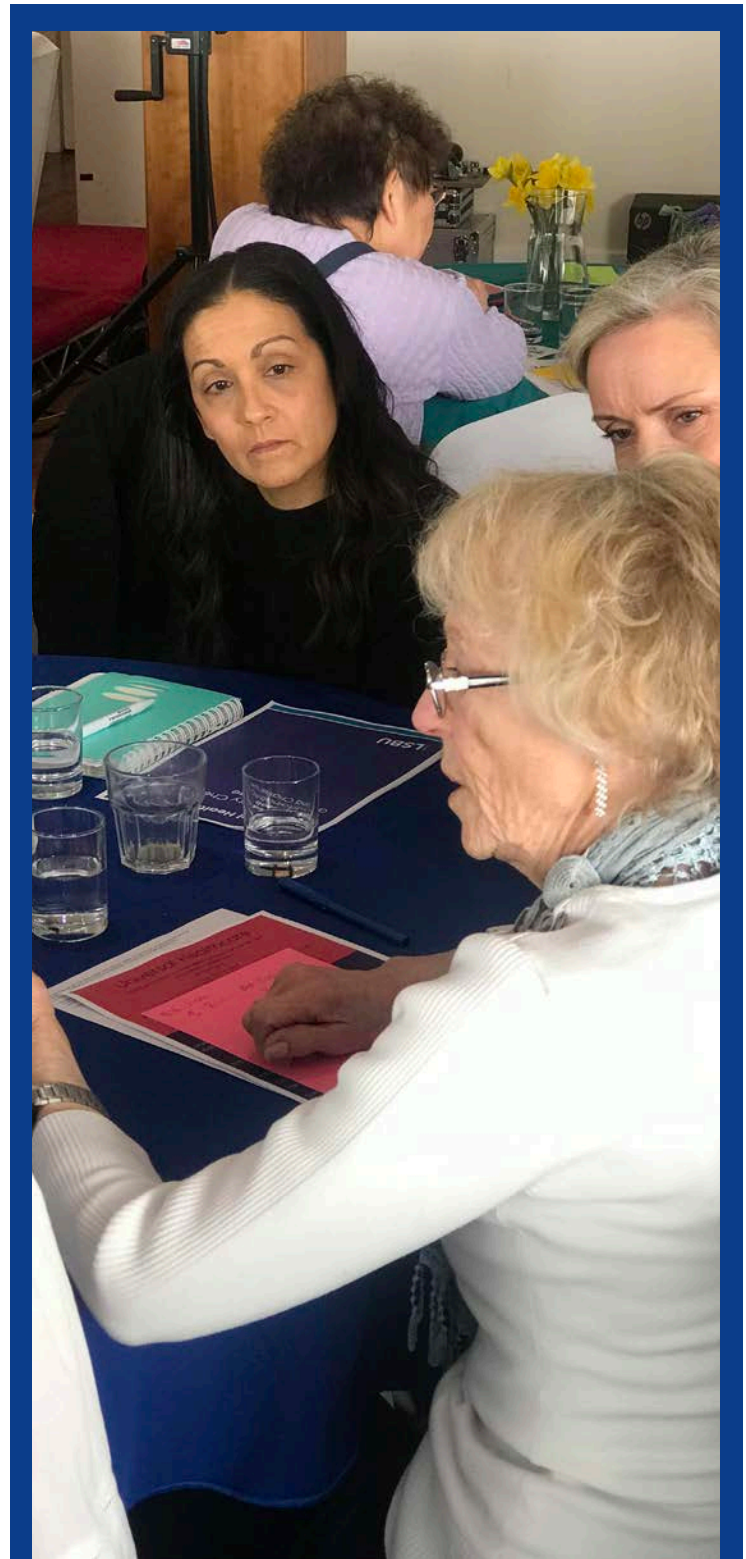
checked what they were finding in local workshops and then shared their joint interpretation.

"What we found was that the old world bites back," said Becky.

Bradford District and Craven participant Bill Graham said: "We found that 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." They also found that:

- **PRIMARY CARE** in poorer communities gets less funding than those in wealthier communities – but there are ways this can be adjusted to be fair.
- **CHILDREN** and young people are receiving relatively limited access to necessary services outside of hospitals, compared to older individuals.
- **A GREAT OFFER** that sounds fair has actually increased inequalities, because it favours people that can access those services.

There are so many third sector solutions that can support
Continued on Page 2



Engaged: Hastings group discussing their project

How to do a Universal Healthcare workshop

SEE INSIDE

Created in association with:

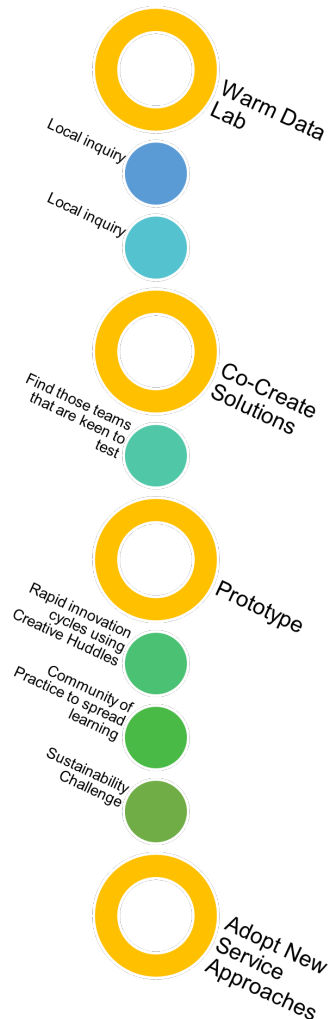
Sussex Health&Care



Becky: The old world 'bites back'

Continued from Page 1

people currently using the NHS as the front door - but the sector needs an enabling collaboration with the NHS.



The 'Check and Challenge' Process

How it works

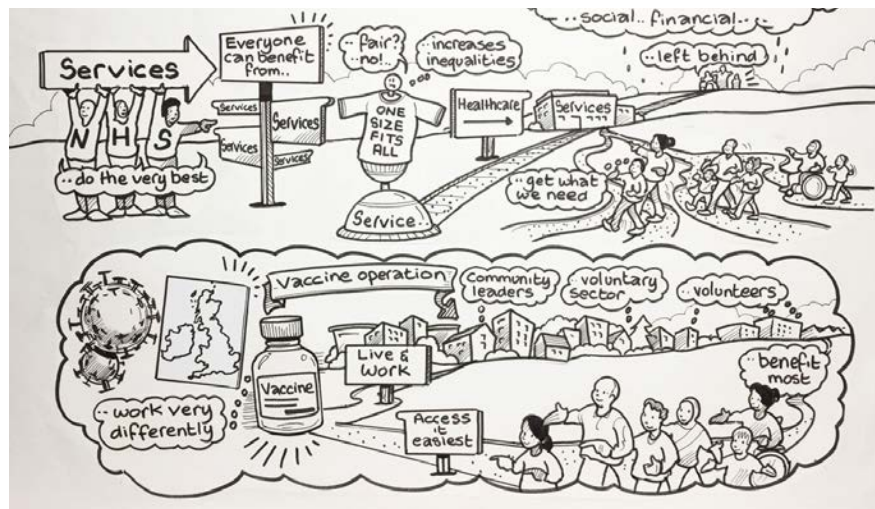
Stage 1: What's going on now? We used data to help us understand what was happening in relation to the 3 propositions. We shared that data with local people and services to find out what people cared about.

Stage 2: Getting everyone in the room to co-create the solutions. We realised we didn't know what everyone could offer to help, so we visited each other's organisations, listened to each other's stories, ate together, and - having discovered more about our passions, concerns, and offers - we decided together what we wanted to be different.

Stage 3: Test the ideas out (prototyping). We formed groups to test the ideas out in practice on a small-scale to see what was possible over a six-week period. From that, we made proposals about what needed to happen in localities, places and across our integrated care systems.

Stage 4: Changing the services. Some of the ideas were about very different ways of organising primary care, or how hospitals work with the voluntary sector, or how communities look after their friends, or how funding flows. Some are new ways of doing current services better; some are a real re-shaping of services.

How can we achieve universal healthcare within the NHS? It's about a big shift...



David Boyle looks at the thinking behind the National Inquiry into Universal Healthcare.

THE whole idea of the NHS is that it has to be fair. Everyone in the NHS is bending over backwards to make the services accessible to all who need them.

Given this, the problem is that nobody agrees about why people's health is so much worse when they are poorer.

The team behind the National Inquiry from London South Bank University (LSBU) have been, very quietly, working away on how the NHS works with Integrated Care Systems in Bradford District and Craven and Sussex.

What they found is that it isn't just a matter of there not being enough money – the roots of the problem are very local indeed.

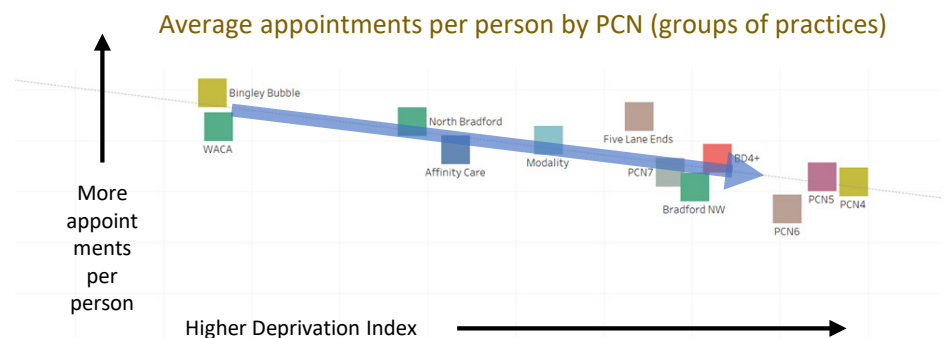
The key issue is that treating everyone the same way sounds fair – but, as they have found, actually isn't.

“What we have found is that not everyone will get what they need,” says Professor Becky Malby, the inquiry leader, “because everyone isn't the same.”

When you have a one-size-fits-all service, the only ones who are able to access it are those whom the one size suits.

People with flexibility get what

From reactive to



Slides from the workshops: Fewer appointments available per person in poorer areas.

they need, but those with less flexibility – because of financial or other circumstances – get left out.

During the pandemic, we had to work very differently - involving the voluntary sector, local charities and thousands of local volunteers – to take the vaccine out to where people were, and to make sure it reached them.

“We simply have to move our operation closer to where people are,” says Bradford District and Craven participant Bill Graham.

Why has it been so ineffective? They believe there are three broad reasons:

1. Already stretched NHS infrastructure is expected to tackle people's deep-rooted problems, like poverty – or maybe poverty itself damages people's health.

GPs want to help, but maybe the reason they are getting such an increase in patients is because patients don't know where else to go. The question is how can we work with

other local organisations so that they can support people in poverty, rather than relying on GPs using sticking plasters to cover up symptoms.

2. People are not 'hard to reach' but they are easy to miss. We need to redesign services that work for local people.

3. The NHS is failing some groups in particular. For example, children and young people don't tend to access services even though they are suffering from worse mental health since the pandemic.

Professor Malby said: “We have been working to find out why this is and what we can do about it.

“With stretched health resources at the moment, we need to make sure that everyone can access medicine and care - and that means re-designing services to give everyone an equal chance.”

It means shifting from reactive healthcare – which sits back and waits for whoever comes through the door - to proactive care – which



Prototype meeting in Hastings. Graphics by Graham Joe Ogilvie. Video available from our Universal Healthcare website (<https://www.lsbu.ac.uk/universal-healthcare>)



proactive

means going out into the community and working with the voluntary sector there.

“WE KNEW that the most important thing was to start, to get going,” said Becky Malby. “From there, the road takes surprising turns as the system reacts to what is happening and everyone gets involved. This is a good thing as it brings new ideas, new people, and new solutions.”

THESE are some of Becky’s lessons on how to do this locally: “The one thing that ‘holds’ the NHS in the mode to innovate and address these

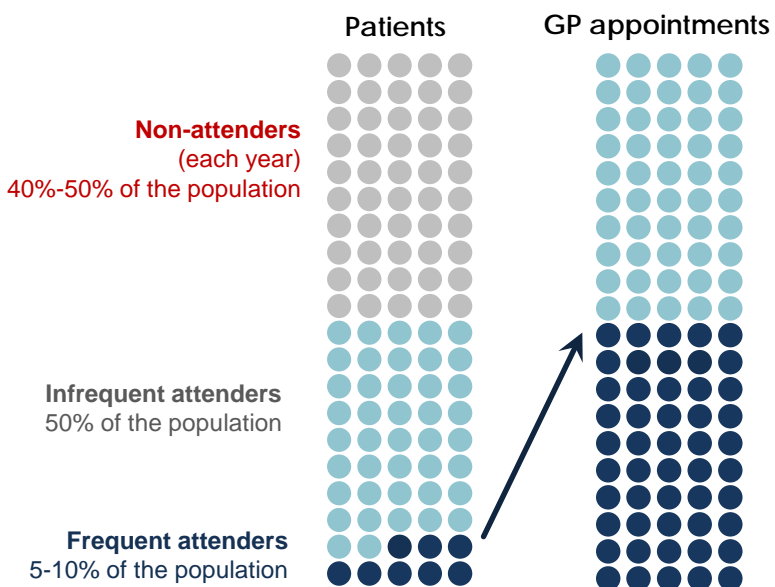
issues is having the community as partners in the inquiry and solution finding. Starting matters – local people have to be involved from the outset.

“Systems leadership is key, paying attention to the emerging ideas and solutions, and supporting people testing these out. People in the ‘middle’ are not confident in leading change without this support.

“Be non-judgemental and honest about the relationships in our system and inquire together about how things are now. Check your assumptions are based on evidence. Welcome people into the work.”

See back page for how you could be involved...

Data example : patient vs appointment ‘skew’ (aggregated across 25 practices)



Slides from the workshops : Reactive care is unequal.

Why equal access?

THE NHS Constitution requires the NHS to provide comprehensive healthcare for everyone, based on need.

It starts with the words ‘The NHS belongs to the people.’

In fact, it is becoming apparent that it belongs to *some* of the people more than others.

According to Charlotte Augst, former CEO of National Voices, the pandemic has highlighted that the NHS is not consistently providing universal healthcare, due to the rationing of

services.

We know from the Marmot Review that this is having a disgraceful impact on health. But poverty can’t be blamed solely for the lack of universality of healthcare.

The Universal Healthcare Network argues that the design of the NHS has also been complicit in these failures. That is why the National Inquiry is expected to make a real shift in the way the health and care system works together.

“We can only make real change happen for the better by listening and acting on the views of people and communities, taking this responsibility seriously and being accountable to everyone.”

Rob Webster, CBE, CEO for NHS West Yorkshire ICB and CEO Lead for West Yorkshire Health and Care Partnership



The iceberg framework: Discussing patterns and discovering how different people see the same event.

What is the Universal Healthcare Network?

THE Universal Healthcare Network at LSBU is a network of senior NHS leaders, community leaders, and thought leaders – linked by the Health Systems Innovation Lab at the university – who want to do something about the NHS’s provision of universal healthcare.

The network aims to show the reality of inequalities in service provision, and work through how best to shape services that are designed around people’s health needs.

They do this by:

- **AMPLIFYING AND MAKING VISIBLE:** They collectively make this issue visible, though this network and from the power of our own institutions.
- **COMMUNITY-BUILDING:** They are growing a communi-

ty of interest around this issue.

- **CONVENING:** They are convening a learning community at the level of place by working with committed health systems to find pragmatic and practical service models to make universal healthcare a reality. They are answering the question: ‘What if we designed health services with a focus on reducing inequalities as a core design principle?’
- **RESOURCING:** They are collaborating to create a ‘practice network’ on Universal Healthcare.

Copies of this newspaper are available from the publishers at Health Systems Innovation Lab, London South Bank University (LSBU), 103 Borough Road, London, SE1 0AA. Designed and created by David Boyle, Em Wallace and Krisztina Reikai.

I was 'staggered', says the team's researcher

IT WAS NOT until he started helping GP surgeries look more closely at where this pent-up demand was coming from that Tony Hufflett realised how much healthcare had been flying blind in recent years.



Tony Hufflett: Amazed.

He found that surgeries not "knowing" their patients is based on several things:

- **The importance of social determinants** of health are widely documented and often acknowledged as the greatest drivers of individual health.
- **But a series of short, time-pressured, clinical-focussed conversations** with a GP don't allow a wider relationship to develop – even less so with email or telephone

contacts.

- **There is widespread discontinuity** of GP care across most practices – with a different GP seen every time the patient attends.

When GPs and surgeries are asked for their knowledge of patients - for example, long-term regular attenders – then the answer is often "we should know more" about a patient's

life context.

"The trouble is", said Tony, "that clinical systems in-practice are not usually set-up to easily capture and collate 'soft' or non-clinical information on patients.

"Of course, other roles have been introduced to practices to allow time for this wider connection, thinking and support - like social prescribers, health and wellbeing co-ordinators, care navigators, and so on.

"The challenge is linking them in a data-led approach to these patients who are seeing GPs heavily to help with that workload."

tony@datasyrup.net

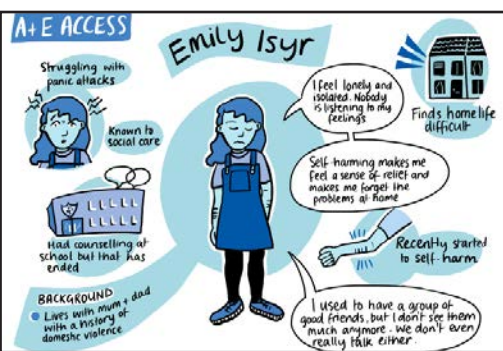
A FEW OF OUR PROTOTYPES

Making sure people can access GPs

THIS Bradford District and Craven prototype aims to make sure that people who need primary care can access it, and that primary care services are proactively designed to meet need.

This group is exploring how best to design services for people who turn up frequently, and people who need continuity, to meet need and reduce demand and free capacity - so that the practice can be more proactive in connecting to the whole community.

They are also exploring who does and does not get access. Two practices have been provided with analysis to identify their long-term high



attenders, look at their "skew to the few" and low levels of GP continuity.

They are doing a deep review of a number of these long-term patients to stimulate thinking about how to engage differently with them - using a wider array of roles at the practice outside of just

GPs and providing GP continuity.

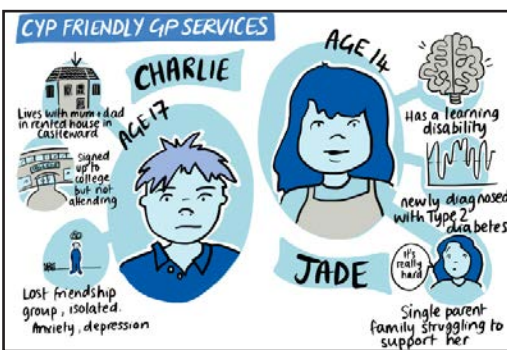
For more information, please contact maria.foulds@bradford.nhs.uk

Images by Juli Dosad. Accessible on the Universal Healthcare website.

Creating youth-friendly primary care

DEVELOPING children and young people (CYP) friendly primary care practices means focusing on making services in GP practices more accessible for children and young people.

This Hastings group plans to do this by young people from the Youth Inspect and Advise Group visiting practices to make recommendations on practice behaviours,

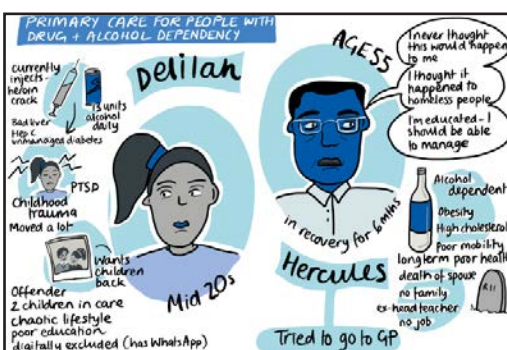


culture and environment about how to make their practices more comfortable for young people. This has extended to making CYP focussed Saturday clinics so that young people feel they have their own space to be seen and listened to.

For more information, please contact cindy.cavie@nhs.net

Support for people with substance dependencies

FOR SIX weeks, a team from multiple voluntary and health services have been prototyping a new model to help people with current or previous substance (drug and alcohol) dependencies to transition back into mainstream health services - learning lessons from the vaccine



on the core themes of relationships, avoiding creating dependency, familiar places, flexibility of services and fairness.

The team achieved this prototyping with no extra funding or resources. Now they want to expand and refine the prototype in 2023/24 to look at focus-

programme on engaging people where they are. The purpose is to avoid service users presenting late with more complex or even crisis needs. The prototyping has involved six iterations over the six weeks and has concentrated

ing the target cohort and building further relationships with general practices at primary care network level.

For more information, please contact alison@esrauk.org

Becky Malby

What we have learnt and what you can do to help...



WE KNEW that the most important thing was to start, to get going. From there, the road takes surprising turns as the system reacts to what is happening and everyone gets involved. This is a good thing. Here are some things that were unexpected but are important outcomes and learnings:

1. The work generated sudden interest from other parts of the systems (integrated care systems). We were met with calls to come and talk about what is happening and hear a different viewpoint.
2. There is an openness to, but lack of knowledge of, local voluntary sector capability and a need for central forums to connect to it.
3. The need for universal fairness in healthcare resonates hugely with the public.
4. Children are at risk of getting less attention than adults.
5. GP practices in poorer communities receive less funding and have less capacity.
6. There is unequal and different care for poorer people - we know the NHS flat offer model is increasing inequalities.
7. What is going on in general practice is unknown - beyond people's satisfaction with appointments - in terms of equity and universality, and very few practices know about their local need.
8. There is little continuity in primary care.
9. There are some fantastic examples of lessons from the vaccine programme sticking, but there are even more where the NHS has reverted to a model of 'come to us'.
10. The NHS needs the voluntary sector, and should help it be the best it can be (longer contracts, supporting infrastructure). There is work going on in primary care that could be better provided by the voluntary care systems, which could be the first point of contact for people needing help with their health and care needs - a new front door.

WE REALLY don't know what's going on in primary care, but once the challenges and inefficiencies surfaced, we found that people will gather around to help. The general public are not judgemental - they are supportive. Once challenges are revealed and openly shared, then everyone can work together effectively.

We know that the current arrangements have often been organised with the best of intentions, but we were still outraged by what we found.

We want people to be outraged too. We think the data tells a story that will outrage people enough to act together. We know that, where people in communities help the NHS, we get better solutions that are fairer for everyone. That's the bottom line.

Becky Malby is professor of Health Systems Innovation at LSBU and has been leading the national inquiry.

GET INVOLVED!

Could you manage a similar process in your area? Find out by looking at some of our materials at <https://www.lsbu.ac.uk/universal-healthcare>.

For more information, contact anam.farooq@lsbu.ac.uk or healthlab@lsbu.ac.uk