

Our health, our care, our say: a new direction for community services
Department of Health white paper on care outside of hospitals, 30 January 2006

GPC SUMMARY

The Department of Health white paper 'Our health, our care, our say: a new direction for community services' was published earlier today and can be accessed online at the following website address:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXllecj

This document provides an initial and very brief summary of the main points included in the white paper, in particular those that will be most relevant to general practice. The text in the grey boxes has been taken directly from the paper.

Further information and briefings will be produced in due course.

Chapter 1 'Our ambition for community-based care'

This Chapter on our strategic direction includes:

- What we heard people say in *Independence, Well-being and Choice* and in *Your health, your care, your say*
- The challenges we face: demographic change; the need to radically realign systems; the need to work with people to support healthier lifestyles
- The new strategic direction:
 - more services in local communities closer to people's homes;
 - supporting independence and well-being;
 - supporting choice and giving people a say;
 - supporting people with high levels of need;
 - a sustained realignment of the health and social care system
- Support for the active, engaged citizen: making our vision a reality

Chapter 1 sets the scene for the Government's White Paper and introduces the following themes:

- preventive care
- putting more power in the hands of professionals
- forging closer links between local authorities and PCTs, especially in their commissioning roles
- plurality and innovation from both existing and new providers
- need to shift services closer to patients.

Chapter 2 'Enabling health, independence and well-being'

This Chapter on health, independence and well-being includes the following commitments:

- Developing an NHS 'Life Check' starting in Primary Care Trust (PCT) spearhead areas
- Better support for mental health and emotional well-being: promoting good practice; demonstrator sites for people of working age, as part of our action to help people with health conditions and disabilities to remain in, or return to, work; access to computerised cognitive behaviour therapy;
- Local leadership of well-being: improving commissioning & joint working through defining and strengthening the roles of Directors of Public Health (DPHs) and Directors of Adult Social Services (DASSs);
- Better partnership working in local areas: a new outcomes framework; aligning performance measures, assessments and inspection; aligning planning and budget cycles for the NHS and local authorities;
- Stronger local commissioning: shifting towards prevention and early support; expanding the evidence base through Partnerships for Older People Pilots (POPPs); National Reference Group for Health and Well-being; re-focussing the Quality and Outcomes Framework (QOF)
- National leadership: stronger leadership for social care within the Department of Health; a new Fitter Britain campaign

This chapter introduces 'NHS Life Checks'. Here the key stages in life are outlined from birth, through childhood and teenage years, to adult working life and old age. All schemes currently in operation are described and the Government explains in general terms how it would like to improve matters. For example, specific measure is made of the recent Department of Work and Pensions green paper and wanting to work with GPs to get people back to work sooner.

On regular check ups, the document states the following (paragraph 2.28):

“There is, however, clear evidence that simply offering routine physical checks such as cholesterol testing to everyone in the population is not an effective way of identifying people at risk of disease and ill-health¹. Nor would it be a good use of the considerable resources which would have to go into developing such a global screening programme.”

It goes on to say (paragraph 2.30):

“We will therefore develop a new NHS ‘Life Check’ service to help people – particularly at critical points in their lives – to assess their own risk of ill-health. The NHS ‘Life Check’ will be based on a range of risk factors, such as those outlined above, and on awareness of family history. The service will be developed and evaluated in 2007, with a view to wider roll-out thereafter.”

The health checks will be developed initially in spearhead PCTs and look to tackle the most under-privileged. If successful, they will be rolled out further. The involvement of general practice at this stage appears very limited.

On the QOF, it states the following (paragraphs 2.90-2.92):

“The QOF now covers 10 disease areas including mental health, diabetes, heart disease, asthma and chronic obstructive pulmonary disorder; and from 2006/07 it will have seven new areas including obesity, learning difficulty, chronic kidney disease and palliative care. The QOF will drive health improvement in two ways.

First, practices will be rewarded for managing the care of patients effectively and in line with the best evidence available. **As the QOF evolves we intend that by 2008/09 it will include new measures which provide a clear focus on wider health and well-being outcomes.** The National Reference Group for Health and Well-Being will have a key role in development of the QOF, providing expert advice to NHS and social care employers who will consult primary care representative groups in the normal way.

Second, the QOF means that every practice now has a register of patients with long-term needs. These registers provide a clinical database that is unparalleled anywhere else in the world. It is essential that such a unique database is used to improve local decisions on meeting needs. **We will ensure that commissioning decisions use QOF data about the local population.”**

Chapter 3 ‘Better access to general practice’

This Chapter on primary care services includes:

- Helping people register with the GP practice of their choice
- Rewarding responsive providers
- Increasing provision in deprived areas: supporting Primary Care Trusts (PCTs) to attract new providers
- Helping practices to expand by helping with expansion costs and making more money follow the patient
- Reviewing the funding of NHS Walk-in Centres
- Giving people information on local services
- New drive to improve the availability and quality of primary care

provision in areas of deprivation, so that problems of health inequality and worklessness can be tackled

This is the chapter of most direct relevance to general practice. It begins by saying how good British general practice is, but then goes on to say how it will need to change. Choice figures large as does the need to put 'patients in control' and give them 'real choice'.

The white paper rules out dual registration. It then moves to tackling closed lists as per the following paragraphs (3.21 and 3.23):

"Registration will continue as the cornerstone of list-based general practice. However, we need to ensure that the right to register is a reality for all. In future patients will be guaranteed acceptance onto an open list in their locality and we will review how we can simplify the process for doing so. Only in exceptional cases of abuse (for example violence) by patients will this not apply."

"The existing closed list procedures will be made simpler to operate, in order to provide greater transparency for patients and to offer practices the flexibility they need to manage short or longer-term capacity issues. Practices will be either open or not. This will ensure that patients choose practices not the reverse."

The paper discusses ways to improve funding to practices that are prepared to expand or in rapidly growing areas. The Department wishes to consider the establishment of an Expanding Practice Allowance and potentially, a review of the funding of PMS practices. They also want to review the payment system for walk-in centres and how to pay practices to provide services to unregistered patients.

The Department wishes to introduce a 'Fairness in Primary Care procurement' scheme as outlined below (see page 68):

First wave of Fairness in Primary Care procurement

1. The Department of Health will begin immediately to identify the localities that are significantly under-provided, especially those in deprived areas.
2. Unless PCTS can provide robust existing plans for rapidly reducing inequality of access to services, they will be invited to join the national procurement process.
3. There will be a competitive tendering process, which will provide a level-playing field and ensure fairness. PCTs will purchase and contract manage the new services.
4. PCTs will draw up specifications for the new services they will procure. These must include arrangements for convenient opening

hours, open lists, a practice boundary, if any, very broadly defined, as well as quality incentives comparable to those in the GMS/PMS contract.

5. The Department of Health will manage the procurement process on behalf of PCTs, ensuring the principles of contestability and value for money (VFM) are realised under a fair, transparent and consistent process.
6. All providers that pre-qualify to quality standards during the tendering process will be put on an accredited list of primary care suppliers, to ensure that in the future commissioners can procure GP services faster.

The paper refers to new incentives for existing and new providers to offer the opening hours that patients want. There is also mention of allowing practices to extend their practice areas, but there is no mention of reducing any obligation to visit.

Chapter 4 'Better access to community services'

This Chapter on the wide range of services in the community includes:

- How we will give people more choice and control over their health and care including extensions of pilots on individual budgets and direct payments
- Expanded use of pharmacies and extended pharmacy services
- A new urgent care strategy aimed at reducing hospital admissions
- Better access to services which can tackle health, social care, employment and financial needs including social security benefits
- Improving community services for teenagers, expectant mothers, people with mental health problems, those who have difficulty accessing services including older people and offenders, and end of life care.

Chapter 4 deals mostly with social care, improving links with the NHS and extending direct payments for social care. It also talks about improving community services – though gives little detail on this – and making better use of pharmacists, mainly through their new contract.

The chapter also wants to create an 'urgent care strategy' as follows (see page 90):

The urgent care strategy will focus on improving patient experience and significantly reducing unnecessary admissions to hospitals by:

- Introducing simpler ways to access care and ensuring that patients are assessed and directed, first time, to the right service for treatment or help.

- building upon best practice to develop the next phase of quality, cost-effective, primary care out-of-hours services;
- ensuring that the quality of care is consistent for patients across the country, whether care is provided over the telephone, in patients' homes or in a fixed location such as a Walk-in Centre, health centre or A&E;
- encouraging all health partners to work together in a system-wide approach to developing urgent care services that is consistent with other priorities set out in this White Paper, including better care for patients with long-term conditions, shifting care from acute hospitals to the community, promoting better public health, integration with social care and improving access to GPs in-hours;
- improving joint PCT and local authority commissioning arrangements to ensure better integration across services, make the best use of resources and prevent duplication. This will be particularly important for telephone and telecare services, and those provided in the patient's home;
- providing high-quality mobile health care for patients who need urgent care, through implementation of *Taking healthcare to the patient*. Over the next five years, ambulance trusts will increasingly work as part of the primary care team to help provide diagnostic services and to support patients with long-term conditions. They will continue to improve the speed and quality of ambulance responses to 999 calls; • developing a multi-disciplinary workforce strategy that makes the best use of local skills and expertise, and supports the training and educational needs of staff providing urgent care to patients;
- ensuring that the IT requirements to deliver urgent care services are reflected in the wider IT agenda;
- ensuring that the skills and experience of NHS Direct are fully utilised by patients and health care organisations. In particular, we would expect NHS Direct to play a key role in enabling patients to self care where this is appropriate. NHS Direct could also help to provide better information about local services;
- providing guidance and advice, sharing learning and best practice examples, and providing toolkits to support health and social care economies to develop integrated urgent care services that meet the needs of patients locally.

There will also be improved access to sexual health services and rapid access mental health services as well as more cancer screening (bowel cancer) and the piloting of direct access by patients to services such as physiotherapy.

There is some mention of GP practices opting out of immunisation services, improving midwifery services, services for teenagers and for those with learning disabilities. All these areas lack detail.

Finally, the chapter talks about offenders, older people and palliative care.

Chapter 5 'Support for people with longer-term needs'

This Chapter on ongoing care and support includes discussion of:

- Empowering those with long-term needs to do more to care for themselves, including better access to information and care plans
- Investment in training and development of skills for staff who care for people with ongoing needs
- New supports for informal carers including a helpline, short term respite, and training
- Collaboration between health and social care to create self care networks to support those people with the most complex needs

In addition to the above summary, there will be an expansion of the Expert Patient Programme and using the QOF to promote self care.

Chapter 6 'Care closer to home'

This Chapter on shifting care, includes:

- Shifting care within specific specialties into community settings
- the need over time for growth in health spending to be directed more towards preventative, primary, community and social care services;
- a new generation of community hospitals, to provide a wider range of health and social care services in a community setting;
- a review of service reconfiguration and consultation to streamline processes and accelerate the development of facilities for care closer to home;
- refining the tariff to provide stronger incentives for practices and Primary Care Trusts (PCTs) to develop more primary and community services;
- accurate and timely information for the public on specialist services available in a community setting.

This chapter does not introduce a great deal of new ideas. It includes many examples about care closer to home and cites effective Practice based commissioning as being crucial to making this happen.

It says (paragraph 6.11):

“Leading the way in looking at models for providing care closer to home are six specialties – ear, nose and throat, trauma and orthopaedics, dermatology, urology, gynaecology and general surgery. **Over the next 12 months the Department of Health will work with these specialties in demonstration sites to define the appropriate models of care that can be used nationwide, based on the models described below.**”

The government also wants a shift of resources (see paragraph 6.35).

Significant support is shown for community hospitals, healthy living centres and improved patient transport services, though not yet to basic primary care.

This chapter then talks about incentives for commissioning such as unbundling tariffs, better data flows and more realistic tariffs based on the costs of delivery in different settings, i.e. possibly different tariffs in a primary care setting.

Chapter 7 ‘Ensuring our reforms put people in control’

This chapter on the structures in place for governance and empowerment includes:

- a stronger local voice to effect change in services when needed;
- the roles of local authorities and Primary Care Trusts (PCTs);
- a framework for commissioning;
- the benefits of Practice Based Commissioning (PBC);
- ensuring best value for money, through improved provision and
- commissioning of services;
- supporting social enterprise and the third sector.

Here the paper talks about increasing the voice of patients and users and states that providers must respond to this. It also encourages better support for complainants and the streamlining of the complaints system.

It says (paragraph 7.21):

“We will go further in giving people the power to demand changes where community services are unresponsive or resistant to their needs. As well as the independent user surveys referred to earlier, **we will ensure that, where a specified number or proportion of users petition the service provider for improvements, the provider will have to respond, within a specified time, explaining how they will improve the service or why they cannot do so.** This will apply to local GP practices as well as other services commissioned or provided by the PCT. **To facilitate the better use of surveys, the Department of Health will review the survey programme, reporting by autumn this year.**”

There is reference to the reconfiguration of PCTs, Practice based commissioning and the role of the Healthcare Commission in assessing providers' effectiveness, including GP practices.

Chapter 8 'Making sure change happens'

This chapter on the mechanisms required for change includes:

- better information to support more joined-up services;
- how quality will be assured;
- mechanisms for a more joined-up service with health and social care colleagues working together;
- how the workforce must evolve to meet the needs of a changing service.

Chapter 8 talks about more, integrated information for users; better, more effective assessment of quality with mention of the RCGP's Quality Team Development (QTD) scheme and mention of regulation changes (though not specific) and patient safety.

It then goes on to discuss developing and valuing the workforce and expanding recruitment.

Chapter 9 'A timetable for action'

For the 'Key implementation tasks and timing by commitment' see page 193.