

The White Paper

“Our Health, our care, our say: a new direction for community services”

A personal view by Dr Nigel Watson, Chief Executive, Wessex LMCs

The White Paper was published on 30th January 2006 and was accompanied with a significant expectation that would challenge the current model of General Practice. It was also expected that there would be a shift in the balance of power from Secondary Care to provision of care in the community.

The document is 236 pages long and makes interesting reading. It describes a number of issues, which need to be addressed, and poses a number of solutions but is thin on detail. The cost of implementation is absent for most of the document.

The White Paper sets out a number of objectives that, for the most part, General Practice would find the proposals at best an opportunity and at worst a threat. The true impact of these proposals will not be truly measured until each of the proposals is worked through in detail and costed.

As most will have little enthusiasm to ‘wade’ through the document, I thought it may be helpful to pull out some of the key points and express some personal comments about them.

The White Paper states that it is aiming to achieve 4 main goals:

That:

- 1. Health and social care will provide better prevention services with earlier intervention.**
- 2. People will be provided with more choice and a louder voice.**
- 3. Inequalities will be tackled with improvement to access of community services.**
- 4. Greater support will be provided to people with long-term needs.**

Chapter 1 “Our ambition for community based care”

Summary

- 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 a high level of need
- A sustained realignment of the health and social care system

Year on year, as the NHS budget rises, there will be higher growth in prevention, primary and community care than for secondary care.

Closer working between social and health care is a recurrent theme with new responsibilities for commissioning services together. The proposal is to shift resources, care and influence from hospitals and bring this closer to peoples homes i.e. in the community, therefore not only empowering patients, but also primary care professionals.

Personal view

This chapter has no real surprises; some may say they have heard it all before. The reality is that the Government has little choice. The NHS budget is going to become increasingly stretched and, unless work that is currently carried out in the most expensive setting, i.e. a hospital, is carried out in the community, healthcare will increasingly become unaffordable.

Closer alignment of health and social care has been happening to varying degrees across Wessex. The overlap between these is clear for all to see, but all too often these services work in isolation, which incurs additional costs and does not provide affordable, high quality care to patients.

Chapter 2 “Enabling health, independence and well-being”

Summary

- NHS “Life checks”
- Better support for mental health and emotional well-being
- Joint working between health and social care in commissioning
- Closer alignment of health and social care budgets and planning
- Focus on prevention and early support, including using QoF to achieve this

Major reforms of children’s services are already underway, with greater integration of local services in Children’s Trusts. ‘Sure Start’ programmes have been introduced in many parts of Wessex and will continue to target care on the most disadvantaged children aged under 5.

The new Childcare Bill will increase the duty on local authorities, working with health, to improve the outcome of all young children under school age and reduce inequalities in outcomes. This will be delivered through Sure Start Children’s Centres, planned for every community and bring together health, family and parenting support, childcare and other services. There are currently 400 of these Centres and by 2010 there are expected to be 3,500.

The Government is shortly to publish a Green Paper called “Youth matters”, which will look more closely at improving the emotional well-being and physical health of school children, therefore improving the chances of success in learning and achievement.

NHS Life checks

These will be developed and evaluated in 2007 prior to wider roll-out. Initially, a person will complete an assessment either online or on paper. The online version could be stored as part of their personal health plan, and this could be shared with GPs.

From this assessment, those identified as being at greatest risk will then be able to discuss the findings with a health trainer. Referral for medical assessment could be one outcome of this discussion.

There are 5 targeted checks:

1. Within the first year of life
2. At age 11
3. At age 18
3. Following the birth of a first child
4. People around the age of 50

Mental health is mentioned on a number of occasions and the Government want to see an expansion of access to psychological therapies. This included making computerised cognitive behaviour therapy available.

There is recognition that mental health services tackle severe and enduring mental health illness, leaving GPs to cope with the rest, often unsupported.

Primary care (in this case not GPs or Practices) can tackle these issues with additional input from a greater provision from psychological therapies involving new mental health workers and GPwSIs.

The Government intends that by 2008/9 the QoF will include “new measures which provide a clear focus on wider health and well-being outcomes”.

Personal view

As many of us have observed, the role of the Health Visitor is moving away from the practice and increasingly being aligned with Social Services and Education. It seems almost inevitable that in future they will be employed by Children’s Trusts and not PCTs. Closer working with Education and Social Services and ultimate integration may be a good thing, but the danger is that they will lose the important relationship with children and parents through the unique relationship within general practice.

The targeted health checks in children should be carried out by Health Visitors and School Nurses and this will, in effect, re-define some of their roles. The targeted lifestyle assessment at people aged approx. 50 seems sensible. There are those who can be identified at greater than average risk of cancer, diabetes, hypertension, stroke, heart disease etc and therefore these patients would be more likely to respond to advice and preventative interventions.

The mental health proposals, if implemented, would help most GPs who struggle with the ever increasing burden in this area. Many of us have no access to services such as CBT, Counselling, and other psychological therapies, but where will the funding come from?

Chapter 3 “Better access to general practice”

Summary

- Helping people register with the GP practice of their choice
- Rewarding responsive providers
- Increasing provision in deprived areas and supporting PCTs to attract new providers
- Helping practices to expand by helping with such costs and making more money follow the patient
- Reviewing funding for NHS Walk-In Centres
- Giving people more information on local services
- Improve availability and quality of primary care provision in areas of deprivation

The Government state “by international standards, general practice in England is efficient and of high quality”. Indeed, many countries view with envy our system of list based general practice and some, for example Spain, have sought to copy it”.

Access to general practice is a major issue that the White Paper seeks to improve. It is repeatedly stated that, in some areas, people have the choice to register with a number of high quality practices, but all too often the most vulnerable are perceived to have little or no choice. To address this, it is suggested that where poor services exist, new providers will be invited in to compete alongside existing practices and current practices will either improve their own standards or will cease to exist.

The White Paper states that the problems with the existing system of general practice are as follows:

- The practice chooses who it registers, rather than the patient having choice
- Moving between practices is often difficult

- Having “open but full” lists (will no longer be acceptable)
- Closed lists (to be restricted or new providers brought in)
- Practice information is often poor and not easily available
- Patient cannot see a GP easily if they work a long distance from their home
- Dual registration (deemed currently to be unworkable and therefore shelved)
- Commuter population (Walk-In Centres to be developed in commuter areas)

It is clear that practices will have greater difficulty in refusing to register patients.

It is also recognised that currently less than 70% of the payment to practices transfers with the patient. The intention is that a higher % of the money will follow the patient and that this could also include premises funding but this could potentially threaten MPIG.

A financial review of PMS contracts is also being undertaken.

Practices who are rapidly expanding suffer particular financial pressures under the new contract, because the value of each patient does not truly reflect the full cost of expansion, especially if the correction factor in the practice is significant. The Government is going to look to establish an Expanding Practice Allowance, to help these practices, as long as they have open lists and offer extended opening hours.

The review of the funding for Walk-In Centres will also include paying for services from practices for unregistered patients.

Paragraph 3.40 contains the statement, “Part of the new contractual deal endorsed by GPs was the creation of new contractual freedoms for PCTs to bring in additional provision”. PCTs that are poorly served by practices will therefore receive national help to attract alternative providers.

PCTs will be expected to provide information to patients about practices’ performance on offering fast access and advanced booking. A local list will be published of practices that have open lists and reach each of these targets.

Paragraphs 4.56 and 3.57 state that “Practices that offer opening hours that the public want will gain new patients, and the money that follows them; those that don’t, won’t” and “We will directly ask the public how easy it is to get into their practice to see a GP and reward those whose patients are satisfied. We will ask registered practice populations whether their surgery offers convenient opening hours including an early morning, evening or Saturday surgery”.

Out-of-Hours providers will be allowed to offer evening surgeries, take booked appointments and even take on registered patients.

The intent is clearly laid down to abolish practice boundaries, but no indication is given to what will happen if a patient requires a home visit.

Personal comment

It is clear what the challenge that is being laid down before us is. “Generally you provide an efficient and high quality service which gains great satisfaction from the majority of patients, but the balance of power between the practice and the patient lies too far in favour of the practice. So to redress the balance, we want market forces to be brought fully into operation. We want you to start competing for patients and, by doing so, the things we currently want to measure (48 hours access, booking ahead, and extending opening), we think patients will be more satisfied. We will reward practices who do this by taking money from ‘inferior’ practices plus a small amount of additional money for a new access DES (funded from the old access DES and money taken from the 50 bonus points in the QoF, for access).

If you are unable to deliver this, or are unwilling to do so, we will bring competitors in to deliver services and, by the way, we have no new money to fund them”

It would appear that MPIG is going to be a target for the next round of contract negotiations as well as PMS budgets. Practices are going to be forced to look at extended opening or face the threat of other providers offering this service and taking their patients. What we need to know is what incentive is going to be offered. I doubt it will be sufficient by itself to entice practices to extend their opening hours.

There are real threats, particularly to small practices contained in this chapter but also opportunities. We need to see the detail before we come to any final conclusion. I believe the larger, well organised and efficient practices have little to fear from this.

Chapter 4 “Better access to community services”

Summary

- Increased choice of community based services, and personal control over health and care
- Extend use of pharmacies
- A new Urgent Care Strategy to reduce acute 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 and those who have difficult accessing services including older people and offenders and end of life care

Individual budgets will become available for people to hold, so that they can decide from where to purchase their social care.

The Urgent Care Strategy aims to do the following:

- Introduce simpler ways to access care, ensuring patients are assessed and directed, first time to the right service for help
- Building on best practice to develop the next phase of quality, cost effective, primary out-of-hours care
- Ensuring a consistent quality of care, wherever it is delivered
- Encouraging all parts of the health service to work together to develop urgent care services, shifting the emphasis from an acute hospital to the community
- Improve joint PCT and local authority commissioning
- Provide high quality mobile health care for patients who need urgent care

The expansion of services will move the setting increasingly from hospital into the community:

- A target date of 2008 has been set where a patient will be able to access a genitor-urinary medicine (GUM) clinic within 48 hours
- From the end of 2006, there will be a comprehensive child and adolescence mental health service (CAMHS) across the country
- A new screening for bowel cancer will commence in April 2006
- Maternity services will be reviewed and focused more on what expectant mothers want. It will allow women to go directly to a midwife without seeing a GP
- Improving ‘end of life’ care will mean extending tools such as the “Gold Standard in Palliative Care Framework”, and the “Liverpool Care Pathway for the dying”

Personal comments

There is little in this chapter that many GPs would argue with. We would like better access for our patients whether it is CAMHS, GUM Clinic, bowel cancer screening or palliative care. The question is, where will PCTs find the funding to deliver this?

Chapter 5 “Support for people with long-term conditions”

Summary

- Empowerment of those with long term conditions to do more self care, have better access to information and receive individual care plans
- Investment in training and skill development for staff that care for people with ongoing needs
- Support for carers
- Collaboration between health and social care for those with complex needs

The expert patient programme (EPP) will be expanded significantly over the next 10 years to increase capacity by 10 fold.

There is an expectation that each practice, using information gained via QoF, will commission care more effectively for those with long-term conditions. QoF will evolve to provide strong incentives for the effective management of other long-term conditions.

By 2008, everyone with long term conditions will be able to have an integrated care plan, if they want one.

The White Paper says it will do more for carers:

- Introduce a helpline, manned by the voluntary sector
- Provide short-term, home-based respite support
- Expand the Expert Patient Programme (EPP) to help carers

Personal comment

I have not had first hand experience of the EPP, so I feel it is difficult to comment how useful expansion of this could be.

The QoF provides an interesting focus for discussion. Some believe it is no more than a data collection exercise, whilst others believe it has significantly improved patient care. I believe QoF rewards those who provide high quality care and incentivises practices to improve in other areas.

There are two dangers around QoF which are:

- 1) *that additional clinical areas are added without any additional recourses*
- 2) *areas are added which are thought to be a “good idea” with little supporting evidence*

Chapter 6 Care closer to home

Summary

- Shifting care within certain specialities into community settings
- Growth in healthcare to be directed 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 the community setting
- A review of service configuration and to develop facilities closer to home
- Refining the national tariff to provide stronger incentives to develop more primary and community services

There is a clear intention to move the majority of outpatient activity into a community setting. Some countries, such as Germany, have virtually no outpatients carried out in hospital. At present England spends 27% of the NHS budget in Primary Care, compared to the OECD average of 33%. The intention, over a period of time, is to move towards the OECD average.

The Department of Health is working with various Royal Colleges to look at different models of care within Primary Care. Leading the way are:

- ENT
- Trauma and orthopaedics
- Dermatology
- Urology
- Gynaecology
- General surgery

In Bradford 60% of GP referrals are seen by GPwSI's, in Wessex many PCTs have no GPwSIs.

PCTs will be set annual targets for a shift of resources from hospitals to Primary Care.

Payment by Results (PBR) tariff prices will be unbundled to help with the investment in primary care regarding diagnostics and post acute care.

There is a directive to PCTs to implement appropriate performance measures to ensure that the overall level of referrals to more specialist services is sustainable.

Personal comment

It is essential to establish community based services before the work and resources can be transferred from the hospital to the community. With the current financial problem within most of our PCTs, it is hard to see how they will achieve this shift. The reality is that PCTs will have to make this shift to try to balance their budgets.

I can see that many Consultants will find this difficult to come to terms with. However, there are going to be many GPwSI opportunities available in the near future.

Chapter 7 Ensuring our reforms put people in control

Summary

- A stronger local voice to effect changes in service when needed
- Revised roles for local government and PCTs
- PBC benefits defined
- Supporting social enterprise in the third sector

It is hard to see from the proposals how the stronger local voice will be put into effect, although this could be via a strengthening of Overview & Scrutiny, Patient Participation Groups, Practice Patient Forums and patient survey involvement.

Over the next 2 years, funding to PCTs is to be reviewed. At present there is a 50% difference between the best funded and the worst funded PCT and it is the intention that this difference will be decreased to less than 20%. Although not specified, I would suspect that this will divert funding from the south to the north.

Commissioning of health and social care will be reviewed, with a framework due to be published during the summer of 2006.

Personal comment

The Department of Health have just created a national post of Director of Commissioning. It would be no surprise to those in Dorset and Hampshire to learn that Sir Ian Carruthers has taken on the role, until a permanent appointment is made during July 2006.

Over the next 2 years, there will be a major drive to improve commissioning both at a national and local level.

Conclusion

The White Paper sets out a long wish list, which is short on detail and costings are virtually absent.

Many of the proposals about developing primary care in general and general practice specifically, would be widely supported if funded and implemented.

General practice has been given a challenge by the Department of Health (DoH). Although repeated reference is made to the high quality of service delivered by GPs, our unique status as independent contractor, is seen as a block to future development. Some may argue that both PMS and nGMS have shown how general practice can respond to incentives and deliver in excess of what is expected. The problem for the DoH is that this has cost them significantly more than expected.

To achieve further change, the DoH appears to be offering incentives and rewards but does not define what these are and, in addition, poses the challenge that, if practices do not deliver what is asked of them, then other providers will be brought in. The new providers will be allowed to compete for patients who are currently registered with local practices.

Over the next year there will be much debate and discussions about the proposals in the White Paper, and the LMC will keep you informed.

The bottom line appears to be "adapt or die".