

Our health, our care, our say

A new direction for community services

In January 2006 the Department of Health published *Our health, our care, our say: A new direction for community services*.¹ It is the government's seventh White Paper on health since coming to office in 1997 and, after several years of reform aimed at the acute hospital sector, it represents what Patricia Hewitt, the Secretary of State for Health, calls a 'fundamental shift'² towards integrated services provided in local communities.

The government's rationale for this shift is that it is popular (people want more convenience, better access and more local co-ordination between services); it is cost effective in the short term (avoiding costly hospital treatment); it is better quality (reflecting technological changes) and it will save money in the longer term (better prevention now will avoid costly illnesses later).

This briefing outlines the main policies in *Our health, our care, our say* and offers some analysis of it.

What is the background to this White Paper?

Strengthening primary care was an early aspiration when Labour took office. Labour's 1997 manifesto emphasised the 'lead role' for primary care, in particular setting out a vision for using the 'combined strength of GPs' to commission high-quality care from hospitals.³ The newly elected government's first White Paper on health contained a solidly primary care focus. It abolished the Conservative's fundholding scheme (where GPs held budgets and bought services on behalf of their patients) but, crucially, retained the split between those 'purchasing' the services and those providing them, which laid the foundations of much of the subsequent reform. The White Paper set up primary care groups (PCGs), (later to become primary care trusts (PCTs)) with the aim of improving the commissioning of high-quality services locally.⁴

Since 1997, many policies have focused on primary care, with the creation of PCTs, setting up of more flexible GP contracts under personal medical services (PMS), the negotiation of new GP contract with new quality incentives built in and, from 2003, the development of a policy very similar to GP fundholding, practice-based commissioning, which will be rolled out nationally in 2006.

Hospital reform

However, hospitals have always attracted the bulk of resources and political attention,⁵ and the government has been diverted from its early aspiration for primary care into hospital reform, in particular reducing waiting times, (a goal with wide public support reflected in hostile media coverage of long waits). This change was achieved through a combination of stringent targets and, more recently (since 2003), setting up financial incentives to motivate NHS trusts to be more efficient and carry out more work. This incentives-based system, known as Payment by Results (PbR) is being rolled out fully in 2006 and lays the foundations for a more competitive environment for hospital trusts. The current White Paper has partly grown out of a recognised need to build some demand management into this new system, both by strengthening the power of the local commissioners and by increasing the range of non-hospital treatment options.

Another issue reflected in this White Paper relates to the optimal size and configuration of hospitals in relation to new technology and working practices. The size, location and function of hospitals had once been the object of considerable central planning,⁶ but the government's early efforts on this issue were channelled into enabling the Private Finance Initiative to flourish and decisions about size and function were left at local level. The tendency to close small local hospitals continued on the grounds of clinical and economic efficiency, until the publication of *Keeping the NHS Local – A New Direction of Travel in 2003* signalled a possible change of approach.⁷

Consumer choice

Increasing consumer choice has also been a powerful strand of Labour's health policy. Patients have had a choice of hospital since January 2006, and choice has been introduced in social care through Direct Payments to users. Choice of GP exists in theory, but the practical ease with which patients can move to a GP practice of their liking is limited, particularly in big cities, where a combination of bureaucracy and a shortage of GPs has led to lists being 'closed' to new applicants.

Prevention

Preventive health care first emerged in policies in the 1990s with health promotion clinics. Pressure to speed up reform in this area came from the Wanless report in 2002,⁸ and the subsequent public health White Paper, *Choosing Health*, published in 2004,⁹ presented a strong case for action. However, in some areas, notably the precise functioning of 'health trainers' and their relation to other services, there was a shortage of detail.

Finally, the White Paper also comes out of an increasing commitment to modernise social care, to shift towards an emphasis on prevention and to deliver integrated care. Previous policies to support partnership working between the NHS and local government have been driven by the need to relieve pressures on the acute hospital sector, created by people being admitted to hospital inappropriately or unable to leave hospital for lack of alternative care.

What does the White Paper seek to achieve?

It is difficult to identify a single overriding aim of the White Paper. It seeks to satisfy public demands for more choice, more access and better co-ordinated care but it also reflects a desire to limit demand and ration health spending over the long term, by prevention and by finding cheaper, out-of-hospital alternatives – which may limit choice.

There are several competing goals that emerge from the White Paper, including:

- To save money in the short term (brought into sharp relief by the current state of NHS finances). A powerful rationale put forward for bringing care 'closer to home' is that it could instantly deliver more efficiency and better value for money than treatment in hospitals; however, the evidence does not always back this up.
- To respond to new technological developments by searching for better, more appropriate care. This may or may not be cheaper.
- To invest in preventive care to avoid future costs: this ranges from broad public health measures (such as the 'life checks', being offered to some people) to better care for people with long-term conditions and disabilities. Although there is evidence to suggest that care for long-term conditions is cost effective, the evidence base for some of the preventive measures, particularly mass health screening measures such as 'life checks' is still weak.
- To link up the existing NHS reform of the hospital sector with the reform programme in primary care. This should make the whole system work better: stronger commissioning to counterbalance the hospitals, more competition and new 'market' entrants.
- To satisfy public opinion. It is unclear what the public wants from primary care; the government's interpretation of public demands are for more and faster access to health care (the 24-hour bank or supermarket analogy) and more screening and preventive consultations, both of which might prove costly and yet deliver few health gains.
- To integrate social care more with the NHS, partly to reduce cost pressures on hospitals and to create other efficiencies, but also to improve autonomy and better co-ordination of services from the patient and carer perspective.

What policies has the White Paper announced?

There are nearly 50 policies and initiatives in the White Paper, although many of these had been previously publicised by the government.

The new ideas to be found in the White Paper can be grouped into six themes.

1. *More services in the community*

- Up to 30 'demonstration sites' are to be established to develop new models of community-based care in six speciality areas. PCTs will be expected to use the findings from these pilot sites to guide their own local plans for transferring services away from acute hospitals.
- All PCTs must produce local development plans (LDPs) to show how they will shift the services they provide and their commissioning from secondary to primary and community care.
- The system by which hospitals are paid for the work they carry out – PbR – will be modified to boost the financial incentives for PCTs and GPs to commission services from primary and community care providers.
- All major new hospital-building projects are to be reappraised to ensure they do not run counter to the White Paper's aim to shift services into the community.
- New providers, drawn from the independent and voluntary sectors, are to be encouraged by the government to enter the community and primary care market and to compete to provide services. The government is keen to develop 'social enterprises' and a dedicated support unit is (with funds available) to be established in the Department of Health. All current and new providers will be assessed by a national accreditation scheme designed to guarantee quality.

2. *Greater prevention*

- NHS 'life checks', the public's most popular idea for improving the health service according to the Department's research,¹⁰ will be piloted for people over the age of 50 who are living in communities that have poor health and high levels of deprivation. Every patient will complete an online self assessment. This will identify those patients most at risk of ill-health, who will then go on to be seen by a 'health trainer' (who will be additional to the GP workforce). The phased approach is designed to mitigate fears that the so-called 'worried well' will channel resources away from those most in need.
- Trials are to be run to give patients requiring physiotherapy the opportunity to refer themselves to these services. The results of these studies will then be used to determine the effectiveness of future self-referral schemes.
- The formula that calculates how much GP practices are paid for their work, the Quality and Outcomes Framework (QOF), is to be modified to reward practices that provide more preventive care and public health services.
- A new Olympic-themed national publicity campaign is to be launched by the government to promote healthier lifestyles.
- The Department of Health will develop indicators to measure and improve the performance of the NHS's public health activities.
- Partnerships for Older People Projects (POPPs) have been set up to provide evidence of how partnership arrangements can improve outcomes for older people and shift health and social care resources towards prevention.
- New guidance is to be issued (by the end of 2006) on joint local authority-PCT commissioning to improve the commissioning of services aimed at healthy living and well-being.

3. *Enhanced access to general practice and community services*

- All patients are to be guaranteed registration with a local GP, and the registration system will be made more open and transparent.
- PCTs will be required to actively increase patient access to GPs in areas that are under-resourced. PCTs will be expected to explore all avenues to fill gaps in provision, including the use of the independent sector and social enterprises.
- PCTs that fail to produce robust plans for increasing access to general practice will be required to join a national procurement programme. This programme will involve a competitive tendering process, managed centrally by the Department. PCTs will be under some pressure to work on this, with national procurement due to start in mid 2006.

- PCTs will be charged with developing local measures to encourage GP practices and out-of-hours services to provide patients with more convenient and flexible access to their facilities.
- Direct payments in social care, which give individuals a sum of money to purchase the services they need, are to be extended. Additionally, individual budgets are to be piloted with the aim of giving people more choice and control and, in addition, stimulating the market in social care.

4. Better support to people with long-term conditions

- GPs will issue 'information prescriptions' to all patients suffering from long-term conditions. These will detail the steps patients should take to improve their own circumstances and the support services they can access locally.
- The Expert Patient Programme, which trains patients with long-term conditions to support themselves better, will be extended so that by 2012 100,000 people will be enrolled on the programme each year.
- Integrated personal health and social care plans, as part of a wider combined health and social care records system, will be offered to all patients with long-term conditions.
- Carers are to be provided with more support from the NHS and local authorities. An information helpline will be established, and each local authority area will offer short-term home-based respite services in crisis or emergency situations. The government will also refresh its 1999 national carers' strategy to better gear public services towards the needs and requirements of carers.

5. Integrating health and social care

- Extending local area agreements (LAAs), which have only been pilots so far, are to become the main tool for joint working between health and social care. LAAs are agreements between local authorities, the NHS and other local bodies, which contain targets and outcome indicators to improve the performance of local services.
- The planning and performance management systems of the NHS and local government are to be synchronised and aligned.
- A unified national complaints system for all health and social care is to be established.
- All PCTs and local authorities are to establish joint health and social care managed networks and/or teams to support people with complex needs. Health and social care services should be co-located in a community setting.

6. Provide people with a louder voice

- Local communities will be given the power to issue 'calls to action' to their local PCTs in response to issues of local concern. The precise status of and obligations a 'call to action' will place on PCTs are not clear; however, more detail is promised, including how to better involve ward councillors and Overview and Scrutiny Committees.
- The Department of Health will conduct a strategic review of the NHS's patient and public involvement practices and procedures.

How will the White Paper be implemented?

The White Paper does not envisage any major reorganisation of health services but relies on the development of the existing structures. Incentives will be delivered through the existing mechanisms of Payment by Results and the GMS contract, which will both be refined to energise the primary care sector. Better commissioning relies on the successful roll-out of practice-based commissioning and on stronger overall commissioning through the reform of PCTs. The extension of a 'mixed market' into new areas of primary and social care will again hinge on the commissioning competence of PCTs and SHAs, with some assistance from the Department of Health to support 'third sector' alternatives. The question of who will regulate this potentially wider market has yet to be addressed.

Very few of the White Paper initiatives will have any kind of immediate impact. The national procurement programme and the pilots for new models of care, including individual budgets and the 'closer to home' demonstration sites, will begin soon, mostly in 2006, and consultation on how 'local triggers can improve primary care will begin later this year.

However, some of the more ambitious plans will not be implemented until 2007/8: 'life check' pilots; action to open up GP registration; improving the national tariff.

What are the challenges ahead for the White Paper?

A clear challenge is how to attempt to satisfy public opinion while also pursuing some of the reforms that imply managing demand.

The government asserts that the public's priorities for health and social care have driven the White Paper, stating that the policies *'stem directly from what people have told us they want'*.¹¹

The feedback received from the Department's public listening exercise does demonstrate support for many elements of the White Paper, such as NHS MOTs and extending access to general practice. However, the 'fit' between the government's agenda and the public's is not complete. The full research report notes that *'people do not spontaneously call for hospital services to be provided locally'* and, indeed, it observes that *'a substantial proportion oppose this suggestion'* not least because they fear the closure of local hospitals.¹²

Funding and deficits

Although the current deficits are confined to a minority of NHS trusts, their magnitude and tendency to deteriorate quickly over time raise a number of clear challenges in relation to the aspirations of the White Paper. The most obvious challenge is that it is now apparent that resources for redesigning and developing new innovative services are scarce: previous King's Fund analysis has shown that much of the increases in funding will be absorbed by known cost pressures, including substantial pay increases for staff.

Deficits also create a pressurised atmosphere within which PCTs are having to balance their books; this militates against considered approaches to demand management. The deficits have also exposed a lack of accountability. Attempts by deficit-hit boards to ration services, often by closing down facilities, have met with considerable public hostility (for instance in Suffolk)¹³, which has not been placated by efforts to consult the public or involve them in formal NHS bodies. Many of the White Paper's recommendations imply substantial service redesign and not all of them may be popular.

The financial climate also makes co-operation between health and social care much harder. It increases the temptation to 'cost shunt', moving costs of a service from health to social care, where the lines are often blurred locally. Also, the presence of underlying deficits can often make potential partners wary for fearing of inheriting some of the debt themselves. Both decrease the chances of effective collaborative working.

Improving choice of and access to GP services

There still seems to be some uncertainty about the scope of reform of GP services. New providers will be allowed into areas that are short of GPs (and it remains to be seen how successful the independent sector will be in recruiting doctors where traditional means have failed). However, the White Paper stops short of opening up the sector as a whole. Patients will not be allowed to register at more than once practice, and it will still be possible to 'close' a registration list. Although in theory money follows the patient in primary care, the White Paper acknowledges that the system is not as flexible as it might be and further changes to both GMS and PMS contracts are required.

Strengthening commissioning

Much of the White Paper's vision hinges on powerful, effective commissioning at PCT level and, particularly, at GP level. The need to improve commissioning has been recognised for some time. Many of the initiatives build on existing policies and plans, including practice-based commissioning and the reorganisation of PCTs into larger bodies. The White Paper offers some adjustment to the financial incentives, for instance offering the 'flexibility' to make community-based options more attractive, but it will take time to implement these incentives, and until then effective commissioning at trust and GP level remains an aspiration.¹⁴

Meanwhile, much remains to be done to build joint commissioning skills between health and social care. Many of the aspirations of the White Paper will falter unless PCTs and local authorities can both deliver better commissioning more effectively.

Will it be successful?

There is much to be welcomed in the White Paper, particularly the intention to use primary care better to deliver prevention and the recognition that social care and health services have to be better linked. But, even though the intentions might be honourable, there are too many uncertainties about the mechanisms the government is using to reform the NHS in England to be confident of success.

Incentives, consumer choice and competition from new providers are being relied on to reform a complex system, which has, until recently, seen most change driven through centrally set targets and top-down regulation. There must be a real risk that the large number of new objectives in the White Paper, however welcome, might disappear from view as the NHS struggles to make the new system work.

¹ Department of Health (2006). *Our health, our care, our say: A new direction for community services*. London: The Stationery Office. Available online at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127453&chk=NXlecj (accessed on 26 April 2006).

² Department of Health (2006). 'Better services and more choice, on your doorstep.' Press release 2006/0044. Available online at http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4127458&chk=hXh%2B45 (accessed on 26 April 2006).

³ Labour Party (1997). 'New Labour because Britain deserves better'. Available online at: <http://www.labour-party.org.uk/manifestos/1997/1997-labour-manifesto.shtml> (accessed on 26 April 2006).

⁴ Department of Health (1997). *A Modern and Dependable NHS*. London: HMSO. Available online at: <http://www.archive.official-documents.co.uk/document/doh/newnhs/wpaper1.htm> (accessed on 26 April 2006).

⁵ BBC News 30th January 2006 'NHS reforms A case of déjà-vu?'

⁶ Ministry of Health(1962). *A Hospital Plan for England and Wales*. London: HMSO.

⁷ http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4073403&chk=l3K/PN or <http://www.dh.gov.uk/assetRoot/04/08/59/47/04085947.pdf>

⁸ HM Treasury (2002). *Securing Our Future Health: Taking a long term view*. London: HM Treasury. Available online at: http://www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm (accessed on 3 May 2006).

⁹ Department of Health (2004). *Choosing Health: Making healthier choices easier*. Cmnd 6374. London: The Stationery Office. Available online at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAndGBrowsableDocument/fs/en?CONTENT_ID=4097491&chk=KPBy7H (accessed on 3 May 2006).

¹⁰ Opinion Leader Research (2006). *Your health, your care, your say: Research report*. London: Department of Health. Available online at:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4127357&chk=UYgWq5 (accessed on 26 April 2006).

¹¹ Department of Health (2006). *Our health, our care, our say: A new direction for community services*. London: The Stationery Office, p 14.

¹² Opinion Leader Research (2006). *Your health, your care, your say: Research report*. London: Department of Health.

¹³ <http://news.bbc.co.uk/1/hi/england/suffolk/4522998.stm>

¹⁴ Lewis R (2006). 'A new direction for NHS community services: the white paper tackles the right issues but may be hard to implement'[editorial]. *British Medical Journal* vol 7537, pp 315-6.