

The aim of reform should be to encourage local agencies to find better ways of delivering high quality responsive services that reflect the needs of individuals and the characteristics of the local population. The role of the centre should be to provide the right incentives and regulatory structure to ensure that is achieved. The centre should concentrate on outcomes and on ensuring minimum national standards are met, it should not devise detailed implementation strategies. We need to move from a system characterised by central targets, to one that is locally determined, which delivers good access and continuity of care.

**Theme 1: Providing quality services**

*I expect someone to take responsibility for making sure that the local health and care services I receive meet a good standard. Those who offer poorly performing services should be required to improve or be replaced. I expect local services to be in pleasant and accessible facilities and to be properly equipped. I should be able to choose to move to another service and I should be made aware that such choices are available.*

1.1 Primary Care Trusts and local authorities are accountable for the services in their area and they should be willing to remove contracts from providers, including GPs, who fail to provide good services. No providers should be awarded indefinite contracts and commissioners should be able periodically to test for alternative suppliers. Commissioners would need to be aware of the impact changes could have on access but in areas where health or care services have failed to meet required standards or where there is under-capacity, PCTs and LAs should contract out those services to new providers. The tender process would bring in new providers, including groups of GPs, who would be required to meet outcome targets.

1.2 Incentives need to be introduced which encourage PCTs and local authorities to focus their efforts on commissioning good quality services and to define quality standards and outcome measures which should include goals to narrow the gaps in morbidity and life expectancy between different areas. The implementation guidance for practice-based commissioning should also include incentives to reduce levels of morbidity and mortality, particularly in areas where these are higher than average.

1.3 Further national standards based on outcomes for health and social care should be developed. PCTs and LAs should be monitored against these standards but should have the flexibility to determine how these are met locally. In addition they should develop local quality standards which could be linked to additional funding for providers who meet them.

1.4 DH should consider setting up a centrally-held fund, to which PCTs could apply, to stimulate the development of services in areas which are currently not well served. Another option would be to offer an enhanced capitation fee in these areas to provide a further incentive to develop high quality services in these areas.

1.5 GPs could be given incentives to meet these standards through changing the way that points are allocated in the QoF (rather than through increasing the QoF budget as a whole).

1.6 DH should make it easier for patients to change their GP practice or other primary care provider by removing current bureaucratic obstacles and by taking further steps to ensure there are enough GPs to enable patients to make a choice. Information should be made

readily available making it clear that patients have the right to switch and telling them how they can do it. The same should apply to anyone using social care - these should be enshrined in the right to a direct payment or individual budget but even where the service is commissioned by the local authority the user should be aware of their right to an alternative.

## **Theme 2: Access and thresholds**

*I want to continue to be able to make an urgent appointment to see a doctor at my surgery on that day, but also to make a routine appointment with the individual professional of my choice at a later date of my choosing. In an emergency, it should be easy for me to access appropriate local health services out of hours and, if I need one, to see a doctor. The levels of service I am offered should reflect my level of need and not where I live.*

2.1 A more sophisticated standard for access needs to be developed which allows patients, carers and users to access services quickly when this is required but which also allows them to book appointments in advance with a professional of their choice.

2.2 National standards should be developed which set out minimum “office hours”, “extended hours” and “out of hours” for both primary and social care. These should be set out in terms of access not the institution - for example, the standards might stipulate that patients should have access to a local surgery on a Saturday morning rather than that all surgeries must open at that time. PCTs and LAs should have discretion about how they meet these standards, but the QoF should be re-balanced to provide incentives to extend opening hours.

2.3 Those who commission local services should encourage providers to introduce a mixture of drop-in and pre-booked appointments where uptake of services such as ante and post-natal care, is low.

2.4 There should be a national standard which requires PCTs, as part of their planning and commissioning function, to consider the implications for access of moving services out of hospital. Those on low incomes should be given help with transport costs to attend services.

2.5 DH should introduce national standards (which go beyond current eligibility criteria) setting out the thresholds for access to social care. As a first step, detailed calculations should be undertaken to gauge the cost of introducing acceptable minimum standards, recognising that there is a danger that if they are too minimal, it may result in thresholds being raised in some areas, thereby reducing access to care.

2.6 These national standards for social care should draw upon the Prime Minister’s Strategy Unit report on *Improving Life Chances of Disabled People* which states that:- “By 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society”. LAs should be given incentives and, if necessary, resourced, to take practical measures to help all those using social care to live as independently as possible and that those who wish to live independently in the community should have a right to do so.

## **Theme 3: Addressing conflicts of interest**

*I expect those who plan and commission services to base their decisions on what will best meet my health and care needs. They should not support poor quality services and there*

*should be rules to ensure there are no conflicts of interest when decisions are made to fund or make referrals to services.*

3.1 At the level of PCTs and local authorities commissioning and provision should be separated. In the event of private companies taking on the commissioning function (an option which should be explored), on no account should they be involved in providing any of the services that are commissioned. Before the roll out of practice-based commissioning the DH will need to devise ways of dealing with the potential conflict of interest between GPs as commissioners and providers. One way of dealing with this would be to regulate the quality of the services GPs provide to make sure that the services they develop to replace hospital based care are appropriate and of a high standard. In addition rules should be introduced to govern the conduct of those who refer to or commission health or social care services in which they have a financial interest.

3.2 Hard budgets should be introduced for practice based commissioning - under the current arrangements the risk is unfairly loaded onto PCTs. Under the proposed soft budget arrangements, PCTs are required to meet deficits but practices are able to retain profits. This does not provide the sufficient incentive to encourage practices to develop new services.

#### **Theme 4: Integrated assessments**

*Whenever possible I expect to be offered a single assessment or for someone to explain why more than one assessment is necessary. Once I have taken part in the assessment, I expect someone to ensure I receive the services that I need. If I have unmet needs I expect those responsible for local services to be informed to help inform future planning.*

4.1 There is a need to develop a streamlined process to reduce the number of multiple and overlapping assessments, especially given to those with long-term conditions or complex needs. The single needs assessment described in the NSF for older people provides a template and younger people with complex needs should have access to a similar service. The professional best placed to carry out such an assessment will vary but could include community nurses or social workers. The assessment should spell out clearly the responsibilities of the different professionals and agencies involved.

4.2 One current model for making sure that the needs identified in the assessment process are met is to give a single professional - a co-ordinator - the responsibility for chasing progress in their own and in other organisations. The co-ordinator should have a good knowledge of local services in both health and social care. For those with long-term conditions, this role may be undertaken effectively by community matrons or care managers.

4.3 Unmet need should be recorded and brought to the attention of commissioners.

#### **Theme 5: User voice**

*I expect the those who commission or provide local health and social care services to find out and take account of my views and those of others who use their services. A summary of those views should be made public. I also expect those who commission local services to be open about how they have set priorities when faced with competing needs.*

5.1 The QoF currently encourages practices to carry out a survey of users' views but this is reviewed by the practice. It would be more effective if surveys in an area were reviewed by a panel of users and the findings published

5.2 PCTs could encourage practices in their area to apply for the Royal College of General Practitioner's quality practice awards. This is a quality assurance process which recognises quality patient care delivered by every member of the practice team.

5.3 Commissioners should be given further incentives to involve service users in the development of the commissioning plans for the health and care of local population.

5.4 The role of service users in the Healthcare Commission's inspection teams (and other relevant inspection bodies) should be strengthened. Those who use services should be given appropriate training and their term of office should be restricted to a maximum of five years.

### **Theme 6: User choice**

*I expect to have good information about the quality and range of services available and to be given a choice of services and for those I use to talk to one another so that any care and support I receive is not duplicated and serves my needs.*

6.1 The Health and Social Care Information Centre (or another agency) should be asked to carry out a scoping study to identify what information should be held at a local level to allow professionals and patients to choose an appropriate service, certainly for common conditions such as mental health, cancer and heart disease. It should also consider the feasibility of developing a template which local commissioners could fill in or adapt to reflect what is available in their area. The scoping study should also consider what information should be held about the quality of different services

6.2 To make informed choices about services, those who use services need access to data on quality, patient and user surveys. Information should be provided in different languages and in appropriate formats. Possible levers to ensure this level of information is available could include writing information standards into contracts and introducing a QoF payment for GP practices meeting this standard.

6.3 The Health and Social Care Information Service should also investigate the feasibility of helping providers to establish feedback systems similar to those operated by internet companies such as Amazon.com which enables customers to comment on the service they received and to view comments from others.

6.4 Continued efforts need to be taken to address workforce issues if health and social care services are to offer meaningful choice, particularly in specialties with pronounced and longstanding shortages such as midwifery. The new Strategic Health Authorities should produce 10 year rolling workforce plans for their areas which address these shortcomings.

6.5 The desirability of receiving a joined-up service should not over-ride the individual's right to determine what personal information is seen by different professionals and different organisations involved in providing care and support. The principles behind a user-held record should be retained when electronic records are introduced as part of Connecting for Health.

6.6 Patients with a long-term condition should have the opportunity to speak to and learn from peers who have received appropriate training which allows them to be objective and offer impartial advice. DH should build on the current manifesto commitment so that by 2010 patients with defined long term conditions will have a right to be offered peer to peer support and that commissioners are obliged to ensure access to such a service. It will also be important to enhance the skills of professionals in involving patients and users in decisions about their care.

6.7 The Health and Social Care Information Centre (or another agency) should be asked to develop an Advertising Standards Authority-type model of voluntary accreditation to improve the quality of information for patients and to offer some quality assurance. This model could be developed in alliance with the Plain English Campaign to make sure that information, as well as being accurate, uses clear and straightforward language.

6.8 Practices and PCTs will need to agree the care pathways which should be commissioned for patients following a needs assessment of the local population. The choice agenda should deliver a number of reasonable choices of provider for patients not just for elective care but also for those with long-term conditions.

### **Theme 7: Supporting self-care and self-management**

*I recognise there is a limit to what the NHS and Local Authorities can do to improve my health and that I am primarily responsible, but I expect the local health and social care systems to do what they can to help me keep myself as healthy and as independent as possible and not just to treat me when I am ill.*

7.1 The overall aim of the health and social care system should be to keep people as healthy and as independent as is possible. To achieve this the system needs to do more than respond when things go wrong. The goal must also be to develop cost effective and, where appropriate, proactive interventions that prevent illness and dependency. Those who commission services should have their performance measured by the extent to which they are able to deliver services that meet this aim.

7.2 As part of this PCTs and LAs should given further incentives to develop joint and robust Local Area Agreements to improve the health of the local population and they should both be held accountable for delivering them. DH should take further steps to provide greater freedom and flexibility to pool budgets between local authorities and PCTs

### **Theme 8: Rights and responsibilities**

8.1 The government should consider publishing a compact spelling out what anyone using health and social care services can expect to receive. As taxpayers and citizens we have certain rights and in a more pluralist service it is all the more important that these are set out clearly. At the same time we all have to accept the limitations of those services and our own obligations both for self care and to use the services responsibly. It is particularly important to have realistic expectations of how quickly we should expect to be seen and that we are responsible in demanding urgent attention.

**Niall Dickson 10 November 2005**