Department of Health

PARTIAL REGULATORY IMPACT ASSESSMENT -

White Paper - Our health, our care, our say: a new direction for community services

Objective

1 The overarching objective of the White Paper is to improve community health and social care services in England. Underpinning this objective are four key themes:

- Better prevention for improved health and well-being;
- Giving people greater choice and control over the care they receive;
- Providing rapid and convenient access to high quality, cost effective, care closer to home; and
- Support for people with long-term conditions.

Introduction

2 This Partial Regulatory Impact Assessment (RIA) provides the Government's considered early assessment of the likely impact of the policy initiatives set out in the 'Our Health, our care, our say: a new direction for community services' White Paper, published on 30th January 2005[1]. The costs set out in this document are preliminary estimates, and will be refined throughout the implementation process.

Background

3 Major strides in health and social care have been achieved in the last five years. Extra investment in capacity has meant that significant reductions to waiting times have been achieved. More than 80 per cent of the health service budget has moved to local people through Primary Care Trusts (PCTs).

4 We are now changing the way we deliver services – recognising that people want more choice, information and support, to enable them to look after their own health and make healthier choices in their everyday lives. *Building on the Best*[2] and the *Choosing Health*[3] White Paper are just two of the major initiatives that are setting that new direction.

---

[1] Department of Health (2006)
[2] Department of Health (2003)
[3] Department of Health (2004)

5 Social care services have also been modernised over the past five years, now offering a wider range of services than ever before, being provided through a more diverse range of service suppliers to support people to maintain their independence and live active and full lives with their families and wider communities.

6 It is vital to drive through these changes and maintain the momentum, by turning the spotlight on services closer to home. A focus on waiting times has meant that much of the attention was on hospitals. But 86 per cent of care occurs in the community, outside hospital. It is now time to concentrate on community health and social care.

7 The White Paper is shaped around two major consultations. The traditional document-based consultation on the adult social care Green Paper *'Independence , Well-being and Choice'*[4] and the *"Your health, your care, your say"* consultation exercise[5], which was different from anything that the Department of Health has done before. Members of the public had the opportunity to deliberate, prioritise and articulate what they want from health and social care in their everyday lives.

Rationale for Government intervention

8 The Department of Health is more than halfway through a ten-year plan[6] to provide a modern NHS that is responsive to patient needs and which is as much about the promotion of good health and well being as treating ill health. Social care services have been changing too to support people to be independent, increase their well-being and give them more choice and control.

9 However, we are some way from meeting peoples' expectations of modern, convenient health and social care. There are long-term challenges ahead: people live longer lives but not always healthier ones; the number of people with long-term conditions is rising; there are increasing pressures on the acute system, with some small groups accounting for a large proportion of hospital activity.

10 Whilst much progress has been made in improving care outside of the hospital, the consultation exercise highlighted areas where services could be improved. These can be summarised as follows:

11 While satisfaction with primary care is high, there is room for improvement around:

- Access, including:
    - the gap between recorded performance in 24/48 hour access and patient experience
    - the times of day when patients can access services[7]
    - difficulties in making and changing appointments

[4] Department of Health (2005)
[5] 'Your health, your care your say: Research Report', Opinion Leader Research (2006)
[6] The NHS Plan: A plan for investment, a plan for reform Department of Health (2000)
[7] Patient Survey report, Healthcare Commission (2004)

- Choice of registration, including:
  - closed lists, and ‘open but full’ lists
  - lack of information to inform choice at registration
- Capacity and contestability:
  - under-capacity in some areas means services are stretched
- Improving equality of access, and reducing health inequalities

12 Localised examples of care closer to home have been seen to deliver high quality cost effective care that gives high patient satisfaction. Often these changes have been enabled by highly innovative individuals, and not necessarily because the system encourages it. Intervention is needed so that these positive changes are more systematic, and so that better care closer to home is more widespread.

13 While public health services that have been adopted are making a significant contribution to health and well-being, England still spends a proportionately less on health promotion and well-being services than its peers[8]. Policies that keep people healthier for longer will reduce the requirement for care downstream.

14 The *Independence Well-being and Choice* consultation demonstrated that people too often find the integration of services to be poor, especially at the boundary between health and social care. This can cause frustration and confusion, and lead to a waste of time and money. The consultation also made clear that people expect social care services to help them, as far as possible, to maintain their dignity and independence and to offer them a greater degree of choice and control over their care. The Green Paper argued that a new vision for social care services was necessary if these challenges and the expectations of users are to be met. The proposals in the White Paper set out that new vision.

15 It is clear, from the *Your health, your care, your say* consultation that there are deficiencies in the way in which the health and social care system delivers care to those with long-term conditions. For example, 50 per cent of people with long-term conditions are not aware of treatment options, 25 per cent do not have a care plan and 50 per cent do not have a self care plan. Only 1 per cent of people being supported with community services receive a direct payment which allows them choice and control over the care they receive.

16 End of life services remain fragmented- although most people would like to be cared for at home, only 20 per cent of people die at home and 20 per cent in care homes. It is also apparent from the consultation, that services for those with long-term conditions are too often not aligned to personal needs and preferences and that services are too often seen as reactive rather than proactive. There is not enough emphasis on prevention and early intervention, which results in poorer long-term health outcomes and also causes too many expensive and unnecessary accident and emergency attendances and hospital admissions.

[8] Calculated from OECD data (2005)

Consultation

With Government

17 There has been consultation with a range of government departments including Her Majesty's Treasury, Office of the Deputy Prime Minister, Department for Education and Skills, Department of Trade and Industry, Department of Work and Pensions, Ministry of Defence, Small Business Service, Home Office and Number 10.

Public Consultation

18 The White Paper builds on two earlier public consultations - Social Care Green Paper *Independence Well-being and Choice* and *Your health, your care, your say.*

19 Social Care Green Paper *Independence Well-being and Choice* consultation resulted in over 1,500 formal responses being received and considered. A wide range of organisations (representing key stakeholders) and individuals were represented in this response, from all sectors. In addition, it is estimated that more than 2,000 individuals participated in discussions carried out a regional and national consultation events. A document detailing the responses to the consultation was published in October 2005[9].

20 *Your health, your care, your say* was an innovative and deliberative listening exercise, one of the largest research-based consultations ever to take place in the country. People were asked to debate what we should do in the future to support their health and well-being. 33,166 people completed on-line and paper based questionnaires and adapted questionnaires in widely read magazines – "Take a Break and in the NHS publications "Fit", "Prime for Men" and "Prime for Women". 8,460 people took part in locally organised events; many used an approach developed by Opinion Leader Research (OLR) to ensure a common approach across the consultation. 254 people randomly selected from electoral registers took part in four regional events organised and facilitated by OLR.

21 Nearly 1,000 people (randomly selected from electoral registers around the country) took part in a National Citizens' Summit in Birmingham on 29 October 2005. The Summit focussed on specific issues that emerged from the earlier deliberative events and in response to questionnaires.

22 In addition, written responses to the *Your health your care, your say* consultation were received from a wide range of stakeholders, including voluntary and community sector or not for profit organisations, statutory and academic bodies, the private sector, staff and professional groups, 'seldom heard' groups and public feedback. Organisations representing these groups also made up the membership of five policy taskforces that ran alongside the listening exercise.

[9] Department of Health 2005

Options

23 The White Paper contains a range of measures to improve health and social care delivery the experience of patients. These are structured around five key initiatives:

- *Primary Care* -to deliver improved performance, more convenient access, and greater choice in general practice.
- *Shifting Care* - to make significant improvements in moving care closer to patients homes, to enable them to be treated quicker, more conveniently and without the need to attend hospital.
- *Healthy Living* - to achieve real and sustainable shifts in how we use national resources, empowering people to care for themselves better, avoiding future disease.
- *Social Care* - to transform the social care system and the way in which it interacts with health care services and other local services; increasing choice and control for people who use social care services, by strengthening partnerships between social care and health services and other local authority services; and by improving information and support to service users, making the system clearer and easier to navigate.
- *Long-term conditions* - to improve health and patient outcomes for people living with long-term health conditions who are likely to need ongoing support from health and social care services

24 An initial assessment of the likely regulatory impact of each of the initiatives announced in the White Paper is set out in the following annexes:

Annex 1: Primary care
Annex 2: Care closer to home
Annex 3: Healthy living
Annex 4: Social care and improving partnership working
Annex 5: Long-term conditions

Costs and Benefits

<u>Sectors and Groups Affected</u>

25 The proposals outlined will have an impact on a range of sectors and groups. The main organisations affected are as follows:

- General practice: general practice will be central to a number of the reforms, including delivering better access and convenience, and providing services to support healthy living and management of long-term conditions
- PCTs and local authorities: stronger tools and support to ensure more robust and seamless commissioning of services
- Secondary care providers: greater range of services provided in the community
- Providers of social care: new pattern of demand for social care services driven by individual choice and control. Informal carers to be offered better support and advice.

- Providers of community care: a greater range of services provided in community settings
- Independent sector providers (including the third sector): removing barriers to enable greater provision of health and care services

26 Service users will also be affected by the changes. All users should see the benefit of more convenient and responsive care, better support to stay healthy and manage their own conditions, more choice over where they receive their services, and higher quality. The proposals have a strong health inequalities focus, and can raise standards in deprived areas, and for ethnic groups.

Benefits

27 The benefits of the preferred policy options are as follows:

Primary Care:
- local solutions to improved access, as determined by local needs
- a focus on targeting less well served areas, so supporting the health inequalities agenda
- fosters greater contestability between practices by attaching higher values on patients
- provides a clear approach to identifying and addressing poor quality services
- greater efficiency through a more focused use of primary care resources

Care Closer to Home:

- greater choice, better clinical outcomes and higher patient satisfaction
- greater innovation and plurality of provision through increased use of third sector providers
- more scope for economies of scale, and greater convenience through providing more services under one roof

HealthyLliving:

- better health and more independence of the population
- stronger commissioning of cost effective interventions
- less demands on secondary care, shift of emphasis from predominantly an illness service to a health service

Social Care

- greater choice, flexibility and control over services and better information and assessment to facilitate these choices
- better integration between health and social care services, making the system clearer, easier and quicker to navigate
- improved care planning system will make services more personalised and better aligned with needs of the service user, improving health outcomes
- better support for carers will help relieve the burden and improve quality of life for both carers and those cared for

Long-Term Conditions

- improved health outcomes and patient satisfaction
- better care planning and provision of better information and support, aligning services more closely with needs of the patient
- reduced demand for secondary care and GP services (particularly urgent episodes) through better prevention and earlier intervention
- facilitation of self care and peer support, putting the patient in control of their care
- stronger commissioning arrangements and financial incentives to support the development of better care for people with long-term conditions

<u>Summary of costs and benefits</u>

Primary care

Option 1: Do nothing

28 There would be no additional direct costs or benefits to option 1. Although there have been major improvements in recent times, problems around access and registration would continue. Furthermore, the wide variations in quality and access to services across geographical areas that currently exist[10] will persist. Disadvantaged areas will continue to receive poorer quality services and this will perpetuate existing health inequalities. Good access to high quality primary care can reduce demand for more expensive secondary care services further downstream.

Option 2: Making the existing system work better

29 This is a staged approach to delivering improved access, choice, and contestability through a blend of incentives, targeted capacity building and performance management.

30 These policies would be delivered between 2006-07 and 2008-09 (see Annex A for details). The services will be delivered through general practice, and the costs and method of delivery will be agreed in negotiation with the General Practitioner Committee (GPC) of the British Medical Association (BMA).

31 The benefits are set out above and include, better access, clarity around closed lists, and more services in areas of low capacity.

Option 3: A national approach to increasing access to every GP practice

32 This option focuses solely on the strongest message about general practice from the consultation, and nationally mandates practices to open 08.00 to 20.00

[10] Hann M, Gravelle H. The maldistribution of general practitioners in England and Wales 1974-2003. British Journal of General Practice 2004;54; 894-8

on weekdays, and 08.00 to 13.00 on Saturdays. The benefits would be guaranteed access to the patients' own practice for nationally determined hours – tackling head on the key issue raised in consultation. However, this approach would lead to significant inefficiencies, as practices are likely to be running with excess capacity at some times of the day. Elements of option two could also be used to complement the national approach to access.

Option two is the preferred option

Care Closer to Home

Option 1: Do nothing

33 System reform changes such as Payment by Results and Practice Based Commissioning provide the incentives to transfer care into community settings where appropriate. However, it is difficult to assess the impact of these changes on the increased volume of activity delivered in the community. Capacity constraints may mean that the shift is limited.

34 There are no direct additional costs and benefits associated with this option over and above the costs of the broader system reform programme. However, failure to progress with this agenda quickly and robustly will mean that patient preferences will not be met, and the potential efficiency savings from delivering services in a lower cost setting will not be achieved.

Option 2: Minimal shift, based on the 'Office Doctor' model

35 Evidence suggests that this approach to increasing activity in the community delivers high levels of patient satisfaction, and better access to services. However, it is up to two to three times more expensive, due to a lower throughput of activity and under-utilised capacity. If we assume that one million outpatients appointments are carried out this way, and that past evidence is borne out and the costs are twice as high as other settings, the additional cost would be in the region of £110m additional running cost.

Option 3: A co-ordinated approach to delivering more activity closer to home

36 This approach will:

- set up a number of demonstrator sites to explore best practice
- develop a new generation of community hospitals
- further develop the system reform agenda to facilitate increased activity in the community
- create a third sector development fund to support potential third sector providers of local health and care services

37 It is estimated that the transfer of activity will be broadly revenue neutral. Costs could be in the region of £12m per annum, reflecting lower throughput in the non-hospital sector.

38 The estimated total capital costs associated with the development of the new generation of community hospitals and other facilities is between £1.1bn to £2.2bn. This will impact from 2008-09. The exact costs will depend on the method of procurement and phasing of the building programme. Further work will be carried out into this.

39 It is estimated that cost and accreditation of Practitioners with Special Interests will be in the region of £10m.

40 The third sector development fund is likely to cost in the region of £25m. The bulk of these monies will be capital.

41 The benefits are set out above.

Option three is the preferred option

Healthy Living

Option 1: Do nothing

42 Changing lifestyles are having a major impact on the health of the population. Obesity rates are increasing and this is expected to lead to significant growth in obesity related disease (for example by 2030, Type 2 diabetes is predicted to have grown by 54 per cent), smoking is still the greatest cause of premature death in England today, and a significant proportion of the population consumes more alcohol than the recommended maximum. If they carry on unchecked, these factors will place major additional burdens on secondary care providers, and the current system of delivering healthcare services is unlikely to be sustainable.

43 While doing nothing would not generate any additional direct costs or benefits, the risk around doing nothing is the greater incidence of poor health in the future, and spiralling costs of hospital care.

Option 2: A co-ordinated approach based on cost effective interventions

44 This will include:

- An NHS 'Life Check' at key life stages
- A commissioning toolkit
- Potentially using the Quality and Outcomes Framework (QOF) to incentivise well-being services

45 The costs of the NHS 'Life Check' proposals are calculated on the basis of working within existing budget (and therefore capacity of) for health trainers (HTs) within Choosing Health (£36m 2006-07; £77m 2007-08) i.e. 3,000 HTs from 2007-08 onwards.

46 The PCT will have discretion over the level of provision, and the amount spent on them. These decisions will be in part informed by the commissioning

toolkit, which will provide evidence of how these services can be provided and the benefits realised downstream.

47 Inclusion of new indicators in the QOF in 2008-09 requires evidence that interventions through general practice are effective. The cost of the QOF incentives will depend on the clinical evidence. This will be agreed in negotiation with the GPC.

48 The benefits are set out above.

Option 3: A more systematic and intensive approach

49 This will include:

- a more systematic health check
- more systematic development of self care services

50 The more systematic health check and stronger approach to self care will cost in the region of £300m per annum. Evidence suggests that this approach to life checks is not cost effective, and in some cases be detrimental to patients.

51 The more systematic approach to self care could cost up to £24m per annum. This would be likely to push the self care agenda further and faster.

Option two is the preferred option

Social Care/ Integration

Option 1: Do nothing

52 This would not impose any direct additional costs but would mean that the system remains too fragmented, particularly the boundary between health and social care. Services would remain too often standardised and organised around the provider, with too little choice and control for the individual user.

Option 2: Co-ordinated Government action to improve social care and partnership with health and other services

53 An initial estimate of the total cost of the proposals in the White Paper to improve social care and integration with health care is £51-60m.

54 Costs of providing care plans for all those with social care needs are estimated to be around £27m per year.

55 Initiatives to improve support for carers include the provision of short-term respite support for carers in emergency situations are estimated at £25m per year, providing funds to councils to commission training for carers are £5m per year, and the introduction of a new phone helpline to provide advice and support for carers £2-3m per year.

Option 3: Full Implementation

56 This option involves the full roll-out of individual budgets and of a common assessment framework for health and social care. This option will mean that the benefits are delivered to more people sooner. The exact costs of this option are not known since these are innovative new policies for which the evidence base for costs and benefits is not well established. This is why Option 2 and the White Paper signals our intent to pilot them first.

Option two is the preferred option

Long-term conditions

Option 1: Do nothing

57 There are no additional direct costs or benefits to option 1. The number of people with long-term conditions is forecast to increase by over one million each decade from ageing population alone. It is clear from the consultation and evidence (see Annex 5) that there are deficiencies in the way the current system delivers care and supports those with long-term conditions. Failure to address these issues will mean that the burden on secondary care will continue to spiral.

Option 2: Co-ordinated approach

58 It is estimated that the annual costs (from 2008/09) associated with the proposals in the White Paper for ongoing integrated support for those in greatest need will be around £164m.

59 Proposals to improve end of life care are estimated to cost £54m in 2007/08 and £64m in 2008/09. Long-term conditions demonstrator sites will cost around £15m in 2007/08 and 2008/09. Establishing joint health and social care teams to support those with complex needs will require £4m per year to support team development and facilitate social care input.

60 Provision of an "information prescription" will cost around £5m in 2008/09 (£2m of which is covered by the Information for Choice programme) but this cost should fall over time. This information prescription will usually be filled in by health or social care professionals (e.g. GPs, social workers or district nurses). It is envisaged that the prescription will be provided during consultations that people with long-term conditions already have with these professionals.

61 Improving self care support in the ways outlined above will cost around £5m per year, in addition to a further £12m to extend the Expert Patients Programme, as signalled in the Manifesto. Any care plans provided through a Directed Enhanced Service (DES) will be subject to negotiation.

62 Costs of demonstrator sites for psychological therapies is likely to be in the region of £3.5m.

Option 3: Further and faster

63 Option 3 would involve an immediate full roll-out of the policies set out under option 2.   This will mean that patients will benefit as soon as possible from the changes. However, it is difficult to accurately estimate as these will be informed by pilots. Benefits are likely to be similar to those under option 2, although piloting first will allow lessons to be learned and ensure good quality and value for money when the policies are rolled out.

Option two is the preferred option

Race Impact

64 Many of the policies and proposals included in the White Paper have been designed with the express goal of reducing inequalities and helping areas of deprivation.

65 During the listening exercise, *Your health, your care, your say*, there was a strong drive to hear input and ideas from seldom heard groups including black and minority ethnic groups. Special events were held to capture ideas from these groups. Key ideas emerging from these events include:

- information on leading a healthy life – in a culturally relevant treatment e.g., an understanding of the health aspects of certain ethnic foods
- information available in different languages
- messages delivered by people from within the communities – train local people to be health advocates
- a one-stop assessment or case manager for those with language difficulties who could give advice and guidance that is culturally sensitive and in the native language.

66 The White Paper has tried to address as many listening exercise inputs as possible where the right evidence base also corroborates public demand. Summarised below are the policies and directions set by the White Paper and their likely impacts on minority populations residing in England. Since all policies are detailed in the White Paper itself as well as this RIA, this section deals solely with the major policies having a potential impact.

Social Care

67 Many social care proposals in the White Paper are really integration proposals where services or processes are being aligned between health and social care. Any alignment is likely to help minority ethnic groups as it will simplify and limit required interfaces with services.

68 Individual budgets and direct payments are being piloted and will only be rolled if shown to be effective for all populations. It is expected that they will greatly improve quality of life as people will be able to choose services which are most helpful and valuable to them instead of the service deciding on their behalf.

69 Single assessment: The single assessment between health and social care will help those in minority ethnic groups as it is designed to ease and simplify interactions with the system overall.

70 Training and information for carers will also help the significant number of carers of minority ethnic status.

Shifting Care

71 A new generation of community hospitals can improve access to care for populations who have had difficulty accessing care under past geographical configurations. Because community hospitals will be local, their services may be tailored to the specific needs of the local population

72 Pilots of community care in select specialties: These pilots will only be rolled out nationally is they are proven to be safe and clinically effective as well as convenient and well liked by all populations

Access to Care and Primary Care

73 Better access to GPs: Patients will be surveyed on a number of topics relating to GP access and quality of service. Responses will be used to formulate opening hours, appointment booking and other access related aspects of service. As long as all populations respond to the survey and results are tabulated weighting for representative populations, this should serve all living in a given community.

74 Funding for GPs will also more closely follow patients, both upon joining and upon leaving a practice – this will increase the marginal value of each patient in the eyes of the GP. This change will improve personal service for all regardless of ethnic background.

75 There will also be improved information for patients wishing to find a special service or know more about practices in their area to select or switch. This information should include details about special cultural outreach or language capacity which could serve specific populations. Thus this new service will help citizens of ethnic minorities.

76 In underserved areas, there will be specific targeted capacity building, guided by the centre and led by the local PCT. New providers need not be traditional GPs but may enter from the private sector or the voluntary sector. They will be required to meet quality criteria and will improve service in underserved areas, which often include areas with high levels of ethnic minorities.

Healthy Living

77 An NHS 'Life-Check' will be introduced to help people monitor their own health and work with professionals when needed – especially at key points in their lives. This service, popular during the consultation, will help ethnic

minorities who in some cases tend to have less contact with health services. The goal is that the NHS 'Life Check' will help bring them in if risk factors are identified. Additionally, during NHS 'Life Check' pilots, ways to engage hard to reach groups will be explored.

Long-term Conditions

78 Ethnic minorities are disproportionately affected by some long-term conditions such as diabetes and coronary heart disease. Thus improvements in services for these and other long-term conditions will help people in black minority ethnic groups.

79 Care plans and self care plans for all living with a long-term condition. This commitment should empower and improve the lives of all of those living with a long-term condition, by enabling them to avoid contact with the health service more often and do more for themselves. The same should apply to all populations, as long as care plans are created for all and each recipient understands the requirements and terms of the plan.

80 On end of life care, the White Paper commits to giving everyone nearing the end of their lives the choice of where they would like to die and of giving support to families. This can support people in all populations equally.

81 There will be long-term conditions demonstrator sites, testing out new techniques to avoid A&E admittance, if successful these mechanisms will be rolled out nationally.

82 There will be a toolkit created to help PCT commissioners commission the best long-term conditions services available. Better services will help all patients.

83 There will be an expansion of the expert patient programme, this can help all populations and especially minority populations if they have an expert patient in the community who can act as a guide and conduit

84 A full Equality Impact Assessment will follow as part of the implementation strategy.

Rural Impact

85 These proposals will not have a disproportionately negative impact on rural communities. We will ensure that when delivering efficiencies through primary care contracting that rural areas are not disproportionately effected. The policies to deliver a new set of community hospitals could increase provision in rural areas.

86 Policies aimed at providing care closer to the home- for example, our proposals for social care and integration- may benefit rural populations particularly since they often have the greatest problems in travelling to access traditional services. Similarly, initiatives to support carers (such as a dedicated

telephone helpline) will be particularly beneficial to rural populations, where carers often find it more difficult to leave the home and to access support and respite care

Small Firms Impact Assessment

87 The White Paper sets out policies to support third sector businesses in health and social care provision. The third sector development fund provides up front financial support to these organisations to mitigate risk and allow them to develop viable business models.

88 A number of policies set out in the White Paper will be delivered through or impact on general practice. These are issues that will be discussed with the GPC.

89 Many small businesses operate in the market for social care services. There is a possibility that providing individuals with better information, more choice and more control over their care may alter the pattern of demand for social care services, perhaps away from traditional services such as residential care towards services provided closer at home. It is likely that any impact on small businesses will be gradual. It will also be counter-balanced by new opportunities for small business providers to design and profit from innovative new models of care which better suit the needs and preferences of users.

Competition Assessment

90 There will be no adverse impact on competition. Proposals make it easier for independent providers to compete for and provide services. By improving the information available to patients and giving them greater choice and control over the services they receive, competition and efficiency should be enhanced.

Enforcement, sanctions and monitoring

91 There are a range of mechanisms proposed to ensure that the policies deliver. These can be summarised as follows:

Performance Management:

- New trigger mechanism will ensure PCTs will have to address poor performance
- Local Delivery Plans process used to ensure that a greater proportion of new investment is focused outside of hospital

Contestability:

- Greater information about choice of practice, and the services they provide
- Higher payment attached to patients to make them more attractive to practices and increase competition
- Trigger new provider entry in poorly performing PCTs

- Development fund to provide loans and grants to potential new third sector providers

Targeted Support:

- Support to strengthen the commissioning function of PCTs and local authorities
- Capacity building in underserved areas

Using contracts to incentivise change:

- Stronger incentives to attract patients to practices
- Patient satisfaction measures to incentivise more convenient access
- Use of the Quality and Outcomes Framework to incentivise well-being interventions in General Practice
- Primary care contracts to incentivise managements of long-term conditions

ANNEX 1: PARTIAL REGULATORY IMPACT ASSESSMENT

White Paper- Our health, our care, our say: a new direction for community services

Improved Access and Responsiveness in General Practice

Objective

92 To deliver improved performance, more convenient access, and greater choice in general practice.

Background

93 General Practice is the first point of call for the vast majority of health service users. The NHS in England is delivering 300 million general practice consultations per year.

94 People expect help to be equally available in all parts of the country, to be able to access care quickly and at a time that suits them, and they want that care to be tailored to their needs. This is one of the highest priorities of the public but in our consultation many people said it is not what they currently experience, particularly in primary care.

95 An individual's right to register with a General Practice is a fundamental part of the NHS. It establishes patients' rights to care from that practice, supports continuity of care and provides the basis for practices and Primary Care Trusts (PCTs) to take responsibility for the wider public health of their registered population. This role of General Practice will be continued and strengthened.

Rationale for Government Intervention

96 There is strong evidence of the contribution strong primary care system can play in promoting health and equity within a country[11]. Public satisfaction with primary care services remains high overall[12] although variations exist. In particular, the young are significantly less satisfied than the old[13], and ethnic minority groups tend to have lower satisfaction[14]. There are a number of key areas patients want to see improvements and a number of key opportunities for reform. At the broadest level these can be summarised as:

[11] See for example 'the Contribution of Primary Healthcare to Health', Starfield Shi and Macinko (2005).
[12] DH Mori Polling, (December 2004)
[13] Trends in Attitudes to Healthcare 1983 – 2003 British Social Attitudes Survey (2003)
[14] Departmental Report 2005, Department of Health (2005)

Access

97 The commonest causes of public dissatisfaction with general practice are essentially around access[15]. Access to GPs was raised consistently throughout the consultation process. Problems include the:

- gap between recorded performance on the 24/48 target and patient experience including the continued existence of 'restricted booking';
- decline in Saturday surgeries;
- lack of extended opening hours – A survey in 2004[16] indicated that 22 per cent of people said that they had been put off using GP/health centre services 'completely or to some extent' because opening times were inconvenient;
- issues with Out of hours services – 43 per cent[17] of people reported that it was difficult to get out of hours GP care; and a significant proportion of patients report visiting trusts accident and emergency departments because of a lack of adequate general practice out of hours services; and
- difficulties faced when contacting the practice to make or change appointments.

98 The deliberative events which were part of the *Your health, your care, your say* consultation have indicated that the publics' strong preference is to have their own practice open at more convenient times, rather than being able to access an alternative service (part of a wider common preference for continuity). These difficulties raised reflect both a change in the service offer arising, e.g. from changes in the GP contract, but also from an underlying shift towards higher expectations of easier access that fit with people's lives and match their experience of other services. These access problems represent the commonest restriction on choice in its widest sense, in that they limit choice of appointment.

Choice at registration

99 Registration sits at the heart of the existing systems for delivering healthcare in England and its importance is growing as Practice Based Commissioning creates a stronger link between registration, access to primary and secondary care and the responsibility for managing that care within a budget. However, a patient's choice over where they register is limited by a number of key factors:

- some practice lists are closed and others operate an 'open but full' policy. Practices with closed lists tend to be clustered geographically
- there is insufficient information available to patients to enable them to make an informed choice over which practice to join[18]

[15] Grol, Wensing, Mainz, Ferreira, Hearnshaw, Hjortdahl et al, (1999)
[16] Patient Survey Report, Healthcare Commission (2004)
[17] International Health Policy Survey, Commonwealth Fund, (2004)
[18] National Primary Care Research and Development Centre (2005)

Capacity and contestability

100A lack of capacity combined with restrictions over choice at registration mean there is little contestability between practices to attract patients. Contestability could provide many benefits to patients, including:

- greater service differentiation, as practices innovate to attract patients; and
- greater service focus as patient satisfaction will become a key to success.

Inequities

101Access and quality of services vary significantly across the country. Latest data from the Department of Health[19] indicates a wide variation in GPs per 100,000 weighted population. The most doctored PCT has more than twice as many GPs per 100,000 than the least doctored PCT. There is also a strong correlation between under-doctoring and deprivation. 21 of the 30 least doctored PCTs are 'Spearhead'[20] PCTs.

Options

102The options considered to tackle these problems are as follows:

- Do nothing
- Making the current system work better
- A national approach to access through mandated extensions to practice opening hours

Option 1: Do Nothing

103Significant improvements have been made in primary care in recent times, including faster access, higher quality and a greater range of services provided in general practice. Patient satisfaction with general practice is high and people have confidence in the advice they receive and the clinicians' abilities[21]. New service developments such as Walk-in Centres also deliver high level of satisfaction.

104The message from the consultation was that primary care is not broken, but certain aspects need to be improved. In some cases it is difficult for patients to book an appointment with practices, and patients may not be able to book appointments in advance. The current extent of closed lists will remain, and 'open but full' practices will continue to be a problem. Furthermore, there are isolated areas where general practice quality is lower across a range of indicators. This tends to be coupled with poorer access and lower patient satisfaction. The 'Do Nothing' option will not address the concerns voiced through the consultation process.

Option 2: Making the Current System Work Better

[19] DH General and Personal Medical Services Statistics (2005)
[20] DH Publications and Statistics: Press Releases and Statistics Reid Announces 'Spearhead' PCTs to tackle inequalities (November 2004)
[21] Healthcare Commission Survey of Patients (2005)

105This is the preferred option. It aims to retain the key features of the existing general practice system, but specifically address the issues of concern raised through the consultation. The proposal has the following key components:

- developing local solutions to improving GP access, based on local demand and local needs;
- capacity building in under-served areas – and building longer opening hours into contracts with new providers;
- making it easier for patients to move practice, including:
    - changes to the existing closed list procedures to ensure that they are simpler to operate and more transparent;
    - providing more information on the accessibility and quality of services provided by practices;
    - shaper incentives on practice to attract new patients.
- providing stronger incentives to provide high quality care and better access by strengthening the patient survey element of the Quality and Outcomes Framework (QOF) in general practice; and
- developing a system of triggers operating at PCT level to ensure poor performance is addressed

106These components are complementary, and provide a blend of incentives, targeted capacity building and performance management to deliver service improvements. All practices will be expected to deliver minimum standards of care, but the aim is to create a system where there are real incentives for the practice to innovate and improve services.

Option 3: A National Approach to Access

107This option focuses solely on delivering the strongest message on general practice from the deliberative events, by improving the times at which patients can routinely access general practice services.

108This option represents a more radical approach to access. It would require all practices to extend the period by which patients may access routine primary medical care from the existing period of 0800-1830 weekdays to 0800-2000 weekdays and 0800-1300 on Saturdays.

Costs and Benefits

Sectors and Groups Affected

109Option 1 will have no impact on service users over and above the changes already made. The proposals in Option 2 aim to improve quality and access across the board, but particularly in areas where services are currently poor. This is likely to have a positive impact on deprived and minority ethnic groups, as these tend to be areas where services are more likely to be of a lower standard and users report lower satisfaction rates. Option 3 would improve access to services in all areas, and have a positive impact on areas where access is currently poor.

110Option 1 will have no direct impact on service providers. Option 2 will be principally delivered through general practice. This will be subject of negotiation with the General Practitioners Committee (GPC).

111Option 3 would require significant new monies going to existing practices to allow them to generate capacity to extend opening hours. It would have a major impact on general practice by requiring that all practices are open longer. This would have major implications for small and single handed practices.

Costs

Option 1: Do Nothing

112Under this option, there would be no additional direct costs to Government, service providers, businesses or users of the service, over and above forecast baselines.

Option 2: Making the Current System Work Better

113The costs are subject to negotiation with the GPC, the main sources are likely to be:

Before 2008-09

Improving Access and Registration

114Before 2008-09 better access will be delivered through:

- better and more accessible information to patients on the range of services available in practices, and the hours they are open;
- addressing the ‘open but full problem’ so that patients have clarity around which practices will take on new patients; and
- providing a stronger and clearer set of incentives for practices to take on new patients

115The approach seeks to facilitate increased competition among practices through sharper incentives and better information. These would need to be developed with the GPC.

116The policies would be complemented by guidance to PCTs on how to offer better access. This will include:

- substituting in some opening hours during the evening and weekends instead of weekday hours during the day; and
- allowing some booking in Walk-in Centres and OOH providers.

PCT level Triggers

117Poorer performance in primary care tends to occur across a range of markers and tends to have been sustained over time. The strand develops an approach designed to target poor performance and raise outlier PCTs to levels of performance achieved elsewhere. The approach involves developing a clear set

of triggers and a requirement on PCTs to develop a recovery and implementation plan with clear targets and supported by performance management from the centre.

118This proposal would be cost neutral, although additional capacity would be triggered if PCTs fell below the agreed level (see next section).

2008-09 and beyond

119In 2008-09 and beyond there is potentially more scope to develop policies to further improve access. This could include:

- Developing the local approach to improving access:
  - PCTs will be required to develop services locally to meet the needs of their populations. In some areas this may mean that additional capacity may be required to improve access, in others it may mean a reorganisation of existing capacity to better match user needs;
  - costs will depend on the local solutions based on directions given to PCTs by the Department of Health. The exact cost and method of delivery will be subject to negotiation;

- Capacity Building in areas of genuine under-capacity:
  - the element aims to target and deliver additional capacity into under-served areas, potentially linked to the PCT triggers mechanism. A range of solutions to the closed list problem have been developed, as set out above;
  - However, the issue will remain that some areas suffer from a genuine under-provision of G/PMS services and specific additional capacity is required. The cost of this additional capacity is likely to be up to £65m per annum. This will be used to procure GP's, nurses, other practice staff and infrastructure from a range of providers through a competitive tender process. There is likely to be some overlap between this and the resources required for improved access.

Option 3

120The aim under option 3 is to increase the service availability from 52.5 hours per week to 64 – an increase of 22 per cent. This would guarantee that patients would be able to access their own practice for an extended time period which is specified nationally. It is unlikely that all practices would need a full staffing complement for the additional opening hours in the evening and weekends, and that a proportion of the daytime capacity could be switched to the evenings. The cost and capacity implications of this approach are likely to be significant.

121The major drawback with this approach is that it aims to a apply a 'one size fits all' approach to the issue of access and does not reflect local needs and circumstances of individual PCTs. In many areas this level of opening hours would be unnecessary, and the approach will create excess capacity and inefficiency.

122This approach could be complemented by some of the policies set out above, such as the PCT trigger mechanisms, the stronger incentives to attract new patients, and clarifying the rules around open and closed lists.

Benefits

<u>Option 1</u>

123No additional benefits.

<u>Option 2</u>

124As a package these proposals would deliver:

- Local solutions to improving access rather than imposing a one size fits all solution that may not be appropriate. Relies on PCTs as commissioners to commission the appropriate services but the new approach to managing PCT practice performance will provide a stronger incentive to do this.
- Targets areas that are less well served by general practice so supports the health inequalities agenda. Increased capacity will increase choice and stronger incentives to attract new patients will drive up quality and convenience.
- Increases the monetary values attached to patients so that practices are more strongly incentivised to keep lists open, and make themselves as attractive possible to new and existing patients. Competition will drive up quality and accessibility.
- Provides a clear approach to identifying and addressing poor performance in primary care

<u>Option 3</u>

125The key advantage of this approach is that it tackles the messages from the consultation exercise head on. Patients will be able to expect that every practice in the country will provide services 8-8 on weekdays, and on Saturday mornings.

126The approach is also likely to spread demand more thinly over the period practices are open. This would improve waiting times for appointments, and could facilitate longer consultation times.

127A key risk with this approach is that practices may struggle to cope with the extra service demands placed on them, resulting in a lower quality of care and/or an increased incidence of closed lists. This option also provides no further benefits – i.e. no targeted support to underserved areas.

Equity and Fairness

128We do not believe that these proposals will result in any negative disproportionate impacts on, or cause any significant disadvantage to, any particular social or ethnic groups. The proposals target under served areas and

are likely to improve health inequalities and provide better services for minority ethnic groups.

129We have also considered the likely effects of these proposals on rural populations and do not believe that the impact will be disproportionate or disadvantageous. Policies that aim to encourage PCTs to actively address access issues for their populations are likely to improve services to rural and remote populations.

Small Firms Impact Test

130The major burden of these changes is likely to be on general practices. This will be discussed with the GPC.

Competition Assessment

131The general practice provider market is made up of around 8,500 relatively small providers. Option 2 is likely to have a positive effect, through increased contestability, and a higher price attached to attracting new patients.

Enforcement Monitoring and Sanctions

132To ensure high quality and convenient services are provided, PCTs will be analysed using the following approach:

- assessing how well PCTs commission primary care services. This will look at closed lists, patient assignments outcomes, quality and patient experience;
- a trigger system will be developed so that PCTs that are not providing services to the agreed standard will be required to commission services from new providers;
- PCTs will draw up specifications on the services that the new providers will deliver, including convenient opening hours, open lists, and practice boundaries. They will be able to specify particular services to meet local needs; and
- there will then be a tendering process, providing a level playing field and ensuring fairness.

133Stronger incentives to new patients to practices will be delivered through General Practice Contracts, subject to negotiation.

ANNEX 2: PARTIAL REGULATORY IMPACT ASSESSMENT

White Paper- Our health, our care, our say:
a new direction for community services

Care Closer to Home

Objective

134To provide patients with more choice over which services they can access outside hospitals and move services into the community. The aim is to make significant improvements in the shifting care agenda and commit to moving care closer to patients homes, to enable them to be treated quicker, more conveniently and without the need to attend hospital.

Background

135There is increasing evidence to suggest that a range of services, traditionally provided in a hospital setting, can be provided in a cost effective way and to a high standard in the community. For example, the Department of Health led surveys with clinicians has indicated that up to 57 per cent (or 15 million) of a given set of outpatient activities could be safely & effectively offered in community settings. UK evidence[22] has shown that there are many gains which can be made from shifting care, such as:

- greater productivity through cost savings, especially where the shift in care
- an improvement in the care pathway and more rational use of resources
- Better quality and safer provision of care
- Faster access and greater choice for patients
- Increased patient satisfaction
- Greater satisfaction for staff
- Increased capacity

136The *NHS Improvement Plan*[23] states:

"In the next four years we…will focus on the provision of an increasing number of specialist services by community and primary care providers in local settings."

137However, progress has been slow and is dependent on a number of visionary clinicians working in imaginative ways, acting despite the system rather than being encouraged by it. The key is to provide the right conditions to allow the appropriate transfer of care to happen more widely.

138Providing the right care, with the right person, in the right setting involves providing more services in the community. The White Paper sets out those

[22] Review of the scope to extend the role of the acute clinician outside the hospital setting; commissioned by Department of Health (2004)
[23] Department of Health (July 2000)

services that will be provided closer to home, such as some diagnostic tests, minor surgery and outpatient appointments.

139The context and extent to which the White Paper will explicitly address the needs of specific groups with identifiable needs is also determined; with a focus on moving services closer to communities, such as children, mothers to be, older people and people with mental health problems.

Rationale for Government Intervention

140Currently there are a wide number of localised examples in the NHS of innovative models of care delivery across a range of specialties and locations, which have delivered better quality healthcare closer to home. This leads to higher patient satisfaction; which resonates with the clear message from citizens throughout the consultation, that they want and value more services to be provided in the local community.

141The local examples of innovative models of care have demonstrated tightly controlled levels of demands and lower cost through care pathway re-design, in addition to an appropriate focus of specialist and generalist time. It is important to take action to make sure the improvements occur on a more widespread basis.

142International evidence indicates that in some countries almost all outpatient care and more investigative and minor therapeutic procedures are performed outside of hospital[24]. The main drivers for this shift have been improvements in technology, increases in efficiency, and the desire for greater integration of services. Some examples are as follows:

- In Germany, all outpatient appointments are conducted in offices outside of the acute setting. Specialists are moving towards an integrated model where specialists and GPs are grouped together to share buildings and facilities. This is considered to be a more resource efficient way of delivering care, that encourages shared learning and integrated pathways.

- In Sweden, health planners are encouraging implementation of local services, for specialties such as stroke, where the patient may feel vulnerable and not want to leave the local community for follow up care. It is envisaged that these services will be provided by primary care doctors in the future.

143If government took no action, significant levels of care will continue to be delivered in the secondary care sector.

Options

144Three options have been identified:

[24] DH Commissioned study carried out by PriceWaterhouseCoopers (2005)

a. No further reform/ actions
b. Minimal approach based on Office Doctor model
c. A co-ordinated approach to shifting care including:
    - early moves - commitment to pilots in a set of particular specialities;
    - developing new a new generation of community facilities;
    - system reform - strengthening incentives and levers over the medium term ensure commissioners are better able to develop care for patients;
    - dedicated support for potential third sector providers of services;

Option 1: No further reform/ actions

145Three simple themes resonating from the consultation were that people wanted better information for making choices; joined up health and social care services and services provided in the community closer to home.

146While recent system reforms such as Payment by Results and Practice Based Commissioning and Choice put the incentives in place to facilitate the redesign of services where it is cost effective to do so, the exact impact of these changes is difficult to estimate.

147Failure to go beyond this and set out a clear commitment to promoting this agenda would undermine the consultation process and lead to a loss of public confidence in deliberative engagement. At the national consultation listening event held in Birmingham, 91 per cent of people felt that they had had their say, but only 33 per cent felt that their views would influence policy.

148Doing nothing would enforce the PCTs lack of control or advantage to change the way in which services are provided and would put further strain on the relationships between PCTs and acute providers, which has often not been conducive.

Option 2: A minimal approach based on the Office Doctor model

149This approach would deliver a small expansion in the number of outpatient appointments, delivered through GPs, consultants and other staff providing services from existing or refurbished GP surgeries.

150This model was predominant during the General Practice Fundholding Scheme[25]. Individual specialists provided services through GP surgeries, often with limited infrastructure and an insufficient workload to occupy them full time. Evidence from this model of care shows although patient satisfaction was high, the costs associated with this type of care was up to three times higher.

Option 3: A co-ordinated approach to shifting care

151This is the preferred option. It includes the following key strands.

Early moves - commitment to pilots in a set of particular specialities

[25] See for example National Audit Office: GP Fundholding in England (1994)

152Previous analysis has identified a number of specialties as key ones to engage in building models of care outside the acute setting. This strand of option 2 will involve working with the specialty associations in the Royal Colleges to define clinically safe pathways that provide the right care in the right settings, performed by the appropriate skilled person. Over the next twelve months the aim is to develop 20-30 demonstrator sites across England. These will define the appropriate models of care which can be used nationwide, including the following specialties:

- Dermatology
- Ear Nose and Throat
- General Surgery
- Orthopaedics
- Urology
- Gynaecology

Developing a New Generation of Community Facilities

153By investing in modern premises and equipment we have an opportunity to create a new generation of community hospitals delivering excellent integrated services to the local community. The hospitals will bring together the right set of services for small local populations of 50-100,000 people or a small sized town/city. They will provide a critical mass of services through having at least two specialties involved.

154We will aim to develop between 30 and 60 new or refurbished community hospitals and 80 to 160 smaller facilities by 2012. This will deliver the manifesto commitment on community hospitals. Further work into the exact number, location and method of procurement will be carried out throughout 2006.

155A number of wider themes could be addressed by this commitment including: co-location and integration of health and social services; better access for patients in deprived areas; consultant engagement; better treatment and management of long-term conditions; and the introduction of new providers into the NHS.

156The transport arrangements that currently apply to secondary care providers will be extended to activity that is shifted. This will be cost neutral, or even reducing, if distances to travel are reduced through care being delivered closer to home.

System reform - strengthening incentives and levers over the medium term ensure commissioners are better able to develop care for patients

157In the longer term, a number of changes to the way services are bought and priced will be needed to deliver integrated services in the community. Reforms such as Practice Based Commissioning (PBC) and Payment by Results (PbR) will do much to encourage purchase of more cost effective models with better success rates and higher patient satisfaction. Services that could be delivered in

the community will need appropriate tariffs to apply the same incentives to activity as applies currently in the secondary sector. Unbundling the tariff for intermediate care and diagnostics will be important to facilitate this transfer in a cost effective way.

158Furthermore, PCTs will also be required to implement appropriate performance measures to ensure that overall levels of demand are managed appropriately.

Setting up a development fund to support third sector providers

159The White Paper focus on reform of the primary and community sector provides an opportunity to develop a new relationship with the third sector[26] that can provide benefits to patients, the NHS and the wider community.

160There are good reasons to increase the use of the third sector in healthcare provision. Including the following:

- a strength unique to the sector is their ability to provide services to 'hard to reach' groups, and some have drawn their membership directly from groups they aim to serve. By harnessing the skills and motivation of the third sector the NHS can therefore aim to provide services designed around the patient.
- the third sector includes a wide range of innovative individuals drawing experience from both within and without the health service. And this innovation has not been driven by the primary desire to increase shareholder value. As such, engaging with the third sector offers the NHS a new source of social entrepreneurs.
- many social enterprise models provide wider benefits to local communities, either directly by re-investing surpluses directly into the community, or those the local ownership and stakeholder involvement that they bring.
- the third sector may be able to reduce health inequalities by targeting under-served areas.
- the third sector can also provide contestability with existing services. This contestability should draw on the innovation, capacity and focus on excluded groups that the sector can bring.

161 However, there have been a range of barriers preventing greater involvement of the third sector in healthcare provision. A key one is that potential providers may not have the right skills to develop viable business models and the up front investment required may be prohibitive to organisations wishing to provide services.

162 In order to tackle this problem, a development fund will be created to support third sector providers to address these barriers to entry around access to finance, risk, and skills to develop viable business models. This would

[26] The 'third sector' includes the full range of non-public, non-private organisations that:

- Are non-governmental
- Are 'value-driven' (primarily motivated by the desire to further social, environmental or cultural objectives rather than make a profit per se)
- Principally re-invest surpluses to further their social environmental and cultural objectives.

recognise the different type of support that different organisations require and tailor the support given on a case by case basis. The fund would focus on providing support in the shape of:

- grants to bring in consultancy support to develop viable business models in the pre-contract phase
- early stage capital support in the form of loans (these loans are likely to be high risk and unsecured that organisations would be unlikely to get from commercial lenders)

163 The fund would be a mixture of revenue and capital, and there may be opportunity to redirect existing funds towards this.

Costs and benefits

Sectors and Groups Affected

- New providers of services in the community, including general practice, and third sector providers; and
- Acute trusts

164 This activity represents a shift from secondary care settings into primary care and the full impact on secondary sector needs identifying and managing. 4 million outpatient appointments represents around 9 per cent of total hospital activity, but less than 2 per cent of revenue. On the in-patient side, 30 beds per community hospital would represent just a 0.5 per cent increase in total bed capacity. Further work will be done as part of the implementation strategy.

165 The development of community hospitals will provide greater opportunities for patients to access services locally. Capital will only be released where full service re-design occurs by PCTs, and a number of principles outlined in the White Paper will need to be demonstrated. Although the location of these services is still to be decided the intention is to provide more convenient access for those for whom access is currently poor, including rural and dispersed populations.

Costs

Option 1

166 No additional costs.

Option 2

167 Evidence suggests that the cost of services provided in this way can be up to three times higher than in other settings, and did not always lead to the anticipated fall in referrals to secondary care[27]. If we assume that one million outpatients appointments are carried out this way, and that past evidence is

[27] Gilliam SJ et al. Investigations of benefits and costs of an ophthalmic outreach clinic in general practice. British Journal of General Practice (1995).

borne out and the costs are twice as high as other settings, the additional cost would be in the region of £110m additional running cost. This is because this is a relatively inefficient way of delivering services and the specialist time is not fully utilised[28].

168 There would also be some small start up cost associated with providing appropriate premises and equipment in the surgeries that provide these services. This could be in the region of £20m.

Option 3

Early moves - commitment to pilots in a set of particular specialities

169 The aim is to transfer services from secondary care into community settings – flexibility of the outpatient tariff in community settings could mean that services are provided at a lower cost. Prices of services will be determined locally, but if a 10 per cent reduction in the average price of outpatient services was delivered the cost saving to the NHS would be in the region of £50m per annum. Furthermore, improving the patient pathway could reduce the need for the NHS provider to follow up outpatient appointments, generating further savings.

Development of a new generation of community hospitals

170 The exact cost depends on the preferred financing arrangements. These are likely to be a combination of NHS LIFT (Local Improvement Finance Trust) schemes and Joint Ventures. The overall capital cost of the new generation of community facilities will be in the region of £1.1 to 2.2bn. The exact cost each year will depend on the method of funding.

171 The cost of training Practitioners with a Specialist Interest to provide outpatient services in these centres will be in the region of £10m.

System reform - strengthening incentives and levers over the medium term ensure commissioners are better able to develop care for patients

172 No additional costs.

Third sector Development Fund

173 The additional resources required to set up the third sector Development fund would be around £20m of capital. The other policy and administrative costs are likely to be in the region of £5m.

Benefits

Option 1

[28] See for example National Audit Office: GP Fundholding in England (1994)

174 The system reform agenda (including Practice Based Commissioning, Choice and Payment by Results) is likely to deliver benefits in terms of delivering transfers of activity in a high quality and cost effective way. There will be no additional benefits other than those.

Option 2

175 The Office Doctor approach will deliver a modest shift in outpatient activity from acute settings and into primary care settings. This is likely to be well received, and deliver good satisfaction for those that receive these services in primary care. A study performed in 1997[29] indicated that patients believed the changes to give:

- greater patient satisfaction
- shorter waiting times
- shorter distances to travel and shorter travel times (12 miles or less and 37 minutes or less)
- shorter waiting times once in the clinic.

176 Professionals considered the services to improve patient access and convenience, and broadened the skills of GPs.

177 However, although these services were very popular with patients, there is no evidence that this type of specialist outreach lead to improvements in the quality of health services[30].

178 This approach may also lever in greater plurality of provision, creating greater innovation, more choice and more contestability[31].

179 The volume of the shift is likely to be low, meaning that while some patients will benefit, others will not.

Option 3

180 As a package, option three will deliver:

- where there is a comparative advantage in primary care services could be cheaper.
- greater choice, clinical outcomes and patient satisfaction.
- greater plurality of service provision.
- benefits of third sector innovation and new ways of working.
- more capacity and scope for economies of scale through more services provided under one roof, and
- provide the incentives by which the shifts will be driven in a cost effective way
- community hospitals have been show to provide better recuperative care than District General Hospitals[32]

[29] Reported in DH 'PSI 11-27 BOWLING: The cost effectiveness of specialist outreach schemes (2003)
[30] Harris, A: Specialist outreach clinics. BMJ (1994)
[31] See for example Ellwood S: The response of fundholding doctors to the market CIMA (1997)

Equity and Fairness

181 We do not believe that these proposals will result in any disproportionate negative impacts on, or cause any significant disadvantage to, any particular social or ethnic groups.

182 We believe that the proposals are likely to be advantageous to rural areas, as services will be provided closer to the patients' home, avoiding lengthy travel to major acute trusts.

Small Firms Impact Test

183 No additional costs to small businesses. Option 3 provides greater opportunity for independent and third sector providers to get involved in care provision.

Competition assessment

184 Options 2 and 3 should have a positive impact on competition, as it increases plurality, choice and contestability. The policy to support the third sector gear up towards service provision creates a more level playing field for third sector organisations and will help smaller providers to enter the market.

Enforcement, sanctions and monitoring

185 To ensure that the appropriate level of resources move into the community and primary care settings to support this transfer in activity. The Department of Health will ensure through the Local Delivery Plan Process, that for 2008-09 and beyond, there is a proportionately higher increase of resources going into the primary and community sector, compared with the secondary care sector.

186 PCTs will have a key role as commissioners to ensure that care is transferred appropriately into local settings. PCTs will need to review their current plans for PFI financed hospitals, and ensure that these plans are consistent with a future where resources and activity are moved into primary and community settings.

---

[32] "A Multi-Centre Study of the Effectiveness of Community Hospitals in Providing Intermediate Care for Older People" Professor John Young, St Luke's Hospital, Bradford (2005)

ANNEX 3: PARTIAL REGULATORY IMPACT ASSESSMENT

White Paper- Our health, our care, our say: a new direction for community services

Healthy Living

Objective

187 To achieve real and sustainable shifts in how the Department of Health provides services that support and empower people to better care for themselves, to avoid future disease and ill health.

Background

188 The health risks associated with obesity, low exercise levels, smoking, excessive alcohol consumption, poor sexual health, including contraception, poor emotional and mental well being are increasing. This is set against a backdrop of a widening health gap between the advantaged and disadvantaged**,** literacy, self-care skills and the ability to understand the system. Using the available healthy living resources is the key to achieving shifts in healthy living behaviours. The UK is currently spending less per capita on public health spending than its peers. The comparison is UK £14.5, France £34, Germany £66, USA £100[33].

189 The White Paper describes mechanisms that will develop a more systematic response to the people's request for better services aimed at disease prevention and health promotion, as outlined through the *Your health, your care, your say* consultation process, for the NHS, local government and their partners to help them better care for themselves.

190 Many preventative interventions are better value than many other interventions in which PCTs currently invest. NICE guidance[34] recommends that the NHS should invest in services where the cost/QALY (quality adjusted life year) is £20,000-30,000 or cheaper. Smoking cessation services QALY is approx £1,200, brief interventions for alcohol £1,300[35]. For every £1 spent on contraception services there is an £11 saving to public funding[36].

191 In addition, some preventive interventions have resulted in cost-savings for the NHS, for example, as a result of avoidance of outcomes such as Type II diabetes and coronary heart disease and hospitalisation resulting from substance misuse.

---

[33] Calculated from OECD data 2005
[34] Raftery J. NICE: faster access to modern treatments? Analysis of guidance on health technologies, BMJ 2001; 323:1300-3
[35] Department of Health, Alcohol Misuse Intervention. Guidance on developing a local programme of improvement November 2005.
[36] Harvard School of Public Health, Comprehensive table of cost utility analysis

192 In general, public health services that have been developed and evolved over past decades and are now routinely in place within the NHS have demonstrated a significant contribution to the health and well-being of the population e.g. screening, immunisation and vaccination programmes. Significant investment in smoking cessation and promotion of safe sex and contraceptive services, as well as treatments for substance misuse has also been made.

193 However, the need for further investment in cost-effective health care services has been recognised and is reflected in the commitments within *Choosing Health* that highlight the benefits of:

- preventing obesity;
- improving mental and sexual health, especially for young people;
- addressing addictive behaviours in relation to drugs and alcohol consumption;
- improving health literacy/navigation/self care skills.

Rationale for Government Intervention

194 The White Paper builds upon the strategy for health improvement set out within the *Choosing Health* White Paper. It strengthens the system to raise awareness and deliver an appropriate response to the public – particularly people who live in deprived communities – through targeted information to encourage and enable people to take early action to improve their health. *Choosing Health* sets out what needed to happen; now we are pushing forward on how to do so in the context of other policy developments that underpin system reform, including better commissioning and a drive to improve fitness at work.

Options

Option 1: Do nothing
Option 2: Coordinated approach for cost effective healthy living services
Option 3: A more systematic and routine approach, including annual health checks for all

Option 1

195 Failure to invest in the healthy living option would fail to deliver the benefits realisation achievable via an effective spend to save programme in smoking cessation services; brief interventions for hazardous use of alcohol and drugs; weight management for the obese; comprehensive contraceptive services; and health literacy/self care/navigation skills, aimed primarily at people living in deprived communities and others whose lifestyle places them at high risk of poor health. Health inequalities are likely to increase as those most able to help themselves do so at the expense of the less fortunate.

Option 2

196 Option 2 is the preferred option. This option would include the following policies:

- the development of an 'NHS Life Check' for people at key life stages engaging them in an assessment of their modifiable life style risks;
- the development of a National Commissioning Framework for Well-being Services better delivering systematic evidence based healthy living interventions, addressing inequalities and commissioned proportionate to local need;
- links to a Fitter Britain 2012 campaign raising national engagement and consciousness of better physical and mental well being;
- use of the General Practice Quality and Outcomes framework to incentivise well being services

The NHS 'Life Check'

197 The first stage of the NHS 'Life Check' is to complete a self assessment, which will be available on NHS Health Direct online. This will be downloadable for use as hard copy. For most people the online service NHS *Health Direct,* will be their own personal health trainer, meeting demand in the most efficient way possible.

198 However, those at these key stages who have identified high risks via self assessment will have the opportunity of follow up with an accredited health trainer (HT), receiving tailored healthy living advice and onward referral as appropriate. Commissioners must provide a set of core health and well-being services proportionate to meet local need, especially that driven by the NHS 'Life Check'. This systematises *Choosing Health* initiatives whilst prioritising resources to those who will most benefit.

199 All people can still complete the check at any age on line, at their high street health care outlet, or with their carer, even if frequently seen, just as GPs can refer to health trainers at any time. In response, they will receive automated advice (similar mechanism to the information prescription). Anyone not at the key age but for whom self assessment identifies high risk will be advised to consult their practice on next steps. The practice may choose to invite the person in for a consultation, or may choose to 'override' the system and refer the person on to a local health trainer.

200 The NHS 'Life Check' will be developed throughout 2006-07 and made available in 2007-08 when information technology is available to underpin the online assessment. Development work will test ways to maximise accessibility of the tool, particularly for hard to reach groups and in such a way as to address inequalities.

201 Early development work will focus on the NHS 'Life Check' for 0-3, 12-13 and around 50 years of age. Work on the 0-3 (including both parents) and 12-13 year olds will be developed in partnership with the Department for Education and Skills and be strongly linked to the Healthy Schools and Extended Schools initiatives. For adults, it will be developed for people around the age of 50 and be closely aligned to the aims of the Health Work and Well-being Strategy. Development work will take place in areas of greatest inequality – Spearhead communities – to ensure it is designed as fit for purpose for those that will

benefit most from its use. In due course, the NHS 'Life Check' will be made available at the other key ages and in all appropriate formats to reach all members of communities, however diverse their make up.

National Commissioning Framework for Well-Being Services

202 Commissioners will need to consider how services should be designed to provide a set of core health and well-being services, including commissioning adequate health trainer skills capacity to meet local need. Referring to the local framework of commissioned well-being services, informed by the National Framework for Commissioning Well-being Services, health trainers and practices will be able to offer people the most appropriate service to meet their need.

203 A toolkit, the National Framework for Commissioning Well-being Services, will set out which services commissioners will be advised to offer in order to underpin the NHS 'Life Check'. The framework will describe cost-effective, evidence based interventions. It will link to future shifts to the measurement of outcome measures as current primary care contracts evolve and advise those engaged in their development.

204 A National Reference Group (NRG) will oversee the development of the framework. It is proposed that the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) and other key partners are members of the reference group and support the identification of the evidence base for effective interventions and service provision. The NRG will also determine contractual arrangements, incentives and best practice that commissioners can use when developing services locally.

205 The NRG will be recruited and convened in early 2006. It will produce an initial toolkit by the end of 2006. It's future work programme will be progressed in a manner that facilitates inclusion of any impacts on the General Medical Services Contract into the negotiations for its revision from 2007-08 that will take place throughout the first half of 2006.

206 Its ongoing remit will be to assess not just evidence of effective interventions and services across health and social care, but also what is not effective. It will also assess returns on healthy living investment strategies as compared to current Quality Adjusted Life Year (QALY)[37] accepted thresholds of value for money interventions at the accepted £30,000 level.

207 Core Well-being Services include:

- Smoking Cessation Services
- Weight Management Courses
- Brief Interventions for Hazardous Drinking

[37] A QALY is an accepted measure of cost effective interventions for developed health services to support investment in. For many secondary interventions their value is £20-30K, for many primary interventions their value is £1K.

- Comprehensive Contraceptive Services
- Health Literacy/ Navigation skills/ Self Care Training Courses
- Support for improved emotional well-being

2012 Fitter Britain Campaign

208 Since the publication of *Choosing Health*, London has been awarded the honour of staging the 2012 games. The games provide a unique opportunity to promote a fitter Britain. We will work with partner organisations including Sport England and the London Olympic Games Organising Committee to maximise opportunities for people to take part in recreational and health-promoting activities. A high-profile campaign will be developed encouraging everyone to contribute to the drive to a fitter Britain by 2012. A holistic approach to being both physically and emotionally health will be part of this drive for fitness, which will be inclusive of all age groups. It will also raise awareness of the NHS 'Life Check' at the key ages proposed in Option 2.

Development of the QOF for wellbeing services

209 The new primary medical services contracts already include strong incentives to identify and manage patients with long-term conditions effectively. This framework is evolving as the efficacy of new interventions is demonstrated. The intention is that from 2008-09, where the evidence is available and subject to agreement with the BMA, the QOF will include new measures which provide a clear focus on health and wellbeing outcomes.

Option 3

Option 3 includes the following components:

- a more systematic approach to health and wellbeing checks – including an annual health check
- improving self care through support networks, helping people and professionals to better utilise existing resources to better care for themselves

A More Systematic Approach to Health Checks

210 This option would provide a health check for all, one every three years, delivered through general practice.

Improving Self Care through Support Networks

211 Communities would benefit from a wider range of self care support services. PCTs need to commission a range of services that will engage and support people at high risk of poor health and those with long-term conditions.

212 The Commonwealth Fund has reported that England performs poorly in international comparisons of engagement by professionals with patients to promote self care. According to a recent survey, more than half of those who have seen a care professional in the last six months say they have not often been

encouraged to do self care, and one third say they have never been encouraged[38]. This is despite the fact that 90 per cent of those surveyed appeared to be interested in doing more self care.

213 General practice staff are well placed to encourage self care behaviours in their patients. GPs are also people's most trusted source of health information[39]. Professionals in general practice will therefore play an important role in pump-priming the development of people's self care capabilities.

214 To achieve this, professionals need first to better understand the context of policy developments around self care, including the benefits of self care for their patients, in enhancing the quality of consultations and in reducing the number of consultations that could be appropriate be self managed. They will also need be aware of technology developments that will shortly be able to offer e.g. information prescriptions.

215 Importantly, many will also need to develop a consultation style that encourages self care behaviours, addressing temptations to be overly medical or paternalistic and encouraging the use of self care support services provided outside the practice. Primary health care professionals, working closely with the self care support co-ordinator, will also need to develop patient pathways for different conditions to facilitate referrals to other service providers.

Costs and Benefits

Sectors and Groups Affected

216 The aim of this policy is to place a greater emphasis on maintaining the health of the population and earlier intervention to prevent or reduce poor health for those at greatest risk.

217 This activity would potentially lead to a reduction in demand for secondary care services as a result of interventions that keep people healthier longer.

Costs

Option 1

- There would be no additional immediate costs for this option. However should the proposals in the White Paper not be taken forward there would be significant consequential costs of doing nothing which would rise over time. In an ageing population experiencing increasing obesity rates, poorer sexual health, rising rates of alcohol consumption against a back drop of increasing health inequalities future costs will become significant[40]:

[38] The Public Attitudes to Self Care: Baseline Survey (2005).
[39] DH PCT Patient Survey (2004)
[40] Figures from 'Choosing Health Delivery Plan< Department of Health (2005)

- Higher obesity rates are predicted to lead to a 5 per cent rise in strokes, an 18 per cent rise in heart attacks and a 54 per cent rise in type 2 diabetes by 2023. Three out of ten boys and four out of ten girls are not achieving the recommended one hour per day of at least moderate physical activity.

- Smoking is the single greatest cause of illness and premature death in England today, killing an estimated 86,500 people a year, accounting for a third of all cancer and a seventh of cardiovascular disease. Smoking-related illness disproportionately affects the least well-off. 31 per cent of manual groups smoke, compared with 20 per cent in non-manual groups.

- 15,000-22,000 deaths and 150,000 hospital admissions each year are associated with alcohol misuse.

- Mental illness and stress-related conditions are now the commonest cause of sickness absence and a common cause of social exclusion amongst older people. One in four consultations with a GP concern mental health problems.

- Sexually transmitted infections continue to rise. Up to one in ten young people aged under 25 may be infected with chlamydia, leading to pelvic inflammatory disease, ectopic pregnancy and infertility.

Option 2

NHS 'Life Check'

218 The costs of the NHS 'Life Check' proposal are calculated on the basis of working within existing budget (and therefore capacity of) for health trainers (HTs) within Choosing Health (£36m 2006-07; £77m 2007-08) i.e. 3,000 HTs from 07-08 onwards. The calculated capacity of HTs is based upon the assumption that they will spend 75 per cent of their time in face to face consultation with people, with that time being spent either:
- helping people to complete their self assessment – the first part of the NHS 'Life Check' (10 mins)
- undertaking the second part of the NHS 'Life Check' – the review of the self assessment, setting goals, assessing their service needs and making the referrals (20 mins).

- However, if volunteers (health champions) developed via links to 2012 could instead help people to complete their assessments, then HTs could either:
- increase their consultation time for reviewing the completed self assessment and establishing service needs to 24 minutes
- reduce the proportion of their time spent in face to face consultations to 50 per cent, so that they had more time to follow through with their clients and help to deliver their service needs

219 The cost of researching and developing the self assessment tool are estimated to be £1m and are included in current Choosing Health budgets (dependent on current DH spending and budget reviews)

National Commissioning Framework and Delivering Well-being Services

220 The National Reference Group will oversee development of the evidence base, contractual arrangements, incentives and best practice commissioners will use. This will facilitate the development of a toolkit for Commissioners. We estimate that there will be a one off cost of £250,000 to develop this toolkit. In addition there will be ongoing costs for 3 years of £200,000 to continue the role of the group advising the system reform and contractual programmes as to how best to shift to effective investments in healthy living interventions linked to whole system management and assessment based upon effective community outcome measures.

221 The following estimated costs of the key services for weight management, smoking cessation and alcohol brief intervention are based on those calculated by Milton Keynes PCT, which are marginally more expensive than published evidence suggests, but reflect realistic local service delivery costs as assessed by a commissioning team working locally.

222 When 3,000 HTs are established and key well-being services available as per the forecast capacity, the annual cost of services for those with high risks of poor health are based on the assumption that 80 per cent will take up the HT's/practice's recommendation. The numbers for smoking cessation are based on the number of smokers who want to quit. The level of services commissioned will be up to the PCT in question.

Development of the Quality and Outcomes Framework for wellbeing services

223 Inclusion of new indicators in the QOF requires evidence that interventions through general practice are effective. The cost of the QOF incentives will depend on the evidence and the type of services incentivised. This would be subject to negotiations with the General Practitioners Committee.

<u>Option 3</u>

NHS 'Life Check' for all, once every three years, underpinned by general practice (HCAs/GPs)

224 The costs of this version of the NHS 'Life Check' proposals are calculated on the basis of utilising the general practice workforce but as a new work requirement i.e. requiring additional workforce capacity. The costs use similar assumptions to those for Option 2, but are based upon use of HCAs and GPs, instead of health trainers:

- HCAs, who are the same unit cost as a health trainer, helping 40 per cent of people to complete their self assessment – the first part of the NHS 'Life Check' (10 mins). Nationally, this would require 735 HCAs at a cost of £18.4m. However, if volunteers developed via links to 2012 could instead

help people to complete their assessments, then this requirement of HCAs could be reduced.

- GPs undertaking the second part of the NHS 'Life Check' – the review of the self assessment, setting goals, assessing their service needs and making the referrals (20 mins). Nationally, this would require 795 GP years at a cost of £236.4m.

225 The cost of researching and developing the self assessment tool remains the same as Option 2 i.e. £1m and is included in current Choosing Health budgets (dependent on current DH spending and budget reviews)

Self Care Support

Self Care Support Co-ordinators (SCSC)

226 Working within PCT commissioning, the SCSC will champion the development of a local commissioning strategy for self care, working closely with other commissioners, health and social care professionals and the third sector to identify local need and co-ordinate effort to develop services to meet them.

227 The level of activity required in the early stages of the development of self care support networks suggest that one SCSC is required for every 100,000 population. The national cost of providing the SCSC's is estimated to be £24m.

Benefits

Option 1:

228 No additional benefits, and potential future major costs.

Options 2 and 3:

229 The Wanless report recommended wide scale systematic approaches to public health investment delivering the 'fully engaged scenario'. Spend on complex medical care will only reduce when the UK increases expenditure on public health interventions in line with other developed countries.

230 PCTs are not systematically investing in services that improve health despite evidence of their effectiveness. NICE guidance recommends that the NHS should invest in services where the cost/QALY (quality adjusted life year) is £20-30k or cheaper. Most public health interventions have a QALY nearer to £1k and in addition deliver significant returns on investment for the NHS Despite this they are not receiving systematic investment.

231 There is a range of evidence demonstrating that up front investment in health promotion and disease prevention can release benefits downstream. For example:

- Smoking cessation services will prevent or delay the onset in CHD in 14,000 people, delivering future savings of £142m.
- Effective systematic weight management courses and services can delay the onset of type 2 diabetes in up to 52,000 people. This would generate savings of £455m.
- Brief interventions for hazardous drinking can prevent up to 86,000 days hospitalisation, generating up to £110m savings.

232 Evidence from Milton Keynes[41] shows even larger savings when calculated across a wider range of positive benefits accruing from reduced admissions, complications and broader service utilisation:

- Weight management – an investment of £8.6m over a ten year period would yield a saving of £44.3m – a return on investment of 513 per cent
- Smoking cessation - an investment of £7.5m over ten years would yield a saving of £17.2m – a return on investment of 229 per cent
- Brief interventions for alcohol – an investment of £875,000 over ten years would yield a saving of £1.6m – a return on investment of 186 per cent.
- The compound is that an investment across a PCT of £17m over a ten year period yields a cost saving of £63m, a return on investment of 371 per cent

233 Separate analysis at a county level across Oxfordshire[42] has calculated that over 5 years based on worst case and best case scenarios (whether a smaller or larger percentage of potential beneficiaries use the services):

- £305,000 investment in smoking cessation services to target hard to reach and deprived communities would deliver savings of between £750,000 and £1.55m
- £6.46m investment in the provision of additional GUM clinics and screening programmes would deliver savings of between £8.7m and £17.8m
- £1.98m investment in locally enhanced weight management services in primary care to target all patients with a body mass index of over 28 would deliver savings of between £2.1m and £4.2m
- £812,000 investment in locally enhanced services to reduce hazardous alcohol consumption would deliver savings of between £3.15m and £4.1m

234 Arguably, option three most directly responds to the findings from the deliberative event. However, there is evidence that this type of systematic and routine health check can be costly and have very limited effects[43]. Furthermore, they can generate anxiety and lead to unnecessary use of further services.

Equity and Fairness

235 A key focus of the life check will be to engage individuals who do not currently engage with health and care services. The NHS 'Life Check' therefore has a major potential to reduce health inequalities. It is being designed and

---

[41] Milton Keynes PCT, Investing in Helath: moving towards a Wanless fully engaged scenario in Milton Keynes, 2005

[42] Oxfordshire PCT, Choosing Health: Invest to save plans for Oxforshire 2005

[43] Langham S, Thorogood M, Normand C, Muir J, Jones L, Fowler G. Costs and cost effectiveness of health checks conducted by nurses in primary care: the Oxcheck study. BMJ 1996; 312(7041):1265-1268.

piloted prior to use across the current Spearhead communities, and this piloting will be used to determine the formats and languages to maximise engagement and ensure that everyone's needs are met.

236 We have also considered the likely effects of these proposals on rural populations and do not believe that the impact will be disproportionate or disadvantageous.

Small Firms Impact Assessment

237 No significant costs to small businesses are anticipated. In fact, these proposals may serve to benefit small businesses by improving the health of workers with long-term conditions, thereby reducing sickness absence and improving productivity.

Competition Assessment

238 No impact on competition.

Enforcement, Sanctions and Monitoring

239 These proposals are designed to deliver high quality services in primary and community settings that focus on well-being, and will be cost-effective in the medium term. Engagement in this agenda will help address persistent local deficits. We will develop 'service reconfiguration' teams to support areas who may be in deficit for these reasons.

ANNEX 4: PARTIAL REGULATORY IMPACT ASSESSMENT

White Paper- Our health, our care, our say: a new direction for community services

Social Care, Including Partnership Working With Health and Other Services

Objective

240 To transform the social care system and the way in which it interacts with health care services and other local services. To increase choice and control for people who use social care services, by strengthening partnerships between social care and health services and other local authority services and by improving information and support to service users, making the system clearer and easier to navigate.

241 This will build upon the principles set out in our Green Paper, *"Independence, Well-being and Choice"*[44] and responses to the *"Your health, your care, your say"* deliberative events[45] and to the previous Green Paper consultation[46].

242 These proposals will help support delivery of the following Department of Health Public Service Agreement (PSA) targets[47]:

- To improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing:
    - the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008; and
    - the proportion of those supported intensively to live at home to 34 per cent of the total of those being supported at home or in residential care by 2008.
- To improve health outcomes for people with long-term conditions by offering a care plan for vulnerable people most at risk; and to reduce emergency bed days by 5 per cent by 2008, through improved care in primary care and community settings for people with long-term conditions.

243 The White Paper also sets out how we plan to develop the performance and assessment framework for the future, to support enhanced partnership working.

---

44 http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/AboutSocialCare/AboutSocialCareArticle/fs/en?CONTENT_ID=4106483&chk=QpboYy

45 Published alongside this White Paper

46 http://www.dh.gov.uk/Consultations/ResponsesToConsultations/ResponsesToConsultationsDocumentSummary/fs/en?CONTENT_ID=4121622&chk=6IcaV per cent2B

47 For more information on PSA targets see http://www.hm-treasury.gov.uk/performance/Health.cfm

Background

244 The Green Paper *"Independence, Well-being and Choice"* set out a vision for social care services, which received wide support in the consultation that followed its publication (March-July 2005). The White Paper *"Our health, our care, our say"* sets out how the Government intends to take forward the proposals in the Green Paper, in the light of comments received.

245 Many people who use social care services are also likely to require frequent support from primary and community care services. Both the consultation on the Green Paper and the *Your health, your care, your say* public consultation provided a very clear message that people found the array of services, the number of agencies involved in providing them and the complex and opaque relationships between these agencies to be often confusing and frustrating. People are often unsure of where and how to access information to enable them to make choices and access services. They are often confused by some services being provided free of charge while others they have to pay for and find the rules governing this difficult to understand.

246 The proposals developed in the White Paper lay out how we intend to transform social care services and the way in which they work with health services and other local services. This will create a system that focuses on the needs and choices of those who use services, and which delivers those services in as clear, transparent and seamless way as possible for the individual user of services.

Rationale for Government Intervention

247 Central government is responsible for setting the policy and legislative framework within which local authorities discharge their responsibilities for social care. The *Independence, Well-being and Choice* Green Paper argued that a new vision for social care services was necessary to respond to the changing demands on social care services and to the expectation that social care services should help people to maintain their independence and increase the degree of control and choice that they have over their own care. It set out a strategic vision for social care that received general endorsement through the consultation. The proposals in the White Paper set a clear direction for services, building on the consultation, while maintaining appropriate local flexibility for service planning and provision by Local Government.

248 Feedback from the Green Paper consultation, and from the *Your health, your care, your say* listening events demonstrated that people too often find the joint working between different services to be poor- particularly at the boundary of health and social care. This can cause confusion and frustration, a waste of time and money and can cause people to access the wrong types of services or not to access services from which they would benefit. Although there are good examples of partnership working in local areas the picture is variable, and change is needed to ensure a more systematic approach to promoting partnership working, and to clarify Government expectations of services.

Consultation

249 The White Paper builds on two public consultations. The first, on the adult social care Green Paper *Independence Well-being and Choice,* ran from 21 March to 28 July 2005. Over 1,500 formal responses were received. A wide range of organisations and individuals were represented in this response, representing key stakeholders from all sectors. In addition, it is estimated that more than 2,000 individuals participated in discussions carried out a regional and national consultation events. A document detailing the responses to the consultation was published in October 2005[48].

250 The second consultation, *Your health, your care, your say,* was an innovative and deliberative listening exercise, one of the largest research based consultations ever to take place in the country. It took place during the autumn of 2005. Further details are included in the overarching RIA and in the White Paper. A full summary of the responses to the listening exercise is also published alongside the White Paper.

Options

251 Three options for the future of social care services and their integration with health and other services have been identified:

Option 1 – Do Nothing
Option 2- "Coordinated Government Action"
Option 3- Full Implementation of Option 2

Option 1- Do Nothing

252 Under this option, policy would remain unchanged. Funding for social care has increased significantly in recent years and improvements in services have been made- for example in helping more people remain in their own homes through intensive packages of home care. However, it is clear from the consultations discussed above that the public and service users believe that, without further changes, services would remain too fragmented. Too many people would continue to face difficulties in navigating the system and in accessing a tailored package of care that is right for them, rather than a disjointed package of health and social care services that is driven by different providers rather than designed around the individual.

253 For these reasons we believe that doing nothing is not in the interests of service users, carers or the public at large.

Option 2- The "Coordinated Government Action" Option (Preferred Option)

---

48 http://www.dh.gov.uk/Consultations/ResponsesToConsultations/ResponsesToConsultationsDocumentSummary/fs/en?CONTENT_ID=4121622&chk=6IcaV per cent2B

254 This is our preferred option. The White Paper sets out our proposals to improve social care and tackle the deficiencies that exist in the coordination of social care and health care services and other local services. The main elements of the proposals are:

- The outcomes framework for social care services set out in the Green Paper will form the basis of the future performance assessment framework for social care This will clarify overall expectations of social care services and enable inspection and performance frameworks to be developed and to focus more systematically on benefits for people who use services.
- Introduction of individual budgets (IBs) that will bring together a number of existing streams of funding to allow individuals direct control over the resources they need to manage their care needs. By putting resources under the direct control of the individual user, IBs provide much greater choice and flexibility of services. We announced in *Independence, Well-being and Choice* our intention to pilot IBs for older people and disabled people with a view to rolling them out nationally should they prove to be successful. These pilots are a cross-Government initiative that will commence in early 2006 and will help people take control of their lives and choose the services that suit them best. The 13 pilot sites were announced in November 2005
- Extension of direct payments (DPs) to groups who currently do not have access to them. DPs are cash payments made in lieu of social services to those assessed to be in need of services. Currently, direct payments can be made to disabled people aged 16 and over, to people with parental responsibility for disabled children and to carers aged 16 and over in respect of carer services. Proposed primary legislation would, for the first time, give some client groups, such as people who use mental health services, access to DPs.
- Offer care plans for people who have both a long-term condition and a social care need, but who do not currently have access to them. Some individuals need social care services but do not currently have a care plan, often because they fund the social care they receive themeslves. These care plans will be produced by social care workers and will involve identification of an individual's key worker, agreeing desired outcomes and ways of achieving these, provision of information and advice, identification of preventive or health promotional action and establishing medicine review procedures where approriate. It is estimated that this will cover roughly 780,000 people per year.
- Pilot a common assessment framework which will ensure less duplication across different agencies and enable people to self assess where possible. This will build upon the Single Assessment Process (SAP) developed for older people and will help in consolidating the current assessment process and thus in reducing the total burden on local authorities and other providers.
- Proposals to take forward development of the planning and performance assessment and management systems for social care and the NHS, so as to achieve greater alignment of the systems, and to develop Local Area Agreements (currently being piloted) as a means of encouraging joint planning in local areas.

- Proposals to support carers will establish a new dedicated helpline for carers and allocation of money to councils to commission training for carers. Furthermore, we will ensure that in each council area, short-term, home-based respite support for carers in crisis or in emergency situations is established.

Option 3- Full Implementation

255 This option includes all of the measures set out in the White Paper (and in option 2 above) plus the following additional elements:

- national roll-out of IBs.
- full immediate implementation of a common assessment framework across health and social services.

256 We believe it is desirable to have a more robust evidence base on the costs and operational implications of implementing these measures, preferably from pilots, before committing to national implementation. We therefore believe that Option 2, in which IBs and the common assessment framework are piloted, is preferable to Option 3 in which they are immediately rolled out across the country. In addition, the immediate implementation of a common assessment framework is not possible without the delivery of supporting infrastructure in the NHS and local government, particularly in IT.

Costs and Benefits

Sectors and Groups Affected

257 Additional costs associated with the new policies explained in the White Paper will fall mainly on local authorities. There should be no additional costs to individual users or carers. Indeed, by improving information available with which to make choices, by making rules more transparent and by improving joint working between health and social care services, costs- both financial and time costs- incurred by users and carers may be reduced. By piloting our approach to individual budgets and more streamlined assessment we will be able to systematically assess the likely impact. This will be a factor in determining the shape of possible future roll-out.

258 It is possible that these proposals will impose costs on some small business providers of social care services if they alter the pattern of demand in a way that reduces demand in social care sectors. For example, it is possible that the extension of direct payments and the introduction of IBs will reduce demand for traditional social care services such as nursing and residential home care and increase demand for services provided closer to home. This possibility and the potential impact are discussed further in the “Competition Assessment” and “Small Firms Impact Test” sections below.

259 The beneficiaries of these proposals will be users of social care services and their carers and families, many of whom are among the poorest, most vulnerable, socially excluded members of society.

Costs

Option 1- Do Nothing

260 There will be no additional policy or administrative costs associated with option 1.

Option 2- Coordinated Government Action

261 We estimate that the annual additional cost of our proposals aimed at improving social care services will be around £51m. These costs include the following initiatives that were outlined above and described in more detail in the White Paper:

- providing short -term respite support to carers in crisis or emergency situations is estimated to cost £25m. There should be no significant administrative cost;
- £5m will be spent on providing local authorities with additional funds with which to commission training for carers. A small fraction of this will relate to the administrative costs of commissioning training though the vast majority is the policy cost of training.
- around £2-3m will be spent on providing an information service/ helpline for carers.
- providing a care plan to all new and reassessed individuals with both a long-term condition and a social care need will cost around £18m for the social care elements. The health care elements are costed elsewhere.
- the administrative costs of extending direct payments are estimated to be negligible.

262 The total annual cost of this option is therefore estimated to be approximately £51m per year.

Option 3: Full Implementation

263A programme of IB pilots is already underway in a handful of local authorities. Until robust information from these pilots becomes available, it is difficult to estimate the exact cost of the national roll-out of IBs. However, significant set-up costs are likely to be incurred in order to deliver such a system. It is expected that the pilots outlined in option 2 will deliver this evidence base and provide a robust case for a national rollout in the future. Furthermore, an immediate national rollout would jeopardise the efforts of the existing individual budget pilots to deliver a robust evidence base assessment.

264 We estimate that a national implementation of measures to integrate assessment across the NHS and social care to cost around £160m in the first two years with an ongoing cost of around £20m for all subsequent years. This is based on actual and indicative costs from existing schemes extrapolated for national implementation.

265 Until evidence from pilot studies, particularly those of IBs, becomes available, it is difficult to estimate the full implementation costs of this option.

Benefits

Option 1- Do Nothing

266Compared to the current situation, there will be no benefits of this option.

Option 2- Coordinated Government Action

267 Outcomes framework for social care services: the proposed new framework for adult social care services will be based of the concept of well-being, including improved health and emotional well-being, improved quality of life, providing better choice and control. The principles received significant support from those who responded to our Green Paper consultation. The advantage of an outcomes framework is the clarity that it gives to local partners about the aims that they are working together to achieve, as set by national Government. The Government considers that defining outcomes is a helpful element of the overall framework within which services operate, and contributes to ensuring that services focus on tangible results and change for individuals, rather than solely on inputs and processes.

268 IBs are an innovative and new method of social care commissioning and delivery and as such, there is not currently a well developed evidence base surrounding their benefits. . The aim is to offer greater independence, choice and flexibility, so as to deliver an improved service to users of social care, improving outcomes and user satisfaction. By piloting IBs, we will develop a robust evidence base to inform future policy decisions

269 Extension of direct payments (DPs) to groups which currently do not have access to them will offer service users much greater choice, control and flexibility over their care.

270 A care plan will ensure that a proper assessment of need is undertaken, and a clear plan to meet needs agreed with individuals and carers. This will help to improve the alignment between services required and services received and will also improve equity between those who access free social care and those who fund care from their own means.

271 Piloting a common assessment framework for health and social care services will enhance co-operation and sharing of information between health and social care professionals, streamlining the process for individuals, and reducing inefficiencies including the need to supply information repeatedly to different staff. By piloting this, we will be able to gather robust evidence of the benefits of this approach. In addition, the introduction of a common assessment framework for health and social services will consolidate existing duties on providers, thereby reducing the administrative burden.

272 Proposals to take forward development of the planning and performance assessment and management systems for social care and the NHS are currently being piloted. This will help provide robust evidence as to the benefits but we expect the these proposals will enable more efficient joint planning and cooperation between local services, resulting in improved efficiency and effectiveness of services working together to support individuals' needs.

273 The proposed initiatives to support carers will help relieve the burden on carers and improve quality of life for both carers and those cared for. Additional training for carers will improve the quality of care and emergency respite support will provide reassurance and peace of mind to carers and those cared for. As a whole, the proposals to supports carers may also encourage more people to act as carers for their loved ones, thereby relieving pressure on formal services and allowing those services to be re-focussed on those who benefit most from them.

Option 3- Full Implementation

274 A national rollout of individual budgets would allow all clients of social care to take advantage of a system that will give them improved choice and control over their package of care. The pilots will provide evidence that demonstrates whether this system provides a more or less cost effective service than the current mechanism for the delivery of social care.

275 A common assessment framework for health and social care services would enhance co-operation and sharing of information between health and social care professionals, streamlining the process for individuals, and reducing inefficiencies including the need to supply information repeatedly to different staff.

276 As outlined above, we do not yet have robust evidence on the precise benefits of these policies. This is why we propose to pilot these initiatives first with a view to establishing a better evidence base of their costs and benefits.

Equity and Fairness

277 By focusing on increasing control and choice for people who receive social care services, the proposals on IBs and direct payments contribute to maintaining independence and reducing the risk of social exclusion. The extension of care plans and common assessment framework improve equity and fairness by including groups who currently do not have access to these processes.

278 We have also considered the likely effects of these proposals on rural populations and do not believe that the impact will be disproportionate or disadvantageous. Indeed, by extending individual choice and control of services, it will make it easier for users to choose packages of care delivered in, or closer to, their homes. The benefits in terms of ease and convenience will likely be greater for those users and carers in rural areas, for whom accessing traditional services can be most problematic.

279 Similarly, our proposals to support carers will likely provide greater benefits for rural populations. For example, establishment of a telephone helpline will provide advice and support without carers having to leave the home, which can often be more problematic for those in rural areas.

Competition Assessment

280 The market for care services can be broadly divided into two: the market for domiciliary care services and the market for residential care services. The size of the market for adult domiciliary care services is estimated to be £6.1 billion[49]. The estimated size of the market for residential services for adult clients of social care at April 2005 is £11.7 billion, the private sector accounts for 65 per cent of this market[50]. There are two initiatives in the White Paper that could potentially have an impact on the market for social care services, increased choice and control through IBs and the provision of information through personalised free care plans.

281 IBs encourage a more innovative and experimental approach to the commissioning and delivery of social care services and by significantly extending choice, there are potential risks to existing providers of social care services. This includes providers in the voluntary and independent sectors. In particular, by providing greater control, information and choice to individual users, it is possible that this may reduce the demand for traditional services such as residential and nursing home care or day centres and may increase demand for services, particularly innovative new services, which allow users to be supported closer to home. It is difficult to quantify accurately these potential impacts. It is hoped that the individual budget pilots will provide some evidence of the likely impact of a wider roll-out of IBs on competition and small businesses.

282 However, by improving choice for users and by providing better information to facilitate those choices, it can be argued that the proposals will lead to a more dynamic and efficient social care market. This is because increased choice and control for users should provide incentives for innovative new producers to enter the market if they are able to provide affordable services that meet the needs of users.

Small Firms Impact Test

283 Many small businesses operate in the market for social care services. The small business sector - defined as all for-profit operators not classified as major providers – dominates the elderly care home market[51].

284 The measures outlined in this White Paper will not lead to an increase in the regulatory burden faced by small businesses operating in the market for adult social care services.

[49] Laing and Buisson (2005) - "Care of Elderly People - UK Market Report 2005"
[50] Laing and Buisson (2005) - "Care of Elderly People - UK Market Report 2005"
[51] Laing and Buisson (2005) - "Care of Elderly People - UK Market Report 2005"

285 However, as outlined in the Competition Assessment above, there is a possibility that providing individuals with better information, more choice and more control over their care may lead to changes in the pattern of demand for social care services. It is likely that these initiatives will have at most a gradual impact on the small business sector.

Enforcement, Sanctions and Monitoring

286 To underpin the implementation of these proposals we will develop a balanced scorecard approach that will provide a meaningful and comprehensive assessment of progress by local authorities and health partners against a number of our commitments. This will draw upon feedback from service users. Over time, we expect to develop user reported outcome measures that will help to assess the effectiveness and cost-effectiveness of new services and new services models.

287 The Commission for Social Care Inspection (CSCI) Performance Assessment Framework (PAF) will also be used to monitor progress, including the implementation of care plans for all those who want them

288 In order to help strengthen commissioning, we will develop, in 2006, a commissioning toolkit that will provide a framework for commissioners to implement the changes developed in the White Paper.

289 We will make commissioning more important in performance assessment. Working with SHAs, the Healthcare Commission and CSCI, the Department of Health will develop during 2006 a revised assessment for PCTs and local authorities to focus more effectively on how well they are discharging their commissioner functions, separately and jointly. CSCI and the Healthcare Commission will also inspect local commissioners to ensure joint commissioning becomes a major part of commissioning work.

ANNEX 5: PARTIAL REGULATORY IMPACT ASSESSMENT

White Paper- Our health, our care, our say: a new direction for community services

Support for People With Long-Term Needs

Objective

290 To improve health and patient outcomes for people with long-term health conditions who are likely to need ongoing support from health and social care services. The aim is to provide support and care which is built around individual needs and choices and which is not fragmented by current service boundaries. A greater focus is to be put on disease prevention, with people being treated sooner, closer to home and earlier in the course of their disease.

291 This is closely linked to the Department of Health's Public Service Agreement targets to[52]:

"improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5 per cent by 2008, through improved care in primary care and community settings for people with long-term conditions."

and to:

"increase the proportion of older people being supported to live in their own home by 1 per cent annually in 2007 and 2008."

Background

292 The *Our health, our care, our say* White Paper sets out the extent of the current and future challenge of supporting those with continuing health and social care needs: around 1 in 3 of the population in England have significant, ongoing health or social care needs. This group of people account for over two thirds of total NHS activity. For 8.5m people their illness or disability affects their daily life and around 2.5m people are unable to work as a result[53].

293 Changing demographics and increasing incidence of risk factors such as obesity are likely to further increase demand for health and social care services in the future. For example, it has been estimated that the number of people with long-term conditions will increase by over a million every decade from ageing of the population alone. The number of people aged 85 and over, who are the highest users of health and social care services, is expected to double by 2020[54].

---

[52] Further information on PSA targets can be found at http://www.hm-treasury.gov.uk/performance/Health.cfm
[53] General Household Survey
[54] Government's Actuary Department

294 The White Paper also sets out, drawing extensively from results of the consultation exercise, problems in the current system of delivery which impede effective, coordinated care for those with long-term conditions. For example, there is a lack of good quality information, problems with navigating the system and a disjointed interface between health and social care which cause confusion and frustration and waste people's time and money. Services are viewed as reactive rather than proactive and issues about eligibility criteria and charging for some services causes confusion for users, carers and their families.

295 These results from the consultation exercise are borne out by recent national survey evidence and performance data that show:

- 50 per cent of people with long-term conditions are not aware of treatment options
- 37 per cent of all those receiving social care services had not had a review of their care needs in the last year
- 25 per cent with long-term conditions do not have a care plan and 50 per cent do not have a self care plan
- 30-50 per cent of all medicines are not taken as intended
- Of the 640,000 older people being supported with community services at March 2005, only 1 per cent were receiving a direct payment
- only 9 per cent of all adults who received one or more community services in 2004/05 had a carer who received a specific carers' service, though more would have had other sorts of support.
- over 500,000 adults die in England each year. Although most well people say they would like to be cared for and die at home if they were terminally ill, only 20 per cent of people die at home and 20 per cent in care homes.

Rationale for Government Intervention

296 It is clear, from the consultation and from the evidence outlined above and in the White Paper, that there are deficiencies in the way in which the health and social care system currently delivers and supports care for those with long-term conditions. This too often causes confusion and frustration for service users, their carers and families and means that care is not as integrated or personalised as it could be.

297 These problems, highlighted above, would continue to affect the lives of millions of people and the burden on those with long-term conditions, their carers and their families would increase as demographic and other trends increase the number of people with long-term conditions over coming decades.

Options

Option 1: Do nothing.
Option 2: Coordinated Government action to ensure that all those with long-term conditions have access to services that are responsive to their individual needs, proactive and seamless.
Option 3: Further and faster

Option 1- Do Nothing

298 Significant progress has already been made in the prevention and treatment of long-term conditions, grounded in best practice guidance contained in National Service Frameworks[55] and embedded in the General Medical Services Quality and Outcomes Framework (GMS QOF)[56].

299 One option is to do nothing further and to rely on these policy initiatives that have already been introduced to drive further improvements in care for those with long-term conditions. However, we believe that failure to act now to build upon this base would result in services remaining too reactive and too disjointed at the interface of health and social care. Services would remain impersonal and focussed on acute care and too far down the disease pathway. Consultation evidence (outlined above) makes clear that the public share this view.

300 Patient health and satisfaction would remain poorer than it might otherwise be. In addition, given that the burden of long-term conditions is projected to grow rapidly over coming decades, the "Do nothing" option is likely to be unsustainable in the long-term. Services need to be re-focussed to support better prevention and early intervention to halt or slow disease progression and to reduce demand for acute services further down the line.

Option 2 (Preferred Option)- Integrated support and care built around individual needs

301 This is our preferred option. The proposals set out in the White Paper constitute a coordinated and comprehensive approach to support and care for those with long-term conditions, building upon progress which has already been made. These proposals will shift the focus from hospitals to integrated community-based care, will stress a joint approach between health and social care and will encourage and support individuals to play a key role in their own care, supported by new technologies, better information and peer networks.

302 A systematic approach to needs assessment and care planning will be developed, with care plans introduced gradually. By 2008, all those with both long-term health and social care needs will be offered a care plan and by 2010, we expect everybody with a long-term condition to be offered a care plan. In Option 3 below we consider the alternative of offering all those with long-term conditions a care plan more quickly – by 2008. However, given that there are 15m with a long-term condition we believe that it would be unreasonable to expect all of this group to have been offered a care plan by 2008. We therefore favour the staged approach outlined above and in the White Paper, begininning

[55] http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthAndSocialCareArticle/fs/en?CONTENT_ID=4070951&chk=W3ar/W

[56] http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/fs/en

with those with the most complex and diverse needs. We will issue guidance in due course detailing good practice and minimum requirements.

303 In addition, by 2008, an information prescription will be given to all patients, users and carers to help them access more easily information about their condition and supporting services. This information prescription will be given by health and social care professionals (GPs, social workers, district nurses) and will signpost people to further information and advice to help them take care of their own condition.

304 In order to improve the co-ordination of care, multidisciplinary teams will be created by 2007/08 to support patients with very complex needs. In addition, a "demonstrator site" based upon a whole system approach to managing long-term conditions will be introduced from October 2006. Early findings should be available by the end of 2007/08. This will cover a resident population of at least 1m people and will bring together NHS, social care, private and voluntary sector providers, as well as NHS Connecting for Health. These will aim to exploit the use of assistive and communications technology, process redesign and new ways of working to significantly reduce emergency hospital admissions and improve the lives of those with long-term conditions.

305 The proposals will further help to put people with long-term conditions in control of their treatment and care. By providing self care skills training for staff and by developing a competence framework, this will help to foster of culture of supporting self care. We also intend to provide improved support for self care by encouraging access to self care support networks of local peers through *NHS Direct online* and interactive digital television services and self care skills training for people, for example through expansion of the Expert Patients Programme. A guide will be issued which will set out in detail the components of an integrated self care support resource.

306 The Government recognises that additional investment is required to improve end of life care and has undertaken to increase choice for patients and families by doubling investment in palliative care services. This will give more people the choice to be treated outside the acute hospital, including at home, when they are dying.

307 In particular, we will introduce end of life care networks to better identify those in need and to improve coordination of the care they receive. We will also ensure that all staff who work with the dying receive proper and appropriate training in looking after the dying and their families. In addition, in building on multi-agency assessments, we will ensure that health, education and social services are organised around the need of the individual and we will provide rapid response (hospice at home) services to patients in need by investing in community-based specialist palliative care services.

308 We will seek to underpin all of these new proposals by strengthening commissioning arrangements and by providing sharper incentives for local commissioners and providers to provide better care for those with long-term conditions. In particular, we plan to provide a toolkit to local authorities and

PCTs to help them stratify population risks and to provide needs assessment. We will also encourage PCTs to make greater use of existing levers for change, including the pharmacy contract (for example, to enhance the use of medicine reviews) and pooled budgets and will develop a balanced scorecard tool to help drive improvement. We will also be examining funding flows, including Payment by Results, to ensure that they better support and incentivise care for those with long-term conditions.

Option 3- Further and faster

309 Under this option, all of the White Paper proposals outlined in Option 2 would be implemented. In addition:

- instead of piloting demonstrator sites, these radical new models of care would be rolled out across England.
- on care plans, all people with a long-term condition would be offered a care plan by 2008 (instead of by 2010)

310 While we recongise the potential of demonstrator sites in helping to improve the health and care of those with long-term conditions, we also recognise that there is not currently a robust evidence base as to their exact benefits. A full immediate roll-out would be expensive and the exact costs are difficult to estimate currently (see “Costs” section below). Until their costs and benefits have properly been evaluated through the pilot initiative announced in the White Paper, we do not believe, therefore, that a full immediate roll-out would be a prudent use of resources.

311 With regard to care plans, Option 3 would see all people with long-term conditions being offered a care plan by 2008. While we support this as a long-term aim, we believe that it is unrealistic to expect all 15 million people with a long-term condition to be offered a care plan by 2008 and that this might place undesireable pressure on the service and deflect from other important priorities. We therefore consider that the White Paper proposal of offering those with the most complex health and social care needs a care plan by 2008 and all those with any long-term condition a care plan by 2010 represents a sensible phased implementation.

Costs and Benefits

Sectors and Groups Affected

312 There are an estimated 15 million people with long-term health conditions, many of whom also have social care needs. Many of these people are unable to work and are among the poorest, more vulnerable and socially excluded members of society.

313 There are a variety of sectors involved in providing care and support for people living with long-term health conditions- the NHS, local authorities, business, the voluntary sector and informal carers.

Costs

Option 1- Do Nothing

314 Under this option, there would be no additional direct costs to Government, businesses or to individuals associated with services for those with long-term conditions. However, compared to the proposals contained in the White Paper, the costs of doing nothing would be high and likely to rise over time.

315 In addition, compared with the proposals in the White Paper, the "Do Nothing" option imposes a significant human cost in terms of poorer health, lower satisfaction and lower life expectancy for millions of people with long-term conditions. In addition, the "Do Nothing" option would mean that too many people with long-term conditions receive treatment too far down the disease pathway (for example, in A&E or as hospital inpatients) which causes unnecessary expense and distress.

Option 2- Integrated support and care built around individual needs

316 It is estimated that beginning in 2008/09 the annual costs associated with the proposals in the White Paper for ongoing integrated support for those in greatest need will be around £155m in addition to one-off costs of around £10-15m.

317 Proposals to improve end of life care are estimated to cost £54m in 2007/08 and £64m in 2008/09.

318 Long-term conditions demonstrator sites will cost around £10m in both 2007/08 and 2008/09. Establishing joint health and social care teams to support those with complex needs will require £4m per year to support team development and facilitate social care input.

319 Provision of an "information prescription" will cost around £1m in 2006/07, £2m in 2007/08 and £2m in 2008/09 (£1m of which is covered by the Information for Choice programme in both 2006/07 and 2007/08). This information prescription will usually be filled in by health or social care professionals (e.g. GPs, social workers or district nurses). It is envisaged that the prescription will be provided during consultations that people with long-term conditions already have with these professionals.

320 Improving self care support in the ways outlined above will cost around £7m for self care support networks (all of which will be covered by existing moneys; £3m in 2006/07, £2m in 2007/08 and £2m in 2008/09). This is in addition to a further £12m for self care skills training by extending the Expert Patients Programme, as signalled in the Manifesto.

321 We will assess ways of improving self care and long-term conditions management through general practice. This will be the subject of discussion with the General Practitioners Committee.

Option 3- Further and faster

322 It is difficult to estimate accurately the costs of Option 3 since estimates of the costs of rolling out demonstrator sites nationally will be informed by pilot studies.

Total Cost

323 The total cost of the proposals in the White Paper relating to ongoing integrated support for those in greatest long-term need and outlined above (Option 2) will be £145m in 2007/08 and £160m in 2008/09.

Benefits

Option 1- Do Nothing

324 There will be no additional benefits to patients under this option.

Option 2- Integrated support and care built around individual needs

325 The proposals detailed in the White Paper are based on a robust evidence base which indicates that integrated support and care for those with long-term conditions can improve both health outcomes and patient satisfaction and can also reduce demand from these groups for other health services, particularly acute care.

326 For example, there is a large body of evidence that attests to the benefits of supporting self care, including through the development of an integrated self care support resource comprising self care plans, self-monitoring devices, self care skills training and self care support networks. This has shown, in various disease areas to:

- reduce numbers of GP consultations[57]
- reduce medicine prescriptions (but also facilitate better compliance with medicines)[58]
- reduce hospitalisation- both outpatient visits and inpatient stays[59]

---

[57] Choy et al (1999) Evaluation of the efficacy of a hospital-based asthma education programme in patients of low socio-economic status in Hong Kong. *Clinical Experimental Allergy* 29: 84-90. [Though the programme is hospital-based, it led to 69 per cent reduction in GP visits.]; Fries J et al (1998) Reducing need and demand for medical services in high risk groups. *West J Med* 169: 201-207. [Evidence suggests 40 per cent reduction in GP visits and 9:1 benefit-cost ratio.]; Gillies et al (1996) A community trial of a written self management plan for children with asthma. Asthma Foundation of NZ Children's Action. *New Zealand Medical Journal* 109: 30-3. [67 per cent decrease in GP consultations, significant reduction in nights woken, and significant reduction in days on steroids and nebuliser use.]

[58] Ryan P, R Kobb and P Hilsen (2003) "Making the right connection: Matching patients to technology." Telemedicine Journal and e-Health 9(1): 81-88. [Self monitoring leads to 30 per cent increase in regular medicine intake]; Mannix et al (1999) Impact of headache education program in the workplace. *Neurology* 53: 868-71. [Improvement in disability due to headache, reduction in OTC medicines.].

[59] Montgomery et al (1994) Patient education and health promotion can be effective in Parkinson's disease: a randomised control trial. *The American Journal of Medicine* Vol 97: 429. [Evidence suggests

327 It is difficult to quantify these benefits: the evidence quoted relates to specific interventions in particular patient groups and settings. It is therefore not possible simply to extrapolate from this to precisely estimate the financial benefits from introducing the proposals in the White Paper for *all* those with long-term conditions.

328 In some studies, provision of information and support to support self care has been shown to be cost saving- initial costs of supporting self care are more than outweighed by later savings through reduced use of services. Estimates are that for an average spend of £100 per person on self care support (a combination of self care skills training, pharmacy-led self care information and advice schemes, self care support networks, electronic/ TV self care information facility - in decreasing order of average cost per scheme) savings in the first year would amount to at least £150. It is hoped that savings would be higher still further down the line as the full benefits of self care are realised.

329 The proposals on end on life care will lead to significant improvements in coordinated care, providing privacy, dignity, relief of distressing symptoms and support for those needing end of life care and their families.

330 In addition, by reducing the number of people who die in hospital - by providing other options which better suit their needs and wishes - it is likely that a significant number of acute hospital bed days and their associated cost will be saved. Currently, over 10 per cent of all bed days are accounted for by people who die at the end of their stay, so the scope for reducing bed days as a consequence of these proposals for end of life care is significant:

- nurse management for chronic heart failure in England could save 250,000 bed days. [60]
- case management of women with heart disease focused on behavioural change can payback 5 times original investment.[61]
- experience from the CHD collaborative suggests a 300 per cent reduction in mortality compared to normal care.[62]
- case management of people with diabetes can payback 3 times the original investment.[63]
- case management of COPD can reduce admission rates by 40 per cent.[64]
- Asthma self management support can payback 4-10 times original costs [65]

---

24 per cent reduction in visits to doctors, 50 per cent reduction in hospitalisation and 12:1 savings-cost ratio.]; Lorig et al (1985) A work place health education programme that reduces outpatient visits. *Medical care* 23, No 9: 1044-1054. [up to 17 per cent reduction in visits to outpatients]

[60] This corresponds to a cash saving of up to £75m.
Based on findings from study European Heart Journal (2002) 23 pp1369-78.
[61] Medical Care (2003) 41 (6) pp706-15
[62] http://www.npdt.org
[63] BMJ (2002) 325 pp860-65
[64] Arch Intern Med 2003;8:252-62
[65] *Inquiry (2002)* 37 pp188-202

331 It is believed that implementation of option 2 will lead to financial savings, particularly in the longer term, as people who have their long-term conditions managed more effectively and earlier will subsequently require fewer health care services, particularly acute services. These savings may partially or fully offset the programme costs.

Option 3- Further and faster

332 The benefits of option 3 are likely to be similar to those under option 2, but would be realised more quickly.

333 Under this option, Demonstrator Sites based upon a whole system approach to managing long-term conditions would be rolled out nationally immediately rather than in pilot form. However, although this type of model has been shown to be effective in certain settings in the United States, there is currently no evidence that these benefits can be replicated in an NHS setting. Therefore, we believe that piloting this scheme first to assess the effectiveness and learn lessons is a more prudent strategy. The benefits of a universal roll out are not yet known.

Total Benefit

334 The proposals outlined in the White Paper (Option 2) will help towards achieving the PSA target of a 5 per cent reduction in emergency bed days by 2008. It is estimated that the financial savings associated with meeting the target will be around £270m in 2007/08, relative to a baseline of 2003/04.

Equity and Fairness

335 These proposals will help improve the lives of the 15m people with long-term health conditions, many of whom are amongst the poorest and socially excluded in society. For example, around 2.5m people are unable to work and receive incapacity benefit due to long-term health conditions. Many long-term health conditions are disproportionately prevalent in economically deprived and ethnic minority populations, such as diabetes and coronary heart disease. Another example is that of digital interactive TV services. As well as penetration that now exceeds that of the internet, digital TV shows a much more even socioeconomic spread (a range of 55 per cent to 65 per cent across all social classes). The *NHS Direct* interactive TV service has a house style aimed at C/D/E rather than A/B classes and has in under a year reached the levels of use (about half a million viewers a month) that the *NHS Direct Online* internet service took 6 years to attain.[66]

336 Therefore, the proposals in the White Paper should, by improving the lives of all those with long-term conditions, have a significant positive impact on economically deprived and ethnic minority populations.

[66] MORI Technology Tracker September 2005.

337 We have also considered the likely effects of these proposals on rural populations and do not believe that the impact will be disproportionate or disadvantageous.

Small Firms Impact Test

338 No significant costs to small businesses are anticipated. In fact, these proposals may serve to benefit small businesses by improving the health of workers with long-term conditions, thereby reducing sickness absence and improving productivity. Self care skills training schemes like the Expert Patients Programme can lead to 20 per cent reduction in days off work; international evidence indicates that days off work can decrease by up to 50 per cent[67].

Competition Assessment

339 We do not believe that these proposals will have any significant impact on competition. By improving the information available to patients, by giving greater control and choice to patients and by better integrating health and social care services, the proposals should in fact serve to enhance competition by increasing the incentive for commissioners and providers of health and social care to design services that better match individual patient needs.

Enforcement, Sanctions and Monitoring

340 In order to underpin the implementation of these proposals, we will strengthen commissioning arrangements by developing, during 2006, a Commissioning Toolkit for People with Ongoing Needs, which will provide a framework for commissioners to assess and meet the needs of people with long-term health and social care problems. Commissioners will also be encouraged to make greater use of existing levers for change including the new pharmacy contract.

341 In addition, we will explore potential changes to the Payment by Results tariff system, which will help to provide sharper incentives for commissioners and provides to better support those with long-term conditions. We will also ask NHS Employers to examine how the General Medical Services Quality and Outcomes Framework might be furthered developed to support better care for those with long-term conditions, building upon the recent new agreement for 2006/07[68].

342 In order to help enforce better case management of those with complex long-term conditions, we will mandate the creation of joint multi-disciplinary teams between PCTs and local authorities by 2008.

343 We will investigate models of developing self care support through contractual arrangements.

---

[67] Fries J et al (1997) Patient education in arthritis: Randomised controlled trial of a mail delivered programme. *Journal of Rheumatology* 24, No 7: 1378-1383.
[68] http://www.nhsemployers.org/aboutus/mediacentre-listing.cfm/pressrelease/76