

NHS Next Stage Review

Our vision for primary and community care

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NHS Next Stage Review

Our vision for primary and community care

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Foreword

By the Secretary of State for Health

The National Health Service celebrates its sixtieth birthday this week. Access to primary care – ensuring that any citizen can see a local GP if they are sick or worried about their health, free of charge – is one of the underpinning principles of the NHS. The 1944 white paper, which set out the government's ambition for a national health service, was explicit: "The first-line care of health of everyone requires a personal doctor, or a family doctor, a general medical practitioner available for all problems of health and sickness".

Sixty years on, we can be justly proud of our primary and community care services and the dedication of the hundreds of thousands of staff who work in these services, providing high-quality care to millions of patients every day. More than 90% of all contacts with the NHS take place outside hospital with the staff who work in GP practices, pharmacies, dental surgeries and opticians and with the nurses, health visitors and other professionals who work in our community health services.

The NHS was created to meet the needs of a society very different from that of today. Over the years, healthcare staff have sustained its enduring values and principles, applying them to changing circumstances. We lead hectic but less active lives. We live in a fast-moving information age. We rightly demand high-quality services as the norm, not a privilege afforded to the few. The focus on strong and effective primary care and

the personal relationship between GP and patient are powerful attributes.

That is why I believe the vision and strategy for primary and community care that we publish today will be welcomed by both staff and patients. It builds on what is best about our local services and sets out new aspirations for the twenty-first century. Just like the wider NHS Next Stage Review of which it is a part, it anticipates the changing forces at play in healthcare and society and helps prepare us to face the future with confidence.

This is the next stage in the journey of primary and community care. The public will have greater opportunities to shape their health and healthcare, with the NHS playing a much stronger role to promote healthy lives and tackle health inequalities. Power and control will be devolved to where it is most needed – to patients and the public and to front-line clinicians.

The history of the NHS is the history of continuous evolution and advance. This document sets out how we can work together to secure a flourishing future for primary and community care.

A handwritten signature in black ink that reads "Alan Johnson". The signature is written in a cursive, flowing style.

**The Rt Hon Alan Johnson MP
Secretary of State for Health**



Executive summary

Primary and community care services are regarded with pride at home and admiration abroad. Thanks to the dedication of family doctors, community nurses, health visitors, allied health professionals, social care professionals, pharmacists, dentists and opticians, most patients enjoy good quality care, close to home. There are high levels of satisfaction with services and trust in the staff who provide them.

We need to ensure that high-quality care is a consistent part of everyone's experience of primary and community care. Services need to evolve to reflect the changes in healthcare and society described in *High Quality Care for All*¹: rising expectations, the 'information age', advances in treatments, the changing nature of disease and the evolving nature of the workplace.

The vision and strategy in this document have informed, and been informed by, the wider NHS Next Stage Review. We and our Advisory Board have discussed extensively with members of the public, with clinicians across the NHS including many involved in the regional reviews, and with colleagues from local government and other sectors how together we can raise and realise our ambitions for primary and community care.

Our conclusions fall into four broad themes:

- People shaping services (chapter 4);
- Promoting healthy lives (chapter 5);
- Continuously improving quality (chapter 6);
- Leading local change (chapter 7).

People shaping services

1. We will promote personal and responsive services that systematically listen to and act on patient views. We are developing the

GP patient survey to give patients a greater say in whether practices are providing not just fast, convenient access but an all-round quality patient experience (paras 4.1–4.7).

2. We will help GPs work with community health teams, pharmacies, social care, schools and other groups to give patients access to a greater range of services in their local communities that fit around their needs (paras 4.8–4.14).
3. Patients will have greater choice of GP practice and better information to help them choose. We will develop a fairer funding system, giving better rewards for GPs who provide responsive, accessible and high-quality services (paras 4.15–4.18).
4. NHS Choices will provide greater information about all primary and community care services, so that the public can make informed choices (paras 4.19–4.22).
5. By 2010, some 15 million people with long-term conditions will be offered their own personalised care plan. Named lead professionals will help ensure that plans and services are tailored to support the needs of those with the most complex care needs (paras 4.23–4.27).
6. We will publish a Patients' Prospectus to provide excellent advice for those wanting to take greater control of how they manage their long-term conditions (paras 4.28–4.29).
7. Learning from social care, and working with patient groups, we will pilot individual budgets to help people have greater control of their health and care (para 4.30).

¹ 'High Quality Care for All': NHS Next Stage Review Final Report, June 2008

Promoting healthy lives

1. The NHS will work with local government, the third sector and independent sector to promote health and wellbeing in local communities, with greater pooling of resources. We will develop a suite of indicators that Primary Care Trusts (PCTs), local authorities and practice based commissioning groups can use to measure and incentivise improvements in health and wellbeing (paras 5.2–5.4).
2. Primary and community care services will support people in staying healthy throughout their lives, from the pivotal role of health visitors in the new Child Health Promotion Programme to that of community nurses in helping older people keep healthy and independent (paras 5.5–5.12).
3. We will support people to stay healthy at work and return to work more quickly, piloting integrated access to musculoskeletal, psychological and other services (para 5.9).
4. We will work with GPs, pharmacies and other services to introduce a vascular risk assessment programme for those aged 40 to 74 (para 5.10).
5. We will improve access to a range of healthy living services to help people give up smoking, control alcohol use and improve diet or exercise (paras 5.13–5.15).
6. We will ensure that primary and community care services have a central role in tackling health inequalities (paras 5.16–5.20)

7. We will work with professional and patient groups to improve the world-leading Quality and Outcomes Framework to provide better incentives for maintaining good health as well as good care (para 5.21).

Continuously improving quality

1. As part of our overall strategy for quality outlined in *High Quality Care for All*, we will introduce a programme of professional development to strengthen clinical leadership and skills for community nurses, health visitors and allied health professionals and release more time for direct patient care (paras 6.3–6.7).
2. We will pilot information tools to compare clinical quality, clinical productivity and patient experience in community health services. We will develop new tariffs to improve the commissioning and delivery of services and encourage more healthcare to be provided in community settings (paras 6.8–6.9).
3. We will support the NHS in making local decisions on the governance and organisational models that best underpin vibrant, high-quality community services. Staff will have the right to request setting up social enterprises. Staff who transfer to new social enterprise organisations will continue to benefit from the NHS Pension Scheme (para 6.10–6.11).
4. We will work with professional and patient groups and with NICE to create an independent, transparent process for developing and reviewing the indicators in the Quality and Outcomes Framework,

reduce the number of process indicators and focus resources on health outcomes and quality (paras 6.13–6.14).

5. We will support the NHS in collecting, analysing and publishing data on service quality to recognise and reward excellence and support patient choice (paras 6.15–6.18)
6. We will promote accreditation schemes to improve quality and identify best practice, including working with the Royal College of General Practitioners to drive forward accreditation of GP practices (para 6.19).
7. The new Care Quality Commission will, subject to consultation, register all GP and dental services and help tackle persistently poor performance whilst assuring standards for all (paras 6.20–21).

Leading local change

1. We will support PCTs and clinicians in making local decisions on how best to develop more integrated primary and community care services (paras 7.3–7.8).
2. Practice based commissioning (PBC) is central to our ambitions for health improvement and high-quality care. PBC groups will be entitled to improved information and management and financial support, for which PCTs will be held to account through the world class commissioning assurance system (paras 7.9–7.11).
3. PCTs, as the local leaders of the NHS and strategic commissioners of health and healthcare for their population, will give

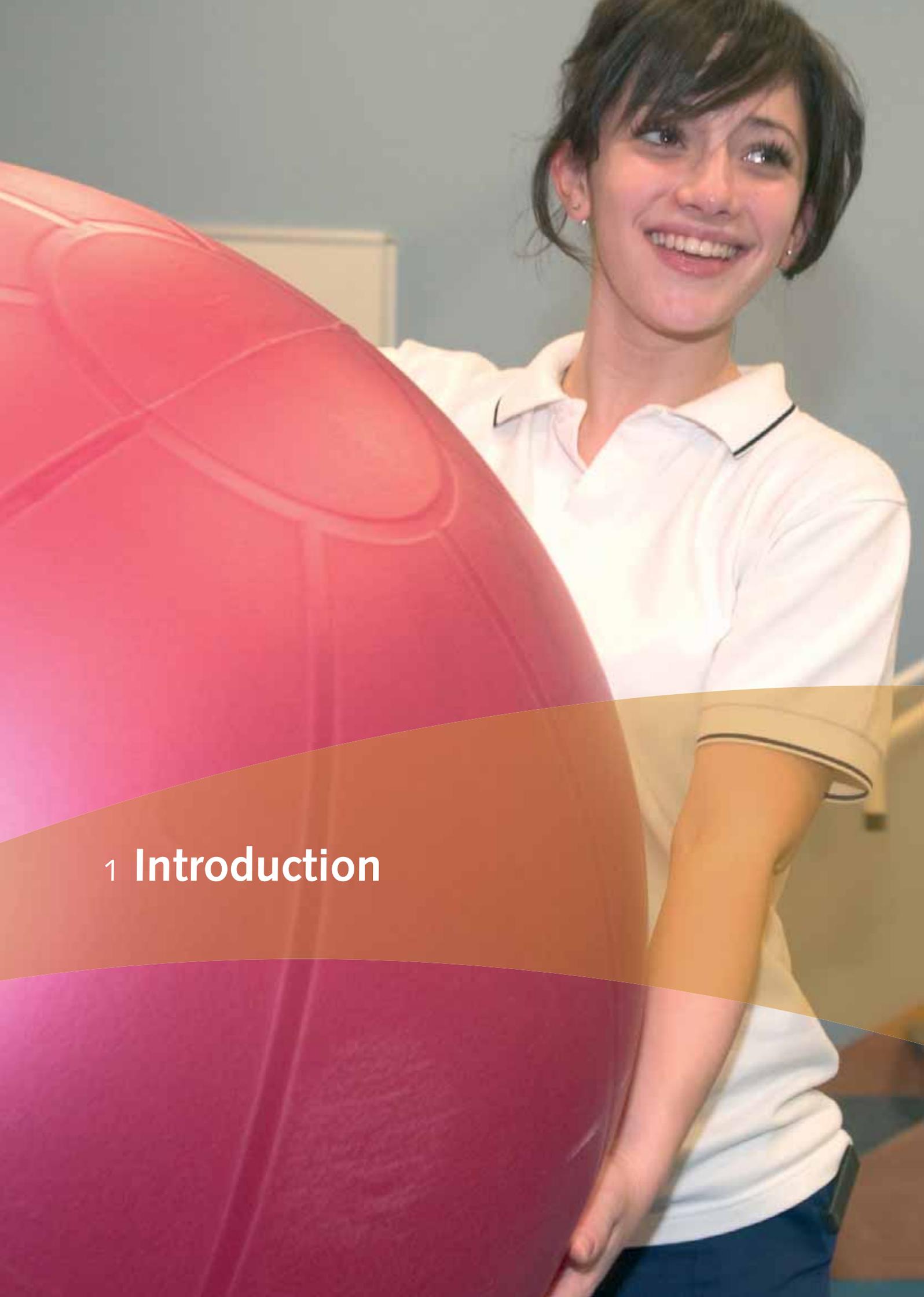
increasing power and responsibility to high-performing, multi-professional PBC groups that achieve better health outcomes for local patients in a transparent and accountable way (paras 7.12–7.13).

4. With the support of PCTs, we will pilot new ways of allowing primary, community and hospital clinicians and social care organisations to provide more integrated services for patients, including the formation of new integrated care organisations (paras 7.14–7.16).
5. With the NHS, we will provide support and development programmes which enable primary and community services to be better commissioned, securing improvements for patients and taxpayers alike (paras 7.17–7.23).
6. We will establish a Minister-led group to identify how best to support those organisations that wish to go further in integrating health and social care (paras 7.24–7.25).

Next steps

Our conclusions work with the grain of the NHS and we will now support the NHS, healthcare professionals, patient groups and local government, third sector and independent sector partners in developing local strategies for primary and community care that secure improved health and enhanced healthcare for the people and communities they serve.

We will establish a national clinical advisory group to review progress and will continue to work with national patient groups.



1 Introduction

- 1.1 When people think of health and health care, it is often hospitals that spring to mind. Fortunately though, the great majority of people every year don't need hospital care. Over 90% of all contact with the NHS takes place outside hospital – with the primary care staff who work in GP practices, pharmacies, dental surgeries and opticians and with the nurses, health visitors, allied health professionals² and healthcare scientists working in our community health services.
- 1.2 The services provided in these high street and community settings – and their strong links with wider services such as social care and education – are at the heart of our vision for the NHS. All the evidence shows that high-quality health systems and healthy populations require strong and effective primary care.
- 1.3 In July 2007, we announced 'Our NHS, Our Future', a once-in-a-generation review of the future of the NHS. Over the last year, more than 2,000 clinicians from every region of the country have come together to shape the main conclusions of the review. They have worked in partnership with thousands more patients, members of the public and other stakeholders to develop each region's vision for improving health and healthcare services.
- 1.4 As part of 'Our NHS, Our Future', we have engaged in an intensive listening process to develop a shared vision for primary and community care. We have met patients and the public. We have visited different parts of the country and met GPs, community nurses, allied health professionals, pharmacists and other front-line clinicians. We have worked closely with an advisory board drawn from leading primary and community clinicians and national stakeholder groups. We and the advisory board have met clinicians from the regional groups and drawn closely on those groups' conclusions, which have clear resonances for primary and community care services.
- 1.5 During this process of listening and engagement, there was considerable agreement among patients and clinicians about the key characteristics of high-quality primary and community care services – services that treat people fairly, delivered by staff with the power to improve care and make decisions locally.
- 1.6 We are particularly indebted to the external members of the primary and community care Advisory Board who played a vital role in helping develop this vision and strategy.

² Allied health professionals are art, music and drama therapists, chiropodists/podiatrists, dietitians, occupational therapists, orthoptists, orthotists, paramedics, physiotherapists, prosthetists, radiographers, and speech and language therapists

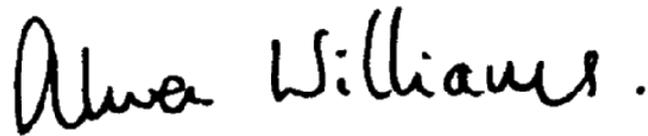
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Ursula Gallagher, Community nurse and Director of Quality, Clinical Governance and Clinical Practice, Ealing Primary Care Trust

Professor Michael Dixon, GP from Devon and Chair of NHS Alliance



2 Our vision

2.1 The provision of healthcare is constantly evolving. This document sets out a vision for how services will continue to grow and develop over the next ten years. It is a vision of a continuously improving service, where essential standards are guaranteed and excellence is rewarded.

2.2 The services provided by family doctors and other primary and community clinicians must be shaped by and around individuals, listening and responding to their needs. Patients should be able to expect to access services at times that are convenient for them, make appointments easily and be seen by helpful and courteous staff who listen to their needs. They should always feel that the system is connected and working for them. They should have access to a growing range of health services in GP surgeries, in a range of other community settings and in their own homes. They should have the ability to make more choices, including the ability to choose their GP practice. The public should have the support they need to take greater control over how they manage their care, particularly for those with long-term conditions.

2.3 Primary and community care services should play a central role in helping people live healthy lives. We can do far more to embed health promotion in the millions of daily contacts with family doctors, community nurses, pharmacists and other community-based staff. We can do more to promote health at all stages of life and more systematically identify and support those individuals most at risk of ill-health. There should be increasing access to services that help people maintain and improve their health and wellbeing. Primary and community clinicians should play a lead role in promoting equality of opportunity and equality of health outcomes.

“Many of the basic building blocks for a truly patient-centred NHS are now in place. But its future success depends on the way doctors, nurses and other clinical staff recognise and support patients’ role in improving their own health and managing their own treatment. Health professionals will need to become partners with patients and true champions of patient empowerment.”

Angela Coulter, Chief Executive of Picker Institute Europe and member of primary and community care Advisory Board



3 Progress so far and the challenges ahead

- 3.1 Primary and community care in this country are regarded with pride at home and admired around the world. This chapter describes why this is so – the strengths of our current system and the achievements of GPs, community health staff, pharmacists and other health professionals over the last ten years.
- 3.2 Around the country, we can celebrate countless examples of excellent, high-quality services and innovative practice, saving and transforming lives, delivered with compassion and respect by dedicated staff every day.
- 3.3 There is, however, clear evidence that the quality of some services falls a long way short of the best. We could also achieve much more by making services fit together better. High-quality care and health improvement demand a stronger partnership approach between family doctors and community health services, between primary care and hospital services, and more widely between the NHS, local government, the third sector and the independent sector.
- 3.4 Primary and community care must also evolve to meet changing circumstances. Public expectations are increasing, advances in treatment are allowing more care to be provided in local communities, people are living longer and we are facing greater public health challenges from obesity and other 'lifestyle diseases'.

Highly valued services with strong ties to local communities

- 3.5 The hundreds of thousands of staff working in our primary and community services provide care, advice and support for millions of people every day. They support people in managing long-term conditions like diabetes and coronary heart disease. They treat a wide range of conditions, from chest infections or back pain to depression or tooth decay. They diagnose and make referrals for conditions that need specialist treatment. They play a key role in preventing ill-health, for instance by providing immunisations, screening, counselling or stop smoking advice. They work closely with social care staff to help people live independent lives at home.



- 3.6 People greatly value these services and the staff who provide them. GPs have the highest trust rating of any profession and there are strong bonds of trust with

other primary care staff. In responses to recent surveys, 97% of patients were satisfied with their last visit to their general practice³ and 93% of people with their last visit to a community pharmacist⁴.

- 3.7 The strengths of our system of primary care are recognised beyond England as well. NHS primary care was ranked top overall in a Commonwealth Fund survey of six OECD countries in 2006⁵.
- 3.8 Almost everyone, 99% of the population, is registered with a family doctor. This system of registration forms the bedrock of our primary care system. GPs still often care for generations of the same family and are well placed to consider health needs in a family context. They and their patients greatly value the trust and personal continuity of care that come from this relationship. The system of registration enables GPs to play a wider role in supporting the health of local populations, for instance through immunisation and screening programmes.
- 3.9 This dual focus on personal healthcare and community health also lies at the heart of the community services which employ some 250,000 NHS staff (a fifth of the total NHS workforce). Community nursing teams help provide a network of care to support people in their own homes. Health visiting and school health services work with children, families and young people

in a range of settings to promote better health. Allied health professionals have a key role at the interface of health and local authority services to help people manage long-term conditions and optimise their independence.

- 3.10 We have an extensive network of pharmacies that offer convenient access to medicines and to a wide range of other health services close to people's homes as set out in our recent Pharmacy White Paper⁶. Our ambulance service is providing and co-ordinating an increasing range of mobile healthcare services for patients who need urgent care, diagnostic services and health promotion⁷.
- 3.11 The broad range of skills in primary care – from the unique generalist medical skills of family doctors to those of allied health professionals working in community settings – means that most people can be treated quickly, effectively and in a convenient location close to (or even in) their homes.

A decade of improvement

- 3.12 Over the last ten years, there have been clear improvements in the care of people with long-term conditions⁸, supported in part by the new Quality and Outcomes Framework for general practice. This ground-breaking system, introduced as part of the new GP contract in 2003/04,

³ Healthcare Commission & Picker Institute, 2007

⁴ You Gov survey, 2007

⁵ Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care, The Commonwealth Fund, May 2007

⁶ Pharmacy in England: Building on strengths – delivering the future (Cm 7341), April 2008

⁷ Taking Healthcare to the Patient: Transforming NHS Ambulance Services, Department of Health, June 2005

⁸ Campbell et al, NEJM 2007: 357:2

supports GPs and practice nurses in systematically tracking and improving quality of care for patients with conditions such as asthma, diabetes and coronary heart disease.

- 3.13 The Quality and Outcomes Framework has improved the way that GP practices record factors such as high blood pressure or smoking status that affect someone's individual risk of developing illnesses. This is focusing more attention on how to help people maintain healthy lifestyles.
- 3.14 The 2003 contract for GPs also successfully tackled long-standing concerns about poor pay and long and stressful hours. There are now over 33,300 GPs working in England, an increase of over 5,300 since 1997, and almost 4,500 more practice nurses.
- 3.15 This growth in the GP practice workforce has made possible a range of improvements in access to primary care and in the quality of services. The great majority of patients can now see a GP within two working days, compared to under 50% in 1998. The average length of a GP consultation has gone up from 8 minutes to 12 minutes⁹. GPs and practice nurses are providing an increasing range of services including blood tests and minor surgery.
- 3.16 In the interim report for the NHS Next Stage Review, we announced further commitments to improve access to primary

care. We have since agreed changes to the GP contract to reward practices that extend their opening hours to provide weekend or evening appointments. We have committed new investment of £250 million to allow the local NHS to establish over 100 new GP practices in the areas that most need them; and over 150 GP-led health centres providing additional access to GP services from 8am-8pm, 7 days a week, which any member of the public can use and still remain registered with their own GP. The local NHS will involve the public, local authorities and other key partners in developing these new services.

- 3.17 Recent years have seen a number of exciting developments in community health services. We are investing £230 million in 28 community hospital schemes delivering more diagnostics, day care, rehabilitation and walk-in services in community settings. The Family Nurse Partnership Programme is proving popular and successful in empowering young first-time parents on low incomes who can face multiple difficulties in providing the best start in life for their children. Pilots for self-referral to physiotherapy services have shown high levels of patient satisfaction and a positive impact in helping people stay at work. Last year, we announced £170 million investment by 2010/11 in a major programme to improve access to psychological therapies for people with common mental health problems.

⁹ Personal Social Services Research Unit at University of Kent, "Unit Costs of Health and Social Care" (9A-9C on GPs)



3.18 Pharmacies are playing an increasingly wider role as healthy living centres and in providing minor ailments services and diagnostic tests. Reforms to dental services in 2006, combined with a 16% per cent increase in funding since 2005/06, have enabled PCTs to expand dental services and match them to local needs. In places such as Tower Hamlets, the NHS is now providing outreach services to make dentistry accessible to socially excluded groups. High-street opticians, who already provide over 10 million NHS sight tests each year, have begun to play a wider role in managing eye care and promoting eye health, for instance by helping to manage the care of people with glaucoma.

3.19 There has been real progress too in bringing together health and local government to tackle wider determinants of ill-health. The NHS and local authorities now have a legal duty to work together to tackle issues of local concern and set

stretching targets for improvements.

There are increasing examples of pooling budgets and setting up integrated services, for instance to improve rehabilitation for older people leaving hospital. The development of children's trusts has helped promote stronger joint working across sectors to promote children's wellbeing.

Raising our ambitions to meet the challenges ahead

3.20 It is essential that we do not allow services to stand still. One of the key challenges often raised by the public is that, however good the individual services are, they do not fit together as well as they could. People with urgent care needs or with more complex needs, in particular, find it confusing to navigate their way around different services. They find that they need to repeat information to doctors, nurses, social workers, call handlers and other staff. People with mental health problems often report a lack of attention to their physical health needs.

3.21 People want more control over their health and care. According to one study, 32% of people with long-term conditions do not feel sufficiently involved in decisions about their own care¹⁰. A lack of information and control can have a significant impact on people's health and self-confidence. An Asthma UK survey of people admitted to hospital in an emergency after an

¹⁰ Healthcare Commission Survey, 2006

asthma attack showed one in eight did not know what to do during an attack, and a quarter received no follow-up information or advice.

3.22 Despite the achievements of recent years, there are still varying levels of satisfaction with access to GP services, for instance the ability to make advance bookings. Last year's GP patient survey showed a fifth of practices with satisfaction rates of under 75% for key indicators of access¹¹. A recent review¹² identified a number of key areas where poorer performing practices could make rapid improvements in patient satisfaction. Although most people greatly value the continuity of care provided by their GP practice, there are those (particularly younger people and those in full-time work) who would like a more flexible range of options for accessing primary care.

3.23 The dental reforms introduced in 2006 provide a much stronger platform for developing services. Yet access to dentistry remains a particular concern in some areas and services need to continue to adapt to changing oral health needs.

3.24 Most importantly, while the quality of care provided by GPs, nurses and other primary care staff is very high overall, this is not true for all services everywhere. There are unwarranted variations between GP practices in the quality of care for

people with long-term conditions. Rates of emergency hospital admissions for conditions that can be avoided (by effective primary and community care) vary more than twofold across the country¹³. In our community health services, we do not know enough about potential variations in quality because we collect so little comparable information about services and health outcomes.

3.25 It is also clear that demand for primary and community care services will grow over the next ten years and that the nature of this demand is going to change:

- > people increasingly expect public services to do more to treat them as whole individuals rather than for isolated symptoms, listen to their needs, and tailor services to meet those needs
- > continuing advances in technology and medical treatments will allow more and more people to receive care in community-based settings (rather than travelling to hospital) or in their own homes. For instance, new technologies will allow people to take physical measurements such as blood sugar and blood oxygen at home and allow these to be monitored remotely by a community matron who can then take swift action if there is cause for concern

¹¹ GP Patient Survey, 2007

¹² Report of the National Improvement Team for Primary Care Access and Responsiveness, Department of Health, February 2008

¹³ Hospital Episode Statistics, 2006-07

- > an ageing society, with the number of people over 85 set to double by 2029, will lead to increased demand for primary and community care
- > growing rates of obesity, among children and working-age adults, threaten epidemics of heart disease and diabetes so we must shift the balance of NHS investment towards prevention.

3.26 These challenges will be greater in more deprived areas and among more disadvantaged members of society. As set out in our recent progress report on health inequalities¹⁴, some have benefited more than others from the vast improvements in health seen over the last century. Conditions such as heart disease and diabetes are all more common amongst poorer people living in deprived areas¹⁵.

3.27 The strengths of our current system of primary and community care – its emphasis on personal continuity of care, its strong links with local communities, and the high degree of trust between patients and primary care practitioners – provide the right starting point for rising to meet these challenges.

“What people want are joined up services that focus on them as an individual living in their community. A partnership approach is essential to achieving this, bringing together locally all the services provided by the NHS, local government, the voluntary and independent sectors.”
Anne Williams, Strategic Director of Community, Health and Social Care, Salford City Council and member of primary and community care Advisory Board.

¹⁴ Health Inequalities: Progress and Next Steps, Department of Health, June 2008

¹⁵ General Household Survey, 2005



4 People shaping services

This chapter sets out how we will:

- > **promote responsive primary and community care services that systematically listen to and act on the views of patients**
- > **support local decisions on how to develop services that fit together and make sense for patients, including integrated urgent care services available around the clock**
- > **enable the public to have a greater and more informed choice of which GP practice they register with**
- > **promote wider choice across primary and community care**
- > **help people take control of their health though offering care plans for all people with long-term conditions and developing a Patients' Prospectus to support self-care**
- > **pilot individual health budgets.**

Listening and responding to patients and local communities

4.1 We live in an information age. Companies succeed when they seek out ever more sophisticated ways of understanding their customers, listening and responding to their views. GP practices and other primary and community care teams should do the same. Our vision for more responsive primary and community care begins with these teams systematically listening to patients and local communities and developing services accordingly.

4.2 The national GP patient survey last year gave five million people a chance to have their say on access to their GP practice – and gave everyone the opportunity to compare how their local GP practice scores on indicators of patient satisfaction with any other practice in the country. From 2009, the survey will ask a much broader range of questions about the quality of services.

4.3 This will make it easier to see how far GP practices are getting the basics right – whether, for instance, patients find it simple to make an appointment, whether they have the option of telephone consultations, whether they can expect to be seen by helpful and courteous staff, and whether the GP or practice nurse listens to and understands their problems. This in turn will help recognise and reward those practices that respond best to patients' views.

4.4 Our aim is also to stimulate more rapid spread of innovation and good practice. There are, for instance, an increasing number of GP practices that now give patients the option of booking appointments online, an approach that we would like to see extended to all. The public should also not expect to have to pay more than the cost of a local call when telephoning their practice.

“We need to find ways to provide seldom heard groups with the services they need – not what we think they need.”

Nurse participant, Primary and Community Care Conference, London, 2008

- 4.5 This systematic approach to collecting and acting on patient views needs to be reflected throughout primary and community care services. It also needs to become more sensitive to the needs of those who find it most difficult to use – or who feel excluded from – current services. This could be patients who do not have English as their first language, people with learning disabilities or people with a severe mental health problem.
- 4.6 This requires new and innovative models of engagement, based not only on patient surveys, but on local involvement networks, advocacy groups, focus groups, patient panels, citizens’ juries, public meetings, other deliberative engagement processes and a range of new online and technology based feedback mechanisms including NHS Choices.
- 4.7 It means ensuring too that patients know how to make a complaint if they are unhappy with their treatment or experience, are encouraged to use the complaints process and receive an appropriate and timely response. It is unacceptable if people are made to feel nervous about complaining. Under our proposals for the new regulation system (see para 6.20),

effective complaints handling will be a requirement of ongoing registration with the Care Quality Commission.

Services that fit together and make sense

- 4.8 People should always feel that the system is connected and working for them – that they are treated not just for their individual symptoms or care needs but as a whole person. They should have the confidence of knowing that the system will provide a joined-up response if, for example, they need urgent care and are not sure where to get it, or if they have complex conditions that require help from both their family doctor and community health and social care teams.
- 4.9 As described in the 2006 White Paper, *Our Health, Our Care, Our Say*, we want to see more services available to people in their local communities or in their own homes to avoid unnecessary trips to hospitals (e.g. for outpatient appointments or diagnostic tests) and to make services more personal and effective.



4.10 Family doctors can play a key role in helping ensure that their registered patients have access to both a wider and a more integrated range of community-based services. This includes diagnostic tests and procedures, specialist clinics for help in managing long-term conditions (e.g. diabetes), psychological therapies, social care and healthy living services. This should extend to wider services that support health and wellbeing, including employment and housing services.

4.11 Some of these wider services may be provided within GP surgeries or health centres, but an integrated approach does not necessarily mean providing care in single buildings or single organisations. The NHS needs to reach out and make services available in other settings, such as schools, workplaces and people's own homes. Integrated care means GPs, community nurses, pharmacists, social care teams, ambulance services, schools and others coming together on a collaborative basis with clear leadership, shared goals and shared information – and designing services around the needs of individuals and local communities.

Integrated care services in Leicester

“Before, if we wanted to see a doctor, we had to travel half way across the city and I know that some people had not seen a doctor for years until the new centre opened.”
Braunstone resident

For many people in Braunstone, a suburb of Leicester, the journey to their nearest GP was long and difficult. Some people avoided going to see their doctor altogether.

The *Leicester Housing Association* worked in partnership with *Leicester City Council* and *Leicester PCT* to develop the Braunstone Health and Social Care Centre. Local GPs at the centre work closely with nursing staff, physiotherapists and social workers, to join up services for patients, making the system simpler with expanded services. Patients with a range of care needs can now be treated in the same place by the same team, rather than by separate teams in different locations across Leicester. Patients can, for instance, visit their GP and then collect medicines at the on-site pharmacy. In the future, patients using the centre will have access to additional health and voluntary sector services.

4.12 Access to urgent and out-of-hours services will need to exemplify this more integrated approach. The NHS provides a range of individually successful services for people who need urgent care. Yet many people still find it difficult to understand what services are available and when. They also find that care can be fragmented and information has to be repeated to different staff.



4.13 Every member of the public should be able to expect integrated local services that provide access to urgent care, 24 hours a day and 365 days a year. PCTs should ensure that local communities know what services are available, where and when. This will require innovative local approaches, which look both at patient needs and how patients are using services, and which draw together the work of GPs, out-of-hours services, pharmacies, walk-in centres, emergency dental services, rapid response teams, ambulance services, A&E departments and NHS Direct. We will introduce a new measure of patient satisfaction with urgent and out-of-hours

services, so that we can consistently measure progress around the country.

4.14 The interim report said we would explore options to introduce a new 3-digit telephone number to help people find the right local service to meet their urgent, unplanned care needs. We have started a process in conjunction with the NHS to look at the various options – including the costs and benefits – and will report our findings in the autumn.

The ability to choose your GP practice

4.15 Over the last five years, the ability to choose hospital services has given more control to patients and given hospitals stronger incentives to develop services that people like and want to use.

4.16 We will now put a stronger focus on extending patient choice in primary and community care. People can already choose which GP practice to register with. However, there are still obstacles in some areas with choices restricted by closed patient lists, or practices saying they are 'open but full', and by narrow practice boundaries. We will support the local NHS, working with local GPs, to give the public a greater and more informed choice of GP practice.

4.17 We will continue to develop the NHS Choices website to include more comparative information about the range of services offered by GP practices, their opening times, the views of local

patients, and their performance against quality indicators. We will also develop the website so that it offers a simpler way of registering electronically with a GP practice. These resources should be mirrored at local level, for instance through local NHS information packs for people who have just moved house that help them choose their new GP.

- 4.18 Improving the ability to choose a GP practice will mean developing fairer rewards for practices that provide responsive, high-quality services and attract more patients. At present, most GP practices receive historic income guarantees that do not necessarily bear any relation to the size or needs of the patient population they now serve. Practices with the highest levels of guaranteed income receive over £100 basic funding per weighted patient per year, while practices with no income protection receive around £55. We will work with GP representatives to channel more resources into fair payments based on the needs of the local population served by each practice. This will help the local NHS work with local GPs to open up closed lists, help expand practice boundaries, e.g. by paying allowances to expanding practices, and allow patients greater choice of existing and new practices.

Extending choice across primary and community care

- 4.19 It is central to our vision that we preserve the system of registration with general practice and use it as the basis for developing more personal, community-based services with a stronger focus on prevention. However, alongside the personal continuity of care that comes from GP registration, we know that people with busy lives (parents juggling childcare responsibilities, manual workers who struggle to get time off work) also want to have flexible access to a range of primary care services.
- 4.20 This is why we invested part of our £250 million access fund to enable the NHS to develop over 150 GP-led health centres that offer walk-in services and bookable appointments from 8am-8pm each day of the week. These services will be available to any member of the public, in addition to the service they receive from their local GP practice. This will provide convenient access to routine GP services for those who are away from home or who would like access to services when their own practice is not open.

"I think it is important to have a 'base' practice where I go most often, with the opportunity to go elsewhere if I need to."

Patient, NHS Next Stage Review deliberative event

- 4.21 Patient choice should extend to a wide range of community-based services. Our recent White Paper on pharmacy describes the growing role of community pharmacies in offering treatment for minor ailments, health promotion services (such as support to stop smoking) and advice on taking medicines, especially those newly prescribed for a long-term condition. In Chapter 6, we describe a major new programme for transforming community health services, which will increasingly allow community nursing teams, allied health professionals and others to provide a range of other choices for the local public. This will range from self-referral to musculoskeletal services for people with back pain to specialist services for homeless people.
- 4.22 The range of services available in each local community will be described every year in each PCT's guide to local services. Everybody will be able to see what services are available in their area, how they can access them, what the future plans are for local services and how people can get involved.

Helping people take control of their health

- 4.23 The majority of people have positive experiences of primary and community care. We need to build on this and raise our ambitions for what primary and community care can achieve so they can focus on treating people as individuals and give them greater choice and control over their health and care.



- 4.24 Care planning helps ensure that people with more complex and long-term care needs receive the best, most appropriately tailored package of care to meet their individual requirements and wishes. This involves individuals working with carers and with professionals such as GPs, nurses and social care teams to agree what their goals are, which services they choose to receive and how and where they want to access them.
- 4.25 We are committed to ensuring that by 2010 all people (of all ages) with a long-term condition, including people with mental health problems, are offered their own personalised care plan. Over the next year, we will be supporting the NHS and social care services in delivering this commitment.
- 4.26 Care plans will be signed off by individuals and their lead professionals to provide a record of what has been agreed. This will help people take greater control of their care, on a more equal partnership with the health and social care teams who support this care. Care plans will ensure that

services and advice for people with long-term conditions reflect the whole person including wider social and psychological needs. The roll out of care planning is central to providing greater choice for patients with long-term conditions, helping them to choose the treatments, settings and providers that best meet their needs and match their lifestyles and aspirations.

4.27 For people with more complex care needs, the care plan will identify the professional (e.g. a community matron or case manager) who will take the lead in advising how best to access the different services agreed in the care plan. For people with a serious mental illness, the 'care programme approach' links seamlessly with this approach¹⁶. PCTs and local authorities are responsible for ensuring this coordinated approach and for offering a choice of treatment setting and provider.

More involved in care

"I feel more involved in the treatment of my diabetes and that's helping me manage my condition better." Gurdip Rahman, diabetes patient

Gurdip is 74 and has had type 2 diabetes for eight years. He has just experienced a new approach to his diabetes annual review, which has made him feel more confident and in control of his condition. Gurdip had his usual blood tests, blood pressure check and weight and foot screening checks with the healthcare assistant at his GP practice. But instead of waiting for the results, the healthcare assistant explained they would be posted to Gurdip in advance of his follow up appointment so he could read them in preparation for his annual review.

Gurdip felt better prepared for his appointment with the practice nurse and was able to contribute to the discussion. He also found it a relief to know the results in advance, as he was usually quite nervous to find out what they were. The practice nurse talked to him about his personal goals for his diabetes care and helped him create an action plan for achieving them. At the end of the appointment he was surprised it had still taken just the usual 25 minutes as it felt like he had covered much more than usual.

¹⁶ Refocusing the Care Programme Approach, Department of Health, March 2008

4.28 Later this year, we will publish a national Patients' Prospectus, initially on the NHS Choices website, to help people understand the support that is available for those who want to take greater control of how they manage a long-term condition. The prospectus will set out the choices that should be available for self care and how people can make sure they are given the opportunity to make these choices locally. It will, for example, include details of local support networks, courses to develop skills and knowledge on particular conditions (such as diabetes or asthma) and the technologies that are available to help people monitor conditions in their own homes.

4.29 We will also create a secure web-based system on NHS Choices called '*HealthSpace*'. This will allow people to access their personal health record, and update it frequently with information about their condition. It will facilitate communication between the individual and their care team, as well as allowing people to book appointments and request repeat prescriptions.

Piloting individual budgets

4.30 Experience with direct payments and individual budgets in social care has shown the benefits of giving people greater say over how public resources are used to provide their individual care. Evidence shows this can give people a stronger sense of control over their lives and a better experience. We want to test if, as part of the care planning process, we could achieve the same benefits for people with complex but predictable health needs. We will therefore work with patient groups to pilot approaches that allow people with long-term conditions greater control over how NHS funds are used.



5 Promoting healthy lives

This chapter describes how we will:

- > **promote greater partnership across primary and community health services and with local government and other sectors to promote health and wellbeing**
- > **help people stay healthy at all stages of their life, including implementing the vascular risk assessment programme and piloting integrated services for people who need support to stay at work**
- > **provide access to an increasing range of healthy living services**
- > **ensure targeted action to improve the health of people and communities whose health is not improving as quickly as that of the better off**
- > **develop the Quality and Outcomes Framework to include a stronger focus on maintaining good health as well as good care.**

5.1 Our aim is to develop an NHS that focuses on prevention as well as cure. That means an NHS that helps people to stay healthy or become healthier and fitter, so they can lead as full a life as possible and wherever possible get back control of their lives after ill-health. Primary and community care services have a central role to play in promoting healthy lives, building on the millions of daily personal contacts that they have with patients and their ties with local communities.

Working together to promote healthier lives

- 5.2 Improving health and reducing health inequalities will only be achieved by primary and community health services working with other organisations. Our health and lifestyle choices are influenced by a wide range of factors rooted in local communities, including how we develop in school, the quality of social care when we need it, access to leisure facilities and the quality of our environment including housing, transport, planning and amenities. Primary and community health services will need to work ever more closely with local authorities and develop innovative partnerships with third sector and independent sector organisations to forge common goals for improving the health and wellbeing of local communities.
- 5.3 Chapter 7 of this document describes how we will give greater freedom to front-line GPs, community nurses and wider primary care teams to invest in the 'upstream' interventions that will help keep people healthier for longer. It also describes how we will further embed joint working across health and local government to agree shared plans and shared priorities and, where appropriate, to pool budgets.
- 5.3 To support this joint focus on promoting healthy lives, we will help develop a fuller suite of health and well being indicators that can be used down to the level of individual wards and practice-based commissioning clusters.

Promoting health for all stages of life

5.5 Healthy living starts from a healthy pregnancy and from excellent antenatal and early years support, where services can have a formative impact on children's future health. Midwives, health visitors, family doctors and the wider primary care team already play a key role in promoting health from these earliest stages of life. Our NHS health visiting service will be at the forefront of working with families to improve children's health, beginning in pregnancy and in the first years of life. Health visitors have a pivotal role in leading the new Child Health Promotion Programme for their local population and delivering preventive services to the most vulnerable children and families.



5.6 England already has the best levels of children's oral health in Europe. We need to build on this and do more to improve the oral health of children in more deprived communities. NHS South Central has recently announced that it will

consult the public on fluoridating water in and around Southampton, and similar proposals are being developed in other parts of the country. This will be the single biggest factor in reducing inequalities in oral health. On top of this, we now have an evidence-based framework for prevention in primary dental care – the first of its kind in the world – which will help dental practices support healthy teeth throughout childhood and beyond.

5.7 Adolescence is a critical development stage for health behaviours, yet we know that teenagers often feel that primary care services could listen more effectively to understand their needs and concerns. We have recently commissioned the Royal College of Paediatricians and Child Health to develop training for all doctors and nurses in understanding how to adapt services to be more teen-friendly. The best primary care services will increasingly work with schools and other community partners to promote the health and wellbeing of young people. Last year, we and the Department for Children, Schools and Families announced a review of child and adolescent mental health services to identify how they could play a more effective role in promoting the emotional wellbeing and mental health of children, young people and their families.

5.8 Community contraceptive services play an essential role in reducing unintended pregnancy, preventing teenage conceptions and improving sexual health. Open access and extended opening

hours make them accessible to those who might otherwise feel excluded. General practice remains the majority provider of contraception, but there is a growing role for community teams in providing training, overseeing clinical governance and reviewing care pathways.

- 5.9 Dame Carol Black's recent review of the health of the working age population underlined the benefits of work and employment for our overall health and wellbeing. Her report¹⁷ described the

important role of employers investing in workplace initiatives to promote health and wellbeing and the considerable evidence that this produces economic benefits across all sectors and sizes of business. It also highlighted how the NHS can reduce risks to long-term health if it offers sufficiently early interventions for people who have to stop working because of back pain, depression or other health problems. Primary care has a key role in helping people get the help and support they need to return to work. From next

Access to health for young people in Oldham

"Our teams have built up trust with young people who then refer their friends: it makes care more accessible for them."

Janette Butterworth – advanced practitioner, Positive Steps Oldham

Young people often avoid going to local health services, as they feel they may be lectured to or not offered the support they need. However, teams from social services departments have regular contact with young people and so are in a good position to help identify potential health and social problems. In Oldham there was an opportunity to use the local networks already working with young people to prevent the most vulnerable from falling between the gaps.

The Positive Steps Oldham Centre brings together health professionals, the Young Offender Service, the Connexions careers advice service and a drugs and alcohol support team under one roof. All the teams work collaboratively on individual cases and referrals between different teams are simpler and quicker. Health and emotional problems can be spotted more easily and support offered early. The centre offers health screening, sexual health services, health education, chronic disease management and referral to other services where necessary.

Offering support in a sensitive way is always at the forefront of the service. Young people are more likely to access different services in one centre because it is easier and less obvious to peers which team they are visiting, removing any perceived stigma.

¹⁷ Working for a healthier tomorrow, Dame Carol Black's Review of the health of the working age population, TSO, March 2008

year, we will pilot services that provide integrated access to musculoskeletal services, psychological therapies and other work-related health support.

- 5.10 Vascular diseases, which cause coronary heart disease, stroke, diabetes and kidney disease, affect four million people and are responsible for 36% of total deaths. Many risk factors for vascular disease are related to lifestyle, such as smoking, physical inactivity and high blood pressure. Changing these can greatly reduce the probability that vascular disease will

strike early, bringing premature death or disability. We are developing a national programme of vascular risk assessment for people aged between 40 and 74. We will work with GPs, pharmacies and other services to agree how best to deliver these checks in a range of community settings. Primary and community care services will also need to work collaboratively to provide access to individually tailored programmes that help people manage the risks identified through the checks, from lifestyle advice to preventive treatment with statins.

Health screening in Birmingham

"I didn't realise my blood pressure was high and didn't think I was someone at risk of heart trouble. I'm keeping things in check and I feel much healthier now I've made changes to my lifestyle."

Patient who received screening

In some of the most disadvantaged communities in Birmingham, it had been found that men over 40 had a significantly lower life expectancy than average.

The *Birmingham Health and Wellbeing Partnership* working with *Lloydspharmacy* has started a cardiovascular screening programme for men over 40 in eleven of the city's most deprived areas. Men identified as at risk are invited to attend a screening centre. The partnership wanted to make sure that as many patients as possible were screened and made these services available at local football grounds, community centres and other health clinics. They're also open during the evenings and at weekends.

The pharmacist or health care professional discusses the results with the patient. All patients are given appropriate lifestyle advice, including information on a healthy diet, exercise, sensible drinking and giving up smoking. Where appropriate patients are referred to specialist programmes, such as the Stop Smoking Service, or to see their GP.

Over 36,000 people have been identified as at risk and 10,000 have so far been screened. Of these, 65% have been referred and 36% were identified as having a high risk of heart disease. More than three-quarters of those screened plan to change their diet and do more exercise.



5.11 Primary and community care services also need to play a central role in helping older people stay healthy and independent. We recently announced a wide-ranging set of prevention services to improve health and quality of life for older people. This builds on a range of existing services for older people, such as the flu vaccinations provided by GP practices and NHS sight tests provided by high street optometrists. We are exploring how to extend other preventive services, beginning with a new focus on and a review of foot care services.

5.12 The landmark protocol 'Putting People First' describes a shared vision and commitment across Government departments, local government, the NHS and social care to transforming adult social care.¹⁸ This emphasises the shared responsibility of health, social care and wider community services in helping

people live independently, stay healthy and participate as active and equal citizens, irrespective of illness or disability.

Improved access to wellbeing services

5.13 It is important that people can easily access extra support for healthy living when they need it, whether it is to help give up smoking, control their use of alcohol, or improve diet or exercise. Pharmacies, community health clinics, third sector organisations and others are providing an increasing range of these services. We will explore how to make more services available on an 'open access' basis and ensure that the public can easily find out how to access them. The NHS Choices website will develop into a single, multi-channel access point where people can get information about health and wellbeing services.

5.14 GP practices and other members of the primary care team also have an important role to play in taking a holistic view of people's health needs, including mental health needs, and promoting access to the services that best meet these needs. The NHS will increasingly be able to include other services on the Choose and Book system (which currently focuses largely on hospital services) so that it is easier for GPs to refer patients to this wider set of services.

¹⁸ Putting People First: A shared vision and commitment to the transformation of Adult Social Care, HM Government, December 2007

5.15 Our recent progress report on health inequalities sets out many other ways in which local health services and communities can help people access the services that are best tailored to their individual needs. This includes using 'Health Trainers' to work with people at greater risk of poor health, helping them identify things that could improve their health and wellbeing, and helping signpost or refer them on to services that will help them.

Promoting equality

5.16 Our health inequalities strategy makes clear the pivotal role for primary and community care services in reaching out to those communities where socio-economic factors are linked to reduced life expectancy and higher prevalence of illness. The strategy also highlights the central importance of ensuring that services promote equality of opportunity

Helping people with learning disabilities

"It's difficult to get enough exercise, but the walking group gave us suggestions on how to get started and showed us how we can fit it into our daily routine. Their encouragement made all the difference. Now I feel healthier and I'm using the car less too."

Individual carer, South Birmingham

South Birmingham PCT identified obesity-related health problems like diabetes which were increasing in people with learning disabilities. The PCT also became aware that carers were having difficulty looking after their own health.

The PCT asked its nutrition and dietetic team to help. The team devised the *Get Walking Keep Walking* project run by the Ramblers' Association which is working across Birmingham to improve the fitness of the community. Together they developed a programme for people with learning disabilities and their carers, which included shorter, more manageable local routes and lots of encouragement. The team used their expertise to help participants gain confidence and introduce regular exercise into their day-to-day routines.

For people with learning disabilities, having a programme designed specifically for them has made all the difference. All the participants feel more positive, are taking regular exercise and helping to protect their future health.

and eliminate all forms of inequality or discrimination, for instance for people with disabilities and for people from black and minority ethnic groups.



5.17 There is extensive evidence that primary healthcare too often overlooks the health needs of people with learning disabilities and does not make the adjustments needed to make services easily accessible. We and other bodies like the Royal College of General Practitioners are now working with the NHS to help commission and provide better services for people with learning disabilities. This includes engaging them (and their families and carers) more fully in assessing their needs and in shaping services to meet these needs.

5.18 We are currently consulting the British Medical Association on proposals to introduce annual health checks for all people with learning disabilities who are on local authority registers. PCTs and GPs will need to build on this platform to ensure that health checks translate into individual 'health action plans' and to ensure that people with learning disabilities have access to the range of services that will help them maintain and improve their health.

5.19 We know from the first ever national GP patient survey in 2007 that people from some black and minority ethnic (BME) groups report significantly lower satisfaction with access to primary care than the population as a whole. In May 2008, we published a report commissioned from Professor Mayur Lakhani¹⁹, which analysed the reasons for these problems and made recommendations for how primary care can make services more responsive to the needs of people from BME groups. We have recently announced proposals to improve recording of data on ethnicity and first language so that GP practices are better able to assess how far they are achieving equitable uptake of services (e.g. for screening programmes) and equitable health outcomes.

¹⁹ No patient left behind: how can we ensure world class primary care for black and ethnic minority people? Report by Professor Lakhani for the Department of Health, May 2008

5.20 This rigorous approach to promoting equality needs, of course, to run through all primary and community care. It extends to a wide range of specialist primary care services, for instance for homeless people, for mental health needs, or for tackling tuberculosis or blood borne viruses. It reinforces our first central theme of services that are shaped by and around the needs of individuals.

“There has been a real challenge for primary care in addressing both mental and physical health needs. The effective implementation of this strategy should help people receive help for both, thereby reducing health inequalities and improving mental wellbeing.”

Paul Farmer, Chief Executive of MIND and member of primary and community care Advisory Board

Fair funding for primary care

5.21 To support the objectives described above, we need to develop a fairer system of funding for GP practices (as described in para 4.18), which properly reflects the relative health needs of local communities. We will also work with professional and patient groups to develop the Quality and Outcomes Framework so that it reflects our overall objectives of promoting healthy lives. We want to see stronger rewards and incentives for practices that achieve the best health outcomes for their local populations. We will work to ensure that QOF rewards better reflect the prevalence of illness amongst the populations served by different GP practices.

“A key national action which will help us deliver better services will be the move to a fairer GP funding system which recognises the high level of health need in areas of high social deprivation.”

Alwen Williams, Chief Executive of Tower Hamlets PCT and member of primary and community care Advisory Board



6 Continuously improving quality

This chapter sets out how we will:

- > put quality at the heart of improvements in community health services
- > develop the Quality and Outcomes Framework for general practice
- > help measure and publish data on quality in all its dimensions, including patient-reported outcomes, and allow patient choice to help drive continuous quality improvement
- > promote more widespread use of professional accreditation
- > assure minimum standards of care across GP and dental practices
- > support the local NHS and local clinicians in providing multi-professional training for the primary and community clinicians of the future.

6.1 Over the past decade, the NHS has made great progress in improving the quality of primary and community health services. Across our community health services, there have been great strides forward in embedding high-quality rehabilitation programmes for patients with long-term conditions. The Quality and Outcomes Framework in general practice, the first example of its kind across the world, has brought about a dramatically more systematic focus on evidence-based care for management of long-term conditions such as coronary heart disease, lung diseases and diabetes.



6.2 We need, however, to have an overarching, clinically-led strategy for quality in primary and community health services and for removing what are still unwarranted variations in quality of care.

*“There must be a unified message that poor quality will not be tolerated.”
Participant at SHA primary and community care roadshow, 2008*

Transforming community health services

6.3 The 250,000 nurses, health visitors, allied health professionals and other staff working in our community health services have a crucial role to play in providing personal care, particularly for children

and families, older people, those with complex care needs and those at the end of life. They are also central to our drive for promoting health and wellbeing and reducing health inequalities. The staff who work in these services speak with passion about the potential for using their professional skills to transform services.

- 6.4 It is a central part of our strategy for primary and community care that we support the NHS and community clinicians in transforming these services and according them an equal status to other NHS services. This requires a more rigorous approach to professional and organisational development along with a more strategic approach to commissioning.
- 6.5 We will promote a range of action to support the development of vibrant, successful provider organisations that systematically review quality and productivity to free up more time for patient care and improve health outcomes.
- 6.6 We will develop a programme of professional development to strengthen clinical skills and clinical leadership. This will be linked to continuing programmes of work to spread evidence-based best practice. With the NHS Institute, we are rolling out the 'productive community hospitals programme' and developing a 'productive community services' programme. These programmes will review the evidence base for care pathways (initially focusing on wound

care, continence services and stroke services), help free up more time for direct patient care, and improve quality and patient outcomes. We will continue to work with the professions to embed the new evidence-based child health promotion programme.

- 6.7 We will support staff in providing the highest quality care by pulling together the best clinical research evidence in accessible formats and by showcasing innovation. We will assess the key improvements in information management and technology systems that are needed to improve data sharing, speed up access to appointments, support evidence-based practice and underpin strategic commissioning.



- 6.8 We will work to support the NHS in applying the principles of the world class commissioning programme to community health services. This will begin by ensuring that commissioning is informed by joint strategic needs assessments and that services develop to meet the specific needs of local communities, particularly

more vulnerable or excluded people with complex care needs. We will develop and pilot from next year a set of metrics and currencies that commissioners and providers can use to measure quality, clinical productivity and patient experience. The ultimate aim of this work is to make the best use of professional skills and resources and free up more time for direct patient care.

- 6.9 Later this year we will publish a standard, flexible national contract, which will develop over time, to enable PCTs to hold community health services to account for quality and health improvement. We will also produce a framework to support local development of pricing for community services.

"This strategy recognises both the essential role of community services and the need to go further in developing their full potential. We have a great opportunity to enhance quality and improve the choices available to patients."

Andrew Burnell, PCT Director of Provider Services and Nursing and member of primary and community care Advisory Board

- 6.10 We will support the NHS in making local decisions on the governance and organisational models that best underpin the development of flexible, responsive community services. Some PCTs have done this by developing arms length provider

organisations that remain accountable to their Board. In other areas, the NHS is exploring other organisational options such as community foundation trusts, care trusts, social enterprises or integration with acute trusts or NHS Foundation Trusts. We will support local decision-making by drawing together and publishing advice on this range of organisational options and their implications for issues such as governance, patient choice, competition and employment, so that staff and PCTs can work together to identify the arrangements that best empower staff to improve patient care.

- 6.11 We will introduce a right for staff to request to set up social enterprises to deliver services. PCTs will be obliged to consider such requests and, if the PCT board approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years. Where PCTs and staff choose to set up social enterprises, the staff who transfer to the new organisation will continue to benefit from the NHS Pension Scheme.

- 6.12 Transformation of community health services will ultimately rely on the local leadership of community clinicians and of PCTs as service commissioners. We recognise, however, that this also requires leadership at national level. We have therefore established a national board that includes leading community nurses and allied health professionals and

staff organisations to drive the overall programme of work and ensure that we continue to engage staff in developing and implementing the vision.

Developing the Quality and Outcomes Framework

6.13 We will create a fresh strategy for developing the Quality and Outcomes Framework, which will include an independent and transparent process for developing and reviewing indicators. We will discuss with the National Institute for Health and Clinical Excellence (NICE) and with professional and patient groups how this new process should work.

6.14 We propose to discuss with the profession how to reduce the number of organisational or process indicators in the Quality and Outcomes Framework so that we can focus resources on new or enhanced indicators to promote health and greater clinical quality. We will explore how to give greater flexibility to the local NHS to work with local GP practices to select quality indicators (potentially from a national menu) that reflect local health improvement priorities. We will explore the use of patient reported outcome measures (PROMs) to enhance overall indicators of quality.

Improving quality of care in Bradford and Airedale

The system of awarding GP practices extra funding based on evidence of quality of care was introduced in 2004, resulting in higher standards across the country. Under the Quality and Outcomes Framework, all indicators and levels of payments are currently decided nationally.

Individual PCTs are now coming forward with their own targets to meet specific local health challenges. Bradford and Airedale Teaching PCT, one of the pioneers of this approach, recently developed a set of local performance indicators as part of a trial to incentivise participation in chlamydia screening and reduce the number of sexually transmitted infections. GP practices in the area are now being rewarded for their part in improving services to meet local health challenges.

Many PCTs would like the Quality and Outcomes Framework to have greater flexibility so that they can agree some local indicators with GP practices, potentially based on a national menu developed by the National Institute for Health and Clinical Excellence.

Improving information on quality

- 6.15 The Quality and Outcomes Framework is one of many valuable sources of data on quality for general practice. PCTs are increasingly working with GP practices to collect, analyse and publish a range of wider comparative data on quality, including results from the GP Patient Survey. NHS Choices will expand to include a wider range of information on GP practices.
- 6.16 We will support the NHS in spreading this approach across all primary and community care. Our programme to transform community health services will, as described above, include new ways of measuring and comparing quality. A number of PCTs are already developing 'quality scorecards' for dental services that bring together information drawn from our new dental clinical data set, from practice visits and clinical governance, and from patient feedback. Our Pharmacy White Paper also emphasises the importance of rewarding quality improvement, underpinned by the development of indicators for the quality of pharmaceutical services.
- 6.17 Comparative quality information of this kind will help primary care clinicians understand and compare different areas of performance and identify areas for improvement. Publication of data will also provide much greater transparency about the quality of local services and support the public in making more informed choices about which services to use.

- 6.18 As people exercise greater choice, this will provide a further driver for improvements in quality. High-quality services, which are responsive to patients and achieve good health outcomes, will thrive and be better able to re-invest resources into improving the range of services they provide for patients.

Accrediting high-quality primary care

- 6.19 We are committed to promoting the use of accreditation schemes to drive quality improvement. We are currently supporting the Royal College of General Practitioners to develop an accreditation scheme for GP practices, which will be rolled out nationally by 2010. This scheme will involve mixed teams (drawn from GPs, other professions and lay assessors) to undertake a rigorous assessment of the systems used by GP practices to ensure safety and quality of practice. As well as assess compliance with minimum criteria, it will pinpoint areas where practices have most scope to improve quality. This will act as a spur for continuous improvement.

Delivering essential standards

- 6.20 We have recently consulted on proposals²⁰ that the new health and social care regulator, the Care Quality Commission, should in time regulate safety and quality for all GP and dental practices. This would mean that, for the first time, any organisation providing primary medical or dental care will be subject to a consistent set of quality standards. The approach must be light-touch, risk-based and proportionate.

²⁰ The future regulation of health and adult social care in England: a consultation on the framework for the registration of health and adult social care providers, Department of Health, 25 March 2008

The Care Quality Commission will work with patients and the public, the NHS and the professions to develop this approach in practice and determine where best to deploy its regulatory focus. In doing so, the Commission will want to take account of the contribution that emerging professionally-led accreditation schemes can play, both in primary care and elsewhere in health and social care.

- 6.21 The Commission will focus on the services provided by healthcare organisations, ensuring there are adequate systems to protect safety and quality. It will work closely with the professional regulatory bodies that are responsible for ensuring that individual practitioners (such as GPs, dentists and nurses) are fit to practise.

“There needs to be a mechanism to monitor performance but without creating a whole industry.”

Nurse participant, Primary and Community Care Conference, London, 2008

Training tomorrow’s clinicians

- 6.22 The growing demand for primary and community care, the changing needs of patients with more complex and long-term conditions, and innovations in technology and care settings all have important implications for how we train the primary and community clinicians of the future. In line with the conclusions of the NHS Next Stage Review on workforce planning, education and training, we will work with

the NHS and the professions to ensure that training programmes keep pace with demand, to promote more multi-professional training, and to help embed training and education within the everyday work of primary and community clinicians. We are also committed to reviewing the length of training for GPs.

- 6.23 Increasing demand for services will require a more flexible, balanced infrastructure to support training. We will be reviewing the historical patterns of GP training with the profession to examine how they can best meet the demands of modern general practice whilst continuing to provide excellent standards of educational supervision in general practices. We will explore ways of supporting the development of advanced training practices that are accredited to provide integrated training for a range of primary and community healthcare staff.





7 Leading local change

This chapter sets out how we will:

- > **ensure local decisions on how best to develop a greater and more integrated range of community-based services**
- > **develop practice based commissioning to provide greater support and opportunities for multi-professional groups of clinicians to shape services**
- > **pilot ways of commissioning and providing more integrated care across boundaries, including integrated care organisations**
- > **develop the role of the local NHS as world class commissioners of primary and community care, working in partnership with local authorities**
- > **continue to support a more integrated approach to health and social care.**

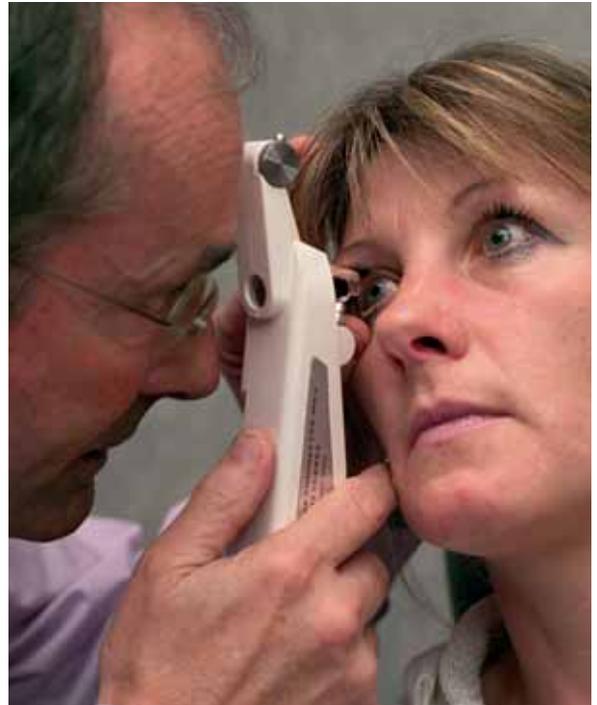
7.1 Our commitment is to create an environment that allows local clinicians and local communities to shape primary and community care – and to enhance the role of primary care trusts as strategic commissioners of health and healthcare for their local populations.

7.2 Greater clinical freedom and stronger commissioning are two sides of the same coin. The best commissioners will be those who create precisely that environment in which clinical leadership and innovation

flourish, in which health professionals can work more collaboratively across traditional boundaries to provide more integrated care, and in which patients and the public are empowered to make their own choices about their health and healthcare.

Locally designed services

7.3 It is clear from the regional visions for health and healthcare developed as part of the NHS Next Stage Review that there is a shared ambition for developing a greater range of services in GP practices, in other community-based settings and in people's own homes.



- 7.4 The potential to use community settings for some services traditionally provided in hospitals – and in a way that really shifts the emphasis to supporting health and wellbeing rather than simply curing disease – is set to grow faster in the coming years as a result of demographic, economic and technological changes. The good primary and community care services of the future will not simply be more efficient and responsive versions of what we have now. They will have seized the opportunity to provide a much wider and more integrated range of services.
- 7.5 We do not wish to create a national blueprint for how this is done. In some cases, as now, clinicians may decide to bring services together in single locations in order to support integration and provide a 'one-stop' point of access. In other cases, clinicians may choose to develop networks of services with strong ties to local GP practices (as described in the Royal College of General Practitioners' 'federated' model²¹). There are already numerous local examples of clinicians bringing services together in these different ways.
- 7.6 To support more integrated care, we will review the scope of access to NHS Care Records Service to embrace a fuller range of organisations that provide care to NHS patients, including social care, voluntary and private sector organisations and pharmacy, dental and optical services. Our aim is for health professionals to be able to provide the best care and advice to patients quickly by accessing the information they need (e.g. on medical history or medication) from any setting.
- 7.7 We are creating a substantial new fund to identify, grow and diffuse innovation across the NHS, including prizes for innovations that benefit patients and the public. This will provide widespread opportunities, including for primary and community clinicians and practice based commissioners, to help foster a pioneering health service.
- 7.8 We will also continue to showcase evidence and best practice. We will shortly be publishing a collection of resources and insights on delivering care closer to home, gleaned from academic research, service improvement initiatives and front-line services.

²¹ The Future Direction of General Practice: A Roadmap, Royal College of General Practitioners, 2007

Federated GP practices in Lambeth and Southwark

“We are able to offer more to our patients and be confident that our colleagues across each of the practices know the patient's specific requirements.”

Dr Clare Gerada, The Hurley Group, London

“Thanks so much for getting it sorted and getting me seen so quickly, it was great to get my gynae problem sorted and so close to home.”

Southwark patient

Patients with specific needs in some of London's more disadvantaged communities were finding it hard to get access to specialist GP services in their area and were being referred instead to hospitals for treatment.

In response, five GP practices across Southwark and Lambeth joined together in a new kind of partnership or “federation”. The individual practices retain their independence and patients register at a single GP practice in the usual way. However, patients across the five practices now have much easier access to a range of local services, brought about by the five practices pooling resources and expertise.

The federation provides a broad range of specialist services, including a musculoskeletal clinic and gynaecological services, which means patients don't have to go to hospital as often. By using shared services and harmonising back office functions, the federation is able to invest more in patient care. The doctors, nurses and other practice staff also receive more professional development and have more opportunities to share knowledge and experience with colleagues.

Empowering clinicians: practice based commissioning

7.9 Practice based commissioning has the potential to transform care services by putting clinicians at the heart of PCT commissioning and strategic planning and allowing groups of family doctors and community clinicians to develop better services for their local communities. However, there is a widespread view that,

with some exceptions, it has not yet lived up to its potential.

7.10 We will work with the NHS and with the professions to redefine and reinvigorate practice based commissioning. We will more firmly position practice based commissioning as providing the clinical leadership that should be at the heart of world class commissioning, ensuring a relentless focus on high-quality services

and on better health outcomes. We will provide incentives for a broader range of clinicians to engage in practice based commissioning, so that it brings family doctors together with other community clinicians and with specialists working in hospitals to develop more integrated care for patients. We will distinguish more clearly between the collaborative, multi-professional work involved in commissioning better care for GP practice populations and the role of GP practices in providing an enhanced range of services for their patients, ensuring both are supported by appropriate governance arrangements.

- 7.11 We know that strong support from PCTs is one of the characteristics of successful practice based commissioning. We will ensure that PCTs are held to account for the quality of their support, including the management support given to PBC groups and the quality and timeliness of data (e.g. on budgets, referrals and hospital activity). We will expect all PCTs to provide a management allowance for PBC groups to support innovative practice.

- 7.12 We will set out different levels of engagement with practice based commissioning, so that there is increasing earned autonomy for those groups that show they can take on increased responsibility. At one end of the spectrum, some GP practices will need more development before they are ready to engage – there should be an ‘entry level’ that recognises the quality of the primary care provided by those practices.

- 7.13 PCTs should ensure that, once engaged, GP practices have the support they need to develop vibrant, multi-professional communities of clinicians and other community partners. As these groups mature and as they demonstrate success – particularly in providing the ‘upstream’ interventions that improve health outcomes for their local communities – they should be entitled to increased freedoms in managing resources and designing services. PCTs will need to be able to hold PBC groups to account for how they fulfil these increased responsibilities.

Using practice based commissioning to facilitate open access to MRI scans in Dudley

A patient having a long-term condition review for epilepsy with his GP demonstrated a subtle change in his symptoms. The GP was part of a PBC consortium that had negotiated open access to MRI scans. A scan was performed two days later. The result revealed the presence of an early brain tumour. The GP was able to discuss the case with the neurosurgeon at a tertiary centre in Birmingham while both of them were looking at the digital image on their clinical systems, allowing proper planning between specialist and generalist. The local acute hospital stabilised the patient's condition before transferring him for neurosurgery. Following a successful operation, the GP was able to monitor the patient online and help co-ordinate the care that he needed on leaving hospital.



Piloting new models of integrated care

- 7.14 We will test and evaluate new ways in which PCTs can commission more integrated services from innovative groups of clinicians. We will invite proposals for pilots that involve clinicians working on a more collaborative basis across primary, community and secondary care – and with local authorities and other sectors – to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices).
- 7.15 These pilots will test a range of innovative approaches for transforming patient services. They will include PCTs commissioning integrated services from GP practices and community health services, with a strong focus on predicting and preventing ill-health. We will pilot how primary and community clinicians can work in a more integrated way with local hospitals to provide seamless care and high-quality health outcomes. We will specifically invite joint proposals

from primary and community clinicians and local authorities to provide integrated health and social care services. The pilots will also test ways of PCTs commissioning 'integrated care organisations' – multi-professional groups based around groups of GP practices – to manage the health care resources for their local populations and decide how best to use these resources to shape services around individuals and promote healthy lives.

- 7.16 The pilots will test and evaluate how PCTs, as commissioners, can most effectively hold 'integrated care organisations' accountable for the quality of the services they provide, the health outcomes they achieve and the experience and satisfaction of the patients they serve. They will allow PCTs and clinicians to identify the most effective governance models for integrated care and how to ensure choice for patients.

*"Integrated care pilots should provide a demonstration of what is possible when general practice, community services and specialist care are working together. This and practice based commissioning should allow us to deliver more integrated services."
Michael Dixon, Chair of NHS Alliance and member primary and community care Advisory Board*

Developing world class commissioning

7.17 PCTs are the local leaders of the NHS and are responsible for securing health and healthcare for the communities they serve. Our world class commissioning programme sets out a framework to support PCTs in developing their commissioning skills and enable them to be held accountable for delivering better health, better care and better value.

7.18 As part of the world class commissioning programme, we will work with the NHS and other stakeholders to ensure that we rapidly enhance the skills of PCTs in commissioning primary and community care. In the past, too much focus has been placed on relatively narrow activities such as managing contracts with GPs. World class commissioning means taking a much wider view.

7.19 To achieve the vision set out in this document PCTs need to be able to:

- > work with the public, local clinicians, local government and other partners to understand the needs of local communities and to agree how these needs should be reflected in the quality specifications for primary care services and the outcomes for which providers of primary and community care are held accountable
- > provide strong clinical leadership and ensure strong clinical engagement in developing primary and community care

- > promote more integrated care, by better aligning the incentives for different providers of primary and community care or – in line with the pilots described above – commissioning integrated services from a lead provider or an integrated group of providers

- > develop primary and community care contracts to ensure increasing incentives for investment in prevention and in early identification and management of risk

- > provide clear, published information for the local public about the range and quality of primary and community care services, so that people can make personal choices about how they manage their health and their care

- > apply the 'system rules' so as to promote both collaboration and fair competition between different providers and to facilitate patient choice

- > stimulate innovation and choice by developing markets in primary and community health services.

7.20 We are working with the NHS and other stakeholders to define more clearly how the world class commissioning competencies apply to primary and community care and how PCTs can be held accountable (through the world class commissioning assurance system) for their success in developing primary and community care.

7.21 Over the next year, we will enhance the range of support and development available to PCTs to transform their skills in commissioning including:

- > the use of predictive modelling and risk stratification tools to profile the needs of different segments of local communities
- > the use of innovative forms of public engagement and social marketing to involve local communities in commissioning decisions
- > developing datasets that allow commissioners to collect, analyse and publish information on performance against quality criteria, including breaking data down by categories such as age, ethnicity and disability
- > the ability to manage contracts more effectively to identify and tackle underperformance and improve the quality of services
- > the development of better estates strategies across primary and community care, using private finance or arms-length property companies where appropriate.

7.22 These world class commissioning skills apply to all areas of primary care. We are for instance already working with the NHS and with professional and patient representatives to develop a five-year vision for dental services and help PCTs use their new commissioning

responsibilities and substantially increased dental budgets to promote oral health, expand access to dentistry and ensure the highest quality of clinical care and patient experience.²²

"This strategy reinforces the role of PCTs as local leaders of the NHS. As world class commissioners, PCTs will work with local clinicians to foster innovation, reduce health inequalities and drive up standards of care in primary and community services."
David Stout, Director of the PCT Network, NHS Confederation

7.23 To achieve more integrated services and to improve health and well being, the NHS will also need to work in stronger partnership with local government and the third sector. There is already a strong framework in place to enable this. PCTs and local authorities have a statutory duty to undertake joint strategic needs assessments to ensure they have a shared understanding of local priorities. These agreed priorities are then reflected in the new generation of Local Area Agreements, which have a strong focus on joint action to improve health and wellbeing.

7.24 We will continue to strengthen arrangements for partnership working across strategic health authorities and Government Offices of the Regions, so that there is a joint approach to planning and prioritisation.

²² NHS Dental Reforms: One year on, Department of Health, August 2007

Supporting integration of health and social care

7.25 An integrated approach to health and wellbeing will require a step change in the relationship between local NHS organisations, local government, other relevant statutory services, employers, third sector and independent sector providers. We want to ensure synergy between the development of vibrant primary and community care services and the 'Putting People First' transformation programme led by local government.

7.26 We will provide support to those organisations that wish to go further in integrating health and social care services. We will establish a Minister-chaired group to work with stakeholders and identify how government can best provide this support, including reviewing policy, financial and cultural barriers to integration.

A pioneering approach to health and social care in Torbay

*"My mum's care was co-ordinated so she didn't have to spend the weekend in hospital."
Torbay resident*

Sally received a call on a Friday to say that her mother had taken a bad fall. Living far away, Sally worried that there was no-one on hand to organise her care and, as her mother's health had been deteriorating, Sally worried that she'd end up in hospital.

Her mother's GP provided initial treatment for the fall and then phoned the local Torquay North health and social care services team through a central number. Sally's mother was immediately assigned a health and social care co-ordinator called Emma who accessed her health and social care records from her GP and social services, then arranged an assessment near where she lives involving a number of health and social care professionals. Based on recommendations from this community team, Emma organised the equipment Sally's mother needed to help her stay in her own home and organised emergency welfare checks and assistance from the local Crisis Response Team to cover the weekend hours.

Emma updated the medical records so her mum's GP knew all that had taken place over the weekend when he came back into his practice on Monday morning. Emma kept Sally up-to-date to reassure her and was able to update the whole local health team face-to-face, as they have regular multi-disciplinary meetings and are all based in the same office. The team then discussed the best long-term care for Sally's mum to make sure the right package was delivered quickly and simply and was tailored to meet her individual needs. Short-term rehabilitation was deemed necessary and carried out by occupational therapists and physiotherapists who were part of the health and social care team.



8 Next steps

- 8.1 This is a vision and a strategy for how the NHS and the hundreds of thousands of staff who work in primary and community care services can work with local communities to drive continuous improvements in the quality of services.
- 8.2 As described in *High Quality Care for All*, each PCT will now be developing its own plans for improving the health of people locally, putting into practice the conclusions of the regional clinical pathway groups.
- 8.3 We will look to the NHS to ensure that these local plans reflect our shared ambitions and objectives for primary and community care, that there is clear clinical leadership for developing services in each area and that plans are developed in genuine partnership with patients and the public, NHS staff, local authorities and other partners (public sector, third sector and private sector).
- 8.4 At national level, we will rigorously follow through the commitments we have made in this report to help create the right environment for local change. We will work with the NHS and the professions both to highlight and celebrate success and to continue to remove any barriers to progress.
- 8.5 We are setting up a national clinical advisory group to help us assess progress against the objectives of this strategy and maintain momentum. We will continue to work with other national stakeholders, including patient groups and local government representatives, to maintain a shared vision, enthusiasm and commitment to improving primary and community care.



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