This chapter on the wide range of services in the community includes:

- how we will give people more choice and control over their health and care, including extensions of pilots on individual budgets and direct payments;
- expanded use of pharmacies and extended pharmacy services;
- a new urgent care strategy aimed at reducing hospital admissions;
- better access to services which can tackle health, social care, employment and financial needs, including social security benefits;
- improving community services for teenagers, expectant mothers, people with mental health problems, those who have difficulty accessing services, including older people and offenders, and end-of-life care.
Introduction

4.1 Through the Independence, Well-being and Choice consultation and Your health, your care, your say, people have told us that they want more convenient local health and social care services. In particular, they want different services more closely integrated to meet their needs, with better information provided to the people who use the services. In this chapter, we consider how we can improve the services available in the community when people are ill or need extra support.

4.2 There is, of course, a major difference between the NHS and the social care services provided or funded by local authorities. With the exception of charges for prescriptions and a few other items (which are only free for those on low incomes), NHS care is free at the point of use.

4.3 But social care – in other words, support for the normal activities of our daily lives – is something that we generally provide for ourselves and each other. Indeed, it is a strength of our society and community that we often provide this for our children, family, friends and neighbours.

4.4 Sometimes, however, the needs of individuals go beyond what friends and family can cope with. It is in these situations that we ensure that local services are available and that, through local government, public resources get to those who need the most help and who cannot afford to pay for that extra support themselves.

4.5 Social care is not a universal service. Currently about 1.7 million adults receive social care and support commissioned by local authorities, while many others organise and commission services themselves. Some people are not clear about what their eligibility for local authority-funded care may be in the future, and this could be a source of uncertainty and anxiety.

4.6 From the public’s point of view, however, there may seem to be little difference in practice between health and social care services. This extends even further into the benefits system; often a careful assessment of health and care needs provides the information needed to claim social security benefits, such as disability living allowance, attendance allowance and incapacity benefit. Advice on claiming benefits needs to go hand in hand with advice on being able to work and maximise family income. The public is often frustrated by the failure of different services to share information and to integrate services. “Why do I have to tell my story over and over again?” several people asked during the national Citizens’ Summit.

4.7 Our goal throughout is to put the public at the centre of the services they receive, and – where services come from different providers, as they often must – to integrate those services as effectively as possible.
4.8 We recognise, of course, that the different funding regimes are a barrier to integrated services. They stem from the decision made by the country in 1948 that, while health services would be paid for and organised nationally, care services would be provided and funded according to local decisions, taken by local people, through local government.

4.9 This devolution of control and power has been a great strength of local government. But without clear national standards it has also led to inequalities in access across the country and sometimes even within neighbouring communities.

4.10 It is clear that people need different kinds of support at different stages of their life. An estimated 30 per cent of adults pay for their own residential care. Other social care services are currently means-tested in most areas, and subject to contributions from those with income and assets that exceed certain thresholds – in accordance with government guidance on ‘fairer charging’.

4.11 Local authorities have varying resource levels and must set their own priorities according to local circumstances and needs. Because of this local priority-setting, local authorities may provide differing types and levels of support for different intensities of need, may apply different standards for means testing, and may charge different prices for similar kinds of support.

4.12 This can lead to differences in the services that are available and in the level of access that people may have to those services through the application of Fair Access to Care Services (FACS) criteria. However, local decision-making is also closer to local communities, meaning that local people have opportunities to influence decisions about resources, charging and priorities.

4.13 People have suggested to us that we should look at making charging regimes and eligibility for services more uniform across the country. However, any conclusion about future charging arrangements and the consequences of local decision-making has to be delivered in the context of the wider agenda of local government reform.

4.14 The funding of local services is being considered by Sir Michael Lyons, Professor of Public Policy at the University of Birmingham, as part of his independent inquiry into local government, in which he is examining the future role and function of local government before making recommendations on funding reforms. As part of its analysis, the inquiry is considering some critical issues including fairness, accountability and efficiency, as well as questions about the role of local government in making decisions on local service priorities.

4.15 Sir Michael’s final report will inform the 2007 Comprehensive Spending Review. The independent review of social care for older people currently
being undertaken for the King’s Fund by Sir Derek Wanless – author of the major report on NHS funding published in April 2002 – which is reporting in spring 2006, will also be an important contribution to this discussion.

4.16 Within current funding, however, there is much we can do to further improve health and care services. We set out our proposals below.

**Giving people more choice and control over their care services**

4.17 There is growing evidence that, where people are actively involved in choosing services and making decisions about the kind of treatment and care they get, the results are better. In addition, as we ask people to take more responsibility for making choices in their lives that will promote their health and independence, we should offer them a greater say in the services we provide.

4.18 In theory, people have always had a choice of GP. In the previous chapter, we explained how we will make that choice more real in practice. About 1.7 million adults receive support and care from services commissioned or directly provided by local authorities, and we will give more of them a greater say in the services they receive.

4.19 Following the direction set out in *Independence, Well-being and Choice*, we will move from a system where people have to take what is offered to one where people have greater control over identifying the type of support or help they want, and more choice about and influence over the services on offer.

4.20 We plan to do this by giving everyone better information and signposting services better, putting people at the centre of the assessment process, increasing the take-up of direct payments, and introducing individual budgets that will give people greater freedom to select the type of care or support they want.

**Direct payments**

4.21 Direct payments – cash in lieu of social services – were introduced in 1997. Since 2001, direct payments have also been available to carers, parents of disabled children and 16- and 17-year-olds.

**Direct payments have given people real choice and control:**

“Direct payments have completely changed my life; choice over who comes into my home equals respect and dignity.”

“I have a baby and a direct payment means I can go out when I want. I know who is coming, when they are coming and they know my routine and how I like things done.”
4.22 Direct payments are a way for people who need social services to have more control over the service they receive. People who are eligible for services (day care, personal care, respite care, equipment and adaptations) can opt to receive the money for the service from the local authority and purchase it themselves. In this way they can choose the exact service they want, when they want it and who provides it.

4.23 We want more people to enjoy these benefits. Due to the strong response to this issue in *Independence, Well-being and Choice*, we will seek to extend the availability of direct payments to those groups who are excluded under the current legislation.

4.24 Although the take-up of direct payments, for those who are currently eligible, was initially slow, there have been increases in recent years (from 9,000 adults receiving a direct payment in 2002/03 to 24,500 in 2004/05). We expect to see the take-up of direct payments grow much further and faster, as the number of people who currently benefit is only a fraction of the number who could.

4.25 We have already acted. We have changed the law so that where there was a power, there is now a duty so that councils must make a direct payment to people who can consent to have them. This means that direct payments should be discussed as a first option with everyone, at each assessment and each review.

4.26 In addition, the take-up of direct payments is now an indicator in the Commission for Social Care and Inspection’s performance assessment regime, and contributes to the overall star rating of a local authority.
4.27 Beyond this, we expect local authorities to set challenging targets for the take-up of direct payments. In order to help with this we have produced user-friendly information, *A guide to receiving direct payments from your local council*. In association with the Council for Disabled Children, we have also produced *A Parent’s Guide to Direct Payments* for parents of disabled children.

4.28 Finally, we will launch a national campaign, working with a range of external stakeholders to increase awareness and improve understanding of the benefits of direct payments.

**Individual budgets**

4.29 Although direct payments have helped to transform the lives of many people, it can sometimes be difficult for people to make full use of them because of the degree of responsibility involved in managing all aspects of a budget, for example in becoming the employer of a care assistant. For some people, direct payments in cash are likely to remain an attractive option, but for others we want to develop a system that has the advantages without the downsides.

4.30 That is why we announced the development of individual budgets in *Independence, Well-being and Choice*. Individual budgets offer a radical new approach, giving greater control to the individual, opening up the range and availability of services to match needs, and stimulating the market to respond to new demands from more powerful users of social care.

4.31 Direct payments only cover local authority social care budgets, but individual budgets will bring together separate funds from a variety of agencies including local authority social services, community equipment, Access to Work, independent living funds, disabled facilities grants and the Supporting People programme.

4.32 Individuals who are eligible for these funds will then have a single transparent sum allocated to them in their name and held on their behalf, rather like a bank account. They can choose to take this money out either in the form of a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget. This will offer the individual much more flexibility to choose services which are more tailored to their specific needs.

4.33 The Department of Health is fully committed to working with the Department for Work and Pensions and the Office of the Deputy Prime Minister to pilot individual budgets for older and disabled people. The first pilot in West Sussex began at the end of 2005, and 12 more will be underway during the first part of 2006. These pilots will run for between 18 months and two years and, if successful, will form the spearhead of a national implementation that could begin as early as 2009/10.
In addition, we will invite all local authorities to join a support network to help them implement approaches to putting people in control of the services they use. The network will share emerging findings from the pilot programme, and will try out and accelerate the implementation of best practice approaches to self-directed care.

Furthermore, we will explore the potential for including transport in some of the individual budget pilots, and for the expansion of the individual budget concept further to take on a wider range of income streams, taking into account the progress made on the pilots. We will ask the support network to report on this to the Prime Minister in the summer of 2007. More broadly, we will also ensure that we join up the developmental work on individual

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### Individual budgets – how they might operate

Mike is 24 years old, and was a sporty and active member of his community until a motorbike accident last year left him paralysed from the waist down. While in hospital he has been worrying about everything he will have to do to get his life back in order, for example the different agencies he will have to contact and the number of assessments he might have to undergo.

Now he is well into his programme of rehabilitation, however, he is keen to use his individual budget to get back to leading his everyday life. His employers have been sympathetic, and Access to Work will be able to support him back into employment. He was already living in a ground-floor flat, but that will need a ramp adaptation to help him get in and out easily. Although he has made really good progress and has regained mobility with his new wheelchair, he is always going to need some help to get up in the morning, so it looks like a personal assistant would be a good idea.

Mike knows what he is entitled to and knows he has support to get the right services. He really appreciates the support he has access to, including from another wheelchair user of his own age who can talk to him about getting back to work after their experience. This support comes from the local Centre for Independent Living, which is working with the council to help people in their area to manage their individual budgets.

Of course, getting these different streams of support was always possible under the old system but it’s so much easier now for someone like Mike to feel secure, knowing what resources are available to him, and that he has help to work out how to use them.
budgets and the continuing development of the welfare reform programme.

4.36 The individual budgets pilot programme is currently restricted to adults. However, the Department for Education and Skills, working closely with the Department of Health, is looking at the potential for further pilots, including disabled children. This scoping work is expected to be completed in the summer of 2006.

4.37 This new approach will require radical changes to the way services are organised and delivered. Giving people an individual budget will stimulate the social care market to provide the services people actually want and will help shift resources away from services that do not meet needs or expectations.

4.38 It will also provide greater opportunities for people using services to control the quality of what is on offer and for providers to develop new and more flexible service models, which meet needs in, for example, a more culturally sensitive way or in a more appropriate location for a rural population.

4.39 It has been suggested that we should extend the principle of individual budgets and direct payments to the NHS. We do not propose to do so, since we believe this would compromise the founding principle of the NHS that care should be free at the point of need. Social care operates on a different basis and has always included means testing and the principles of self and co-payment for services.

Risk management

4.40 Independence, Well-being and Choice encouraged a debate about risk management, and consulted on the right balance between protecting individuals and enabling them to make their own decisions about their lives, including assessment of the risks that such decisions might involve.

4.41 There were concerns that some of the proposals, principally those relating to direct payments and individual budgets, might expose people in some situations to unmanageable levels of risk via a potentially unregulated and under-trained workforce. Many respondents called for a national approach to risk management to address these issues for social care.

4.42 There is currently a multitude of guidelines available to health and social care professionals in multi-disciplinary settings. There is now a need for standardised procedures for identification of risk and appropriate responses among team members. **We therefore propose, working closely with other government departments and stakeholders, to develop a national approach to risk management in social care to address these issues over the coming year.**
Sister Brenda Tompkins has been part of STARS (Short-Term Re-ablement Service) since it was set up by South Somerset PCT in October 2004. This innovative at-home nursing team, run by the PCT, covers a radius of nine miles from South Petherton Hospital and provides care for seven days or more after leaving hospital, allowing people to return to their own homes and regain their independence.

“You get into people’s homes and see all sorts of things that need doing – if they need a new piece of equipment, for instance, or we may suggest they start going to a day centre. We work very closely with district nurses, social workers or even the fire safety people. The ambulance team might ring us and ask us to check on people over the weekend. We also do night sits for people who are on a 48-hour trial home from hospital and who aren’t sure if they’re safe to be at home. We’re very flexible.

“There’s a big difference for patients from being in hospital, to being on your own. How do you carry a cup of tea when you’re walking with a frame? Working out the right pills to take can be quite hard if you have to do it on your own. We want people to be able to stay in their own homes if that’s what they want.

“Palliative care is part of our remit and of course we do night or afternoon sits so that the carer can go out for a while or just have a rest. Terminally ill patients have priority, especially if they want to die at home.

“It’s been a total eye-opener for me and the staff who work with us and of course we really enjoy this type of nursing, going out into the community.”
Community health services

4.43 Most Primary Care Trusts (PCTs) directly provide community health services themselves. PCTs employ about 250,000 staff directly, including district and community nurses, community midwives, health visitors, speech and language therapists and physiotherapists.

4.44 There are lots of good examples of the responsive and innovative new services that are being developed by PCTs. Increasingly, primary care community services are being developed that work closely with other primary and secondary care services to improve services and integration. Some are being co-located with other community services, others are working virtually and collaboratively. This White Paper aims to further encourage innovative services that respond to the needs of communities. Chapter 7 deals further with PCT provision.

Making better use of community pharmacy services

4.45 Some 94 per cent of the population visits a pharmacy at least once a year and over 600 million prescription items are dispensed annually. The public told us in the Your health, your care, your say listening exercise that they want pharmacists to have an increased role in providing support, information and care. Community pharmacies are well placed to be a first point of call for minor ailments.

4.46 Pharmacies are now offering more services than ever before thanks to the new community pharmacy contract that was introduced in April 2005:
- Repeat dispensing, for example, means that patients can receive up to a year’s supply of medicines without having to revisit their GP each time they need more medicine.
- Some pharmacists are running dedicated clinics in the pharmacy, for example for people with diabetes, those with high blood pressure or high cholesterol.
- Signposting people to other health and social care services and to support services, and supporting self care and people’s well-being, are now essential services to be provided by every community pharmacy.
- Many pharmacies are adding consultation areas to provide one-to-one services for patients.
CASE STUDY

Pharmacy-based anti-coagulant monitoring gives instant results

In Durham, pharmacies are already offering innovative new services.

Anita Burdon is a pharmacist at Lanchester Pharmacy in County Durham, one of three pharmacies and a GP practice in the area which offer anti-coagulant monitoring.

“Our patients are normally referred from their GP. We have an initial meeting and thereafter they make appointments with me. I have one patient who's a policeman and works unusual shifts and he'll sometimes pop in during a lunchtime, which I don’t mind doing. We work around his shifts. As well as my clinic, I also visit GP surgeries and do home visits for patients who can’t get to us. In the past, these people would either have been taken by ambulance to the hospital, or the district nurse would have had to come to their home to take samples.”

One of the patients benefiting from the Lanchester service is Frank Redfearn, retired MD of an engineering company, who began using Warfarin in early 1999. “I originally received my treatment at the local hospital and then it involved taking a whole morning off work. Sometimes I'd have to go every week which was very inconvenient because there was only one clinic a week and everyone in the area who was on Warfarin descended on it, so the queues were virtually out of the door!

“I started using the local pharmacy clinic about a year ago. It’s pretty efficient and I know all the people who work there. Also, I can walk there; I can’t drive any more so if I was still going to the hospital clinic it would mean taking the bus – and there’s only one an hour from where we live. The other good thing about the pharmacy is you get the results and the information about whether you need to change the dose straight away. The time is very flexible, too. I just ring and let them know what time I want to be there. I think it’s an excellent service and I’m very happy with it.”

As Anita says, making things easier for the patient could improve compliance. “There were probably some patients who got tired of going to the hospital for the monitoring because it was so inconvenient and decided not to take their Warfarin any more.”

4.47 We will continue to develop the contractual arrangements for community pharmacy services in line with the ambitions set out in this White Paper.

4.48 We are already giving people a wider range of services that can provide urgent care. As well as getting an appointment on the same day with their health care practice or going to a
About three weeks ago I went to my local Walk-in Centre and was really impressed. The nurses listened to me and asked the right questions and the efficiency was spot-on. They gave me a print-out of what to do next.

**PARTICIPANT AT THE CITIZENS’ SUMMIT IN BIRMINGHAM**

hospital accident and emergency (A&E) department, people can now use:
- NHS Direct, which offers advice on self-care and is available 24 hours a day, 365 days a year, via the telephone, internet or interactive TV;
- an NHS Walk-in Centre, usually open from 7am to 10pm weekdays and 9am to 10pm at weekends for mainstream centres, and 7am to 7pm weekdays for centres in commuter areas. There are 71 already open including 2 independent sector operators, with 18 more planned to go live during 2006;
- a minor injuries unit;
- a local pharmacist;
- the local out-of-hours primary care services;
- ambulance services where the care is provided at the scene by a paramedic or emergency care practitioner, or in community social services where these are needed urgently;
- crisis resolution teams (for mental health users);
- support for carers (see Chapter 5).

4.49 Of course, many emergencies require the patient to be taken immediately to hospital. But up to 50 per cent of patients who are now taken to A&E by ambulance could be cared for at the scene or in the community. An even higher proportion of those people who take themselves to A&E could be dealt with, just as well or better, elsewhere.

**CASE STUDY**

**Helping people with diabetes to have more control**

Pharmacies in Hillingdon offer services to help people with diabetes manage their condition and improve their overall health, as part of the PCT’s Community Pharmacy Diabetes Health Improvement Programme.

John Ferguson, who has had diabetes for 15 years, started visiting his pharmacy for treatment last year.

“Obviously, it’s much quicker to go to the pharmacy because it gives you the readout instantly; the pharmacist also advises me on my weight and diet. It’s like having a medical check-up every time I visit, and I’m very pleased with that.”

John gets his checks from Sharman’s Chemist in Northwood where Rikin Patel practises:

“In the pharmacy, we have the chance to discuss the medication, explain how it works, when it should be taken, and why it may be changed. Our appointments last between 45 minutes and an hour, so we have time to educate the patients to help themselves as well as doing the tests on the spot and giving people their results. We explain how the medicines work, because if people understand their medication, they’re more likely to take it. I think, because of this service, people use their treatments to their best advantage.”
Urgent care: to put patients first

The urgent care strategy will focus on improving patient experience and significantly reducing unnecessary admissions to hospitals by:

- introducing simpler ways to access care and ensuring that patients are assessed and directed, first time, to the right service for treatment or help;
- building upon best practice to develop the next phase of quality, cost-effective, primary care out-of-hours services;
- ensuring that the quality of care is consistent for patients across the country, whether care is provided over the telephone, in patients’ homes or in a fixed location such as a Walk-in Centre, health centre or A&E;
- encouraging all health partners to work together in a system-wide approach to developing urgent care services that is consistent with other priorities set out in this White Paper, including better care for patients with long-term conditions, shifting care from acute hospitals to the community, promoting better public health, integration with social care and improving access to GPs in-hours;
- improving joint PCT and local authority commissioning arrangements to ensure better integration across services, make the best use of resources and prevent duplication. This will be particularly important for telephone and telecare services, and those provided in the patient’s home;
- providing high-quality mobile health care for patients who need urgent care, through implementation of Taking healthcare to the patient. Over the next five years, ambulance trusts will increasingly work as part of the primary care team to help provide diagnostic services and to support patients with long-term conditions. They will continue to improve the speed and quality of ambulance responses to 999 calls;
- developing a multi-disciplinary workforce strategy that makes the best use of local skills and expertise, and supports the training and educational needs of staff providing urgent care to patients;
- ensuring that the IT requirements to deliver urgent care services are reflected in the wider IT agenda;
- ensuring that the skills and experience of NHS Direct are fully utilised by patients and health care organisations. In particular, we would expect NHS Direct to play a key role in enabling patients to self care where this is appropriate. NHS Direct could also help to provide better information about local services;
- providing guidance and advice, sharing learning and best practice examples, and providing toolkits to support health and social care economies to develop integrated urgent care services that meet the needs of patients locally.
4.50 The present system of urgent and emergency care can be extremely frustrating for patients, with delays and duplication, and patients being handed over from one service to another. Out-of-hours patients may have to repeat their details as many as four times in a disjointed journey to definitive care. Nor does the system get the best value for NHS resources.

4.51 During 2006 we will develop an urgent care service strategy for the NHS, providing a framework within which PCTs and local authorities can work (see box). This will take full account of the implications for other providers, including social care and ambulance services.

4.52 A number of changes are being made to the Payment by Results tariff to create appropriate financial incentives and financial stability to better support delivery of urgent care in the NHS. As set out in the recent publication on the rules for the NHS in 2006/07:

- In the longer term we will develop a single tariff that applies to similar attendances in A&E, minor injuries units and Walk-in Centres, so that funding is governed by the type of treatment and not where it is delivered. As a first step, in 2006/07 there will be one tariff for minor attendances at A&E and attendance at minor injuries units.

- A reduced rate tariff will apply to emergency admissions above and below a threshold. This will help manage the overall level of risk of inappropriate growth in emergency admissions and share the financial risk between providers and commissioners.

- The short-stay tariff (which results in a reduction for stays of less than two days for defined Healthcare Resource Groups within tariff) has been revised to more closely align the tariff with the actual cost of short stays.

Rapid access to sexual health services

4.53 Access to sexual health services also needs to be faster. As part of our comprehensive strategy for improving the sexual health of the population, investment in services will mean that we will improve prevention and access to treatment for sexually transmitted infections (STIs), human immunodeficiency virus (HIV) and reproductive health, including conception, and by 2008 everyone will have access to a genito-urinary medicine (GUM) clinic within 48 hours.

4.54 In addition, big increases in demand for sexual health services mean it is no longer sensible or economic to deliver sexual health care, particularly STI management, only in hospital-based specialist services. This is because many sexual health services can now be effectively delivered in a range of settings.
To meet the needs and preferences of service users, PCTs should aim to commission a full range of services, which provide different levels of sexual health care in a variety of settings. *Choosing Health*, recommended standards for HIV and sexual health services recommend the development of local managed networks for sexual health, in particular as regards young people. These networks will help to provide a comprehensive service to meet local people’s needs.

The management of STIs should be developed and expanded in community settings and general practice. The voluntary and business sectors can also play a key role as they are in the national chlamydia screening programme and the ‘Chlamydia Screening in Boots’ pilot. Services can be nurse-led and make full use of nurse prescribing and Patient Group Directions. These arrangements should be overseen by clinical specialists who can provide the back-up to frontline services for people with complex needs.

Rapid access to mental health services

Rapid access to mental health services is also crucial in times of stress and crisis. Good progress has been made in implementing recommendations from the *National Service Framework for Mental Health* to establish multi-skilled community mental health teams to help people get the right support at the right time, without necessarily having to go into hospital.

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**CASE STUDY: Self-testing on your high street**

It is not always easy to get young adults to test themselves for STIs. They do not always use traditional health services, but most will be buying beauty products. So a partnership between Boots and the Department of Health has led to chlamydia screening kits being available in Boots stores across London.

This pilot scheme has been running since November 2005 and is proving popular. It marks a real attempt to bring screening to patients, rather than relying on them seeking a test. Hopefully the result will be an earlier detection of chlamydia to allow more rapid treatment.

Kits are free to people aged between 16 and 24. They return a urine sample which is sent off to a laboratory. They receive the result within three to seven days by a method of their choosing – by text, phone or letter. Text has been the most popular method to date.

Patients who test positive are contacted by Camden Chlamydia Screening Office who give advice on the treatment options available.

Twenty-three-year-old Alice, who tested negative, explains why she used the Boots service. “I was really embarrassed about having a chlamydia test and had put it off for ages because I didn’t want to go to my doctor. When I heard Boots were offering testing free I went along. It was really quick and the pharmacist was really helpful. I was really glad I finally got it done.”
4.58 Some of these teams are generic and some have specialist functions: crisis resolution teams, early intervention for first onset psychosis, assertive outreach teams, A&E liaison teams, etc. To work properly, and to continue to improve, all these teams need strong liaison and referral arrangements with each other across other parts of the urgent and primary care systems.

4.59 For young people, child and adolescent mental health services (CAMHS) provide support. By the end of 2006 there will be access to comprehensive CAMHS across the country – this is a priority and a Public Service Agreement target. However, services need to increase the speed of access to CAMHS so that children and young people are seen more promptly.

4.60 In addition, PCTs have more to do in improving the ways in which CAMHS meet the needs of some groups, most notably children and young people from ethnic minorities, those with learning disabilities, looked-after children and young offenders. Further work is also required to ensure there is a seamless transfer from CAMHS to adult services.

Screening for cancer

4.61 Screening for cancer is already predominantly a community-based service. Eighty per cent of the 1.3 million mammograms undertaken by the NHS breast screening programme are done in mobile units. The vast majority of the 3.6 million women who attend for cervical screening each year have this done in primary care.

4.62 Both of these screening programmes are highly successful and are contributing to the marked fall in death rates for breast and cervical cancer. The breast screening programme has recently been expanded, resulting in a 31 per cent increase in screen-detected cancers.
In our election manifesto, we promised to reduce the time taken to get the results of cervical screening back to women. Details of how this will be achieved will be published later this year.

A new screening programme for bowel cancer will be rolled out from April 2006. This will be one of the first national bowel screening programmes in the world and will be the first cancer screening programme in this country to include men as well as women. When fully operational, around 2 million people each year will be sent a self-sampling kit to use in the privacy of their own homes. The kit is then returned by post to a regional laboratory. A pilot in the West Midlands has run very successfully for several years.

Access to allied health professionals’ therapy services

Self-referral to therapist services has the potential to increase patient satisfaction and save valuable GP time. The Your health, your care, your say listening exercise revealed that, while increasing self-referral was not an urgent priority, there was some support for extending this approach. So in order to provide better access to a wider range of services, we will pilot and evaluate self-referral to physiotherapy. We will also consider the potential benefits of offering self-referral for additional direct access for other therapy services.
Reaching out to people in need

4.66 Allowing people to take the lead in accessing the help they need is a fundamental principle we want to uphold, but sometimes health and care services must proactively go out to those who have the greatest needs. This is because some groups, including people who live in residential homes, black and minority ethnic people, people who are homeless or living in temporary accommodation, and travellers, will not always be able to access traditional services, including health care, social services and the benefits system.

4.67 The use of outreach to support these groups is essential if we are going to ensure that equity of access is a reality for people in these groups and if we are to prevent health inequalities increasing. The incentive for PCTs and local authorities to develop outreach services is clear in that it should be cost-effective in tackling conditions early. For instance, early identification of symptoms for care home residents may prevent avoidable hospitalisation.

4.68 The exact nature of the outreach services will depend on the specific needs of the population being served.

4.69 These people can face a range of health problems which can lead to, or be exacerbated by, their housing need. They can also experience difficulty accessing health care.

CASE STUDY

Nurses near you

Lorraine Elliott from Blackburn North District Nursing Team helped to set up a mobile clinic for men, especially those from ethnic minorities, many of whom don’t speak English.

“We wanted to move away from the health centre into other places such as mosques or community centres, where we’d be more likely to reach people. We’ve been able to give advice, or help them find the right person to go to if they have a particular health problem. The feedback has been very positive.”

Asif Hussain, 37, was so impressed with the service provided by the clinic that he encouraged his family and friends to try going there, too.

“I’d only go to the GP if there was something seriously wrong,” says Asif. “With the clinic, I walked straight in and had a one-to-one conversation with the health professionals. It was confidential and I could ask questions. They checked my weight, height, BMI (body mass index) and blood sugar, and gave me lifestyle advice. I’d definitely go again.”

Better access to community services  95
The Department of Health and the Office of the Deputy Prime Minister are encouraging housing and health services to work together to improve the well-being of homeless people and to prevent homelessness. They have issued joint guidance on developing shared outcomes for people who are homeless or in temporary accommodation, including improving access to primary health care, improving substance misuse and mental health treatment, and preventing homelessness through appropriate, targeted health support.

Better partnership working is essential if we are to improve health outcomes and reduce health inequalities for the most vulnerable groups, for instance people who are homeless or living in temporary accommodation.

For those patients who want to work but their health condition or disability is stopping them from doing so, we are working closely with the Department for Work and Pensions who are piloting offering joint health and employment support in GP surgeries, making it easier for people to access the services they need in a single location.

Expectant mothers

We want to ensure that maternity services are women-focused and family-centred. This means increasing choice for women and their partners over where and how they have their baby.

CASE STUDY

Nurse practitioner-led outreach services

The Huddersfield Outreach Service, established in December 2002, focuses on the Deighton Ward, which falls into the top 4 per cent most deprived areas in the country. It supports nearly 17,000 families with children, providing immunisation and vaccinations, contraception and advice on sexual health, teenage pregnancy clinics, child health surveillance and help with smoking cessation.

The service operates from four general practices at different sites and uses common clinical systems with a monthly audit to monitor performance. Working with local health visitors, the service offers home visits, same-day services and Monday-to-Friday open access. Childhood immunisations are given, by appointment, in routine general outreach clinics and opportunistically at home. Immunisation coverage of two year olds has steadily increased by around 8 per cent from 79 to 87 per cent. Attendance and access rates have increased and reflect the confidence gained by the local community in the service. The primary care team plan to build on this success and expand the range of services offered by setting themselves up as an alternative personal medical service.
4.74 In *Your health, your care, your say* we heard people praise midwives and the support they provided, but express dissatisfaction that they could not always choose where their baby was born. Increasing choice is not the only priority – surveys of women and their partners have also identified being treated as an individual and being provided with more information as important.

4.75 A truly individualised maternity service will give women as much control as possible during their pregnancy, birth and post-birth. It will mean midwives ensuring that women have all the information they need about this life event. This will include information about the choices available and in formats and styles appropriate to people with different needs, as well as ensuring that they fully understand the financial support available to them and their partner during and after pregnancy. It will mean women can access a midwife directly, without going to their GP first, if that is what they want.

4.76 It will mean a maternity service in which all women are offered a choice of where they have their baby. Wherever possible, this is likely to include offering midwifery-led services provided at home, in a ‘home-like’ setting or in a hospital, the final choice depending on factors such as individual case needs and geography. Women will also be able to access antenatal and postnatal care in community-based settings, such as Children’s Centres.

4.77 It will mean all women will be offered a choice of pain relief appropriate to the setting in which they choose to give birth. It will mean all women having continuity of care before and after birth provided by a midwife they know, and being individually supported throughout the birth. *This will be in place by 2009.*

4.78 To achieve such a world-class maternity service, we commit to three actions. *Firstly, we need to raise the profile of maternity services in both the public and the commissioning agenda. Then we must ensure that Payment by Results supports the choices women make during pregnancy. And finally, we will work with PCTs to review the current maternity workforce and identify where more staff are needed to deliver these commitments.*

4.79 Regrettably, pregnant women are at an increased risk of domestic violence, with 30 per cent of cases starting during pregnancy. To help
midwives and other health professionals identify and give appropriate support to women who are being abused, we have recently published *Responding to domestic abuse: A handbook for health professionals.*

4.80 This will help the identification of domestic violence as it arises and, where necessary, health professionals should work with social workers and the police and local housing authorities to protect and support the victims of abuse. This is particularly important in safeguarding children in these situations. The potential benefits are huge – not just in terms of reduced harm to the one in four women and one in six men who suffer from domestic violence in their lifetime, but also in reducing the £23 billion domestic violence costs the economy.

**Improving immunisation services**

4.81 Immunisation remains one of the most effective ways for people to protect themselves or their children against diseases that can kill or cause serious long-term ill-health. Nationally, high levels of immunisation have resulted in a significant reduction in the rate of infectious diseases. However, the current trend of greater numbers of general practices opting out of immunisation service provision in deprived areas means that immunisation services could fail those who need them most, including disadvantaged children, older people, people who move frequently and adults not vaccinated as children – increasing the likelihood of outbreaks. Alternative models of providing immunisation services are needed to ensure high immunisation coverage for all.

4.82 We know barriers to access exist among disadvantaged groups and we want a wider network of providers and partnerships with GPs, including out-of-hours providers, Walk-in Centres, Children’s Centres and outreach services. The full range of primary medical care contracts can be used flexibly depending on local immunisation commissioning priorities, and should help to improve services and the way they are delivered.

A principle underlying this change will be that the money spent on immunisation target payments will remain as a whole but is shared across different types of contract. **We are seeking to support the introduction of these changes and will work with NHS Connecting for Health to improve the existing national population-based immunisation reporting system.**

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*Participant at the Citizens’ Summit in Birmingham*
In addition, an immunisation and vaccination commissioning strategy at PCT level is needed. We will require the Health Protection Agency to develop a new plan for providing immunisation coverage information at postcode to help PCTs monitor pockets of low uptake and to support their commissioning decisions.

Teenagers

Teenagers are one group who do not always use traditional NHS services. We have sought to make such services more young people friendly by publishing the *You’re Welcome* quality criteria. These criteria reflect the standards set out in the *National Service Framework for Children, Young People and Maternity Services*. An accompanying resource pack, including case studies, helps PCTs and local authorities to develop services that are accessible and trusted by young people.

We will also be seeking to make health an integral part of the everyday services that young people use. Partly this will be building on the Government’s commitment in the *Every Child Matters: Change for Children* programme to develop extended schools so that we provide welcoming and accessible health care in school settings.

We also expect provision to be made in non-formal educational settings, such as youth centres. The *Youth Matters* Green Paper committed the Government to explore

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**CASE STUDY**

**Schooled in health**

Following the reorganisation and merger of the previously separate Valley Road Infant and Junior schools in 2002, a new state-of-the-art building was created in Sunderland. The governors used this as an opportunity to make Valley Road Community Primary School the hub of the community. It provides a ‘one-stop shop’ for health, childcare and social services as well as education for the community.

The school has three wings, two for traditional school use and one for the community. The community wing has a healthy living centre, a neighbourhood nursery providing care for children aged three months to three years all year round, provision for an early years behaviour team and a child and adolescent mental health services team.

The school is committed to developing its services further and to building on the success of the multi-agency working. They want to set up a branch of the local credit union, as well as creating a community art gallery. They also want to landscape the site and make a woodland walkway and community garden.

Ofsted’s view is that the project as a whole is bringing hope and optimism to an area of social and economic difficulty, and is impacting on the regeneration of the area. As such it can be viewed as a blueprint for the future. A pupil at the school is more succinct, simply saying “The whole school is brilliant.”
the potential of such settings in 2006 in three adolescent health demonstration sites. We will consider how these sites can be linked to the NHS ‘Life Check’ at the transition from primary to secondary education.

4.87 Young people’s involvement in the design and delivery of these services is fundamental to their success and acceptability. We will start this involvement immediately by working with younger people to ensure that services, such as sexual health, are provided in a way and a location that encourage usage. In addition, making real progress in providing health services in educational and youth-centred settings will require close partnership working between the NHS and local authorities.

People with learning disabilities

4.88 People with learning disabilities face particular health inequalities. The NHS has historically not served such people well and the Department of Health has previously committed to introduce regular, comprehensive health checks for learning disabled people. These would help to direct people into the system, from which point onwards they will be better positioned to receive good quality health care. **We will review the best way to deliver on this earlier commitment.**

4.89 People with learning disabilities also want greater choice and control over their own lives, in line with the principles of the *Valuing People* White Paper.

4.90 This includes being supported to live in ordinary housing in their local community and to work. Even today, close to 3,000 people with learning disabilities live as inpatients in NHS residential accommodation, or ‘NHS campuses’. We finally want to see an end to this type of institutional provision. Campus settings limit choices and give poorer outcomes, whereas community-based settings enable a greater degree of independence and inclusion. Campus accommodation also often neglects people’s health needs. For example, some campus occupants are being denied their right to register with a GP practice.
Seventeen-year-old Joseph Tomlinson from Wigan has a severe learning disability. Joseph has the same aspirations as any other 17-year-old but faced barriers in achieving them. Now thanks to In Control, a new scheme being pioneered in Wigan, funded by social services, the local education authority, the Learning Skills Council and Independent Living Funds, Joseph can attend the local college, go to the gym and live an ordinary life. His mum Caroline explains how In Control has revolutionised Joseph’s life.

“Before the pilot started Joseph went to a special school, a good hour away, and had lots of different carers and found that lack of continuity really difficult. At one point I had 46 different people coming through the house! It was also extremely expensive and Joseph really wasn’t receiving the benefit. We were totally dependent on whatever support was prescribed for him. In Control means people who need support are given both the money and the freedom to choose and buy the services they need, so it has enabled us to choose the services that Joseph needs.

“We decided that Joseph needed to be able to do the same things as other young people of his age and that it was very important for him to have continuity of care, so that the same people stayed with him.

“Although we could have used an agency, we decided to employ a team of personal assistants to support him directly. There are six of them altogether and the assistants support him throughout the day inside and outside college, during the week and at the weekend. It has raised the quality of his life phenomenally – before this scheme started he wouldn’t have been able to do three-quarters of the things he does now, like go away for the weekend or go to the gym. If we do something as a family he can come with one of his supporters. He is so much happier. Most importantly he has continuity in the people who work with him, they are people he has chosen to be with.”
4.91 There is a strong evidence base to support moving all people with learning disabilities from campus accommodation and placing them in more community-based settings. However, further consultation on the detailed arrangements is needed so that no individual is moved from a campus until suitable alternative arrangements have been put in place. This will be led by the Valuing People Support Team with a view to ensuring local commissioners achieve the closure of all NHS residential campuses by the end of the decade.

Access to health services for offenders

4.92 Among offenders, there are high levels of need. For instance, 90 per cent of all people entering prison have some form of mental health, personality disorder or substance misuse problem. Many will therefore be unemployed, and having been in prison forms an extra barrier to finding work when they are discharged.

4.93 There is also a high incidence of mental health problems among young offenders, many of whom have been in local authority care, have suffered violence at home and have reported sexual abuse.

4.94 PCTs already have responsibility for commissioning services for offenders in the community. From April 2006 (although some are already doing so), all PCTs will also have responsibility for commissioning services for prisons within their geographical area and all health services for young people in young offender institutions and secure training centres.

4.95 Those who offend often have a significant profile of other needs, including health needs. Many who find themselves in contact with the criminal justice system have drug, alcohol or mental health (or a combination of these) problems. Whether in a community or prison setting, PCTs have an excellent opportunity to work with offenders to tackle these issues, with considerable potential gains for society and health services. Joint work between the health and criminal justice systems offers real potential to reduce health inequalities and crime, as does integrated working between health, education, social care and youth justice in youth offending teams.

4.96 PCTs should be working with probation services and local authorities to meet the needs of offenders. During the Your health, you care, your say consultation, offenders voiced the opinion that public services were hard to access and that there was little support with finding housing, jobs or health services.

4.97 Local health and criminal justice commissioners should ensure that health and social care interventions are accessible to offenders, especially aspects like crisis intervention or ongoing community psychiatric nurse support. This might also mean services
are co-located or provided in places where offenders go to receive their community supervision.

**Older people**

4.98 In the *Independence, Well-being and Choice* and *Your health, your care, your say* consultations people expressed concern about meeting the needs of older people, particularly those with dementia.

4.99 The National Clinical Director for Older People will shortly be publishing plans for improving services for older people in a *Next Steps* document covering three themes: dignity in care, responsive services and active ageing. This will include detailed plans for ensuring dignity in all care settings and at the end of life, improved services for people with strokes, falls, dementia, multiple conditions and complex needs, and information technology for personalised care and for promoting healthy active life, independence, well-being and choice for older people.

4.100 We have already set out plans for improving services for older people with mental health problems, including dementia, in *Everybody’s Business – Integrated mental health services for older adults: a service development guide*.¹⁰ Commissioners and providers of services will need to become familiar with this guide as it provides the blueprint for meeting the needs of dementia sufferers close to home.

**End-of-life care**

4.101 Over 500,000 adults die in England each year. Although over 50 per cent of people say they would like to be cared for and die at home if they were terminally ill, at present only 20 per cent of people die at home.¹¹ In the *Your health, your care, your say* consultation people told us that they wanted the choice to die at home, although they also recognised that this might be difficult for the dying person’s family, who would also need support.

4.102 The Government recognises that additional investment is needed to improve end-of-life care and has pledged to increase choices for patients by doubling investment in palliative care services. This will give more people the choice to be treated at home when they are dying, but we must also recognise the wishes of any family members who are caring for dying relatives.

4.103 To allow this choice, we will establish end-of-life care networks, building on the co-operative approach suggested by the new urgent care strategy (see paragraph 4.51 above). These will improve service co-ordination and help identify all patients in need. The networks will bring together primary care services, social services, hospices and third-sector providers, community-based palliative care services, as well as hospital services. This approach will build on pilots being undertaken with Marie Curie Cancer
Care through the Delivering Choice Programme sites.

4.104 We will ensure all staff who work with people who are dying are properly trained to look after dying patients and their carers. This will mean extending the roll-out of tools such as the Gold Standard Framework and the Liverpool Care Pathway for the Dying to cover the whole country.

4.105 We will build on co-ordinated multi-agency assessments, ensuring health, education and social care services are organised around the needs of the dying person and his or her family.

4.106 We will provide rapid response (hospice at home) services to patients in need by investing in community-based specialist palliative care services. Further details will be provided in due course on the distribution of funding to meet these commitments.

4.107 For disabled children, children with complex health needs and those in need of palliative care, PCTs should ensure that the right model of service is developed by undertaking a review to audit capacity (including children’s community nursing) and delivery of integrated care pathways against National Service Framework standards, agreeing service models, funding and commissioning arrangements with their SHAs.

4.108 Support for carers when the cared-for person is dying is especially important and this will be taken into account in developing the New Deal for Carers described in the next chapter.

4.109 There are those that need to receive care from more than one primary care community service. And, as the population ages, the number of people with ongoing needs that will affect their daily lives will increase. We must confront this challenge. Otherwise people will receive poorly co-ordinated care that is unnecessarily expensive.

References

1 Fairer charging policies for home care and other non-residential social services – a consultation document and draft guidance, Department of Health, 2001

2 Access to Work is run by Jobcentre Plus. See this link: www.jobcentreplus.gov.uk/JCP/Customer/HelpForDisabledPeople/AccessToWork/

3 Achieving positive shared outcomes in health and homelessness, Department of Health and Office of the Deputy Prime Minister, March 2004

4 Responding to domestic abuse: A handbook for health professionals, Department of Health, 2006

5 12.5% of general practices in the most deprived fifth of PCTs have opted out, compared with only 0.2% in the least deprived fifth. (Department of Health, 2005, unpublished)

6 You’re welcome quality criteria: Making health services young people friendly, October 18, 2005

8. Emerson et al, 1999, Quality and costs of residential supports for people with learning disabilities: A comparative analysis of quality and costs in village communities, residential campuses and dispersed housing schemes, summary and implications

9. The term ‘offender’ is taken here in its widest context to include not only those charged or sentenced within the criminal justice system, which will include those in prisons and under supervision of the probation service, but also those known to commit offences by the police

10. Everybody’s Business-Integrated mental health services for older adults: a service development guide, Community Services Improvement Partnership, November 2005