CHAPTER 8

Making sure change happens
This chapter on the mechanisms required for change includes:

• better information to support more joined-up services;
• how quality will be assured;
• mechanisms for a more joined-up service with health and social care colleagues working together;
• how the workforce must evolve to meet the needs of a changing service.
8.1 To make sure change happens, we need high-quality information to help people choose and access services. The quality of the services people use must be guaranteed. And the health and social care workforce must develop to truly put people in control.

High-quality information

8.2 The need for high-quality information about people’s conditions and the services available to them was highlighted as a central theme of the Your health, your care, your say listening exercise. Fifty-eight per cent of people who completed the online questionnaire thought that being given more information would give them more control over their health and well-being.

8.3 Without good information, people may access the wrong services or get to the right services too late – resulting in unnecessary discomfort and added complications. We know that over half the patients who attend Accident and Emergency (A&E) departments with minor ailments do so because they are not aware of alternative, possibly more convenient and cost-effective, services within their local community.

8.4 Earlier chapters have covered some information initiatives – most notably the information prescription in Chapter 5. However, this chapter looks at an overarching approach to making information accessible.

8.5 Most information that people require is already available. For instance, good information sources exist such as the NHS website (www.nhs.uk), which has a facility listing doctors, opticians, pharmacists and dentists searchable via postcode, and the Directgov website (www.direct.gov.uk), which now provides access to information on all local authority services.

8.6 However, sources such as the internet are not accessible to all. People told us in the listening exercise that their preferred means of getting information is face-to-face. Some local authorities and Primary Care Trusts (PCTs) have developed examples of good practice in making information available.

8.7 Yet not everybody has such easy access to information. We need an integrated approach to information that starts from the perspective of what people want.

8.8 During 2006, the Department of Health will review the provision of health and social care information to ensure that people who use those services have the information they need, when they need it, and in a wide variety of formats. We will do
Welcome centre in Manchester

When you are new to an area, it can be hard to get information on public services, especially if English isn’t your first language. Based in Trinity Church, Cheetham and Crumpsall Welcome Centre in Manchester is a resource centre with a wealth of information for its diverse community.

Angela Kenney is a health visitor and was one of the driving forces behind the establishment of the centre, which opened in November 2004:

“We want anyone who walks into the centre to feel really welcome. Well over 30 languages are spoken around here and we greet visitors in their own language. Many people who are new to the area are refugees and asylum seekers but there are also people who have lived locally for several years and are still isolated.

“People can find out about benefits, find support on parenting issues, get help to access health services and other health information, learn how to get their children into school, sort out housing problems and get employment advice. We have a play area with a play development worker provided by Sure Start, and there are activities for the older children in the holidays. All the expertise is here, on the spot, in a relaxed café-style environment and there’s a thriving 15-strong volunteer force, some of whom are in their eighties.

“It’s a true partnership arrangement; the advisers here have a wealth of knowledge and this has a knock-on effect for all of us as we become more aware of each other’s roles.”

For some visitors, the centre has been a real lifeline. Sinita Kaur, who has a son and a daughter, has lived in the area for many years:

“I heard about the centre from my health visitor and one of the workers here. My family was having a hard time because we were getting racist abuse and my children were frightened. Coming here gave me lots of support at a difficult time and I made loads of new friends. The advice worker was really helpful; she helped us to get re-housed and now life is so much better. My husband talked to the employment adviser and now he’s in work.

“Everyone is so friendly and you can get everything sorted out in one place. The children love coming, they use the play area and there’s always something to do. I’ve made friends and I love coming here every week.”
this in partnership with people who use health and social care and their representative organisations, and we will also consider methods of helping people navigate round the many different services.

Integrating information

8.9 A starting point for this review will be that people have told us that sources of information on health and local authority services are not linked. People want information to meet their needs as individuals, not to be provided according to organisational boundaries.

8.10 To find the best way to do this, we will pilot in 2006 a project involving a local authority and a PCT to develop an integrated approach to information, leading to the development of a service specification and timetable for implementation. Our ambition is for PCTs and local authorities to jointly maintain an accessible database of all services and support groups in their local area.

8.11 We will also develop a specification for easily searching available information, by looking at existing models such as ChildcareLink.¹ To help local authorities and PCTs implement this commitment in a way that dovetails with the Government’s broader eGovernment objectives, and to support individuals, families, carers and professionals providing advice, we will seek to design and implement a support application for social care needs.

The vision for ‘SocialCareLink’ will be to develop an application which enables individuals, families or carers to: navigate round the many different services, research providers and current service availability; access relevant reports; and email enquiries or requests to providers from one place.

People’s own information

8.12 At the national Citizens’ Summit, one of the areas that some people supported was for patients to have smartcards with their own medical records on them. These records could then be accessible wherever someone accessed services.

8.13 We are not persuaded that such cards are necessary. The NHS Connecting for Health strategy is already developing a system of electronic care records that will be accessible across the NHS by 2008. There are plans for these records to be accessible to social services from 2010. This key underpinning reform will avoid the need for people to repeat information about their condition, a major complaint in the listening exercise.

8.14 Having smartcards would require new technology to read the information contained on the card and there would also be occasions when people did not have the card with them when they needed treatment. Our existing approach offers more flexibility.
Guaranteeing quality

8.15 The NHS has one of the strongest and most transparent systems for quality in the world: clear national standards, strong local clinical governance arrangements (to assure and improve quality locally), robust inspections and rigorous patient safety arrangements. The development of National Service Frameworks has helped to spread best practice in tackling specific conditions and caring for particular groups of people.

8.16 Social care quality is currently monitored by: the Commission for Social Care Inspection (CSCI) – the regulatory body for social care with additional powers to take an industry-wide view of social care; a set of statutory regulations and underpinning national minimum standards; and the General Social Care Council (GSCC) to regulate the social care workforce. CSCI will be merged with the Healthcare Commission to form a single regulatory body for health and social care, as referred to in Chapter 2.
Assessment of quality

8.17 We will ensure that our means of guaranteeing quality improve further, to reflect the changes in this White Paper. Chapter 6 sets out our desire to provide more specialised services in community settings. Presently, while the Healthcare Commission assesses hospitals and other specialist health providers, there are no recognised schemes of assessment for the provision of these services in the community.

8.18 We therefore propose to introduce a national scheme of accreditation for the provision of specialist care in the community, to apply to new entrants and existing providers. This will ensure that both services and the staff working there, such as practitioners with special interests, are working to safe, high-quality standards. We will discuss further with the Healthcare Commission, the Royal College of General Practitioners and other interested parties the best means of doing this.

8.19 We will also consider the wider need for assessment of the quality of primary care practices and other primary care providers. We will work with the Healthcare Commission to develop an appropriate scheme. This may well involve the Healthcare Commission in assessing and approving the professions’ own accreditation schemes, where it believes these: provide a strong framework for service improvement, including holding to account poorer providers; are effective but non-bureaucratic; and meet the Commission’s move towards more risk-based regulation.

8.20 For example, the Royal College of General Practitioners’ Quality Team Development (QTD) scheme has already been used by some PCTs and over 2,000 practices to review their own performance. QTD is a framework to enable primary care teams and their PCTs to assess the quality of the services they provide for patients. Its focus is on the whole team, their functioning and the services they provide, and it meets the Healthcare Commission’s requirements.

8.21 In social care, CSCI already regularly assesses all providers. The Department of Health, working closely with CSCI, is currently reviewing the existing national minimum standards established under the Care Standards Act 2000 and the associated regulations, to ensure a targeted and proportionate system of regulation, with a focus on dignity, quality and the best possible outcomes for people who use social care services.

8.22 In addition, all local councils are assessed annually and are required to produce a delivery and improvement statement to show how they are progressing against national objectives and targets.

8.23 Individual professionals in health and social care are also likely to participate in a regular reassessment of...
their fitness to practice. In the medical profession, proposals were developed by the General Medical Council following a consultation in 2000 but were put on hold following the fifth report of the Shipman Inquiry. The Chief Medical Officer will shortly be advising the Government on the way forward, following a review of revalidation and other aspects of the regulation of doctors. A similar review of non-medical regulation has been carried out by the Department of Health and the result of that review will be published in the spring.

8.24 The Department for Education and Skills, in partnership with the Department of Health, will shortly introduce legislation to create a new vetting and barring scheme, as recommended in the Bichard Inquiry, to tighten up procedures to prevent unsuitable people from gaining access to children or vulnerable adults through their work, whether paid or unpaid. The new scheme will build on the existing pre-employment checks available through the Criminal Records Bureau, the Protection of Vulnerable Adults scheme, the Protection of Children Act scheme and List 99. It will extend the coverage of the existing barring schemes and draw on wider sources of information, providing a more comprehensive and consistent measure of protection for vulnerable groups.

Regulation

8.25 Regulation will become more streamlined and joined up, following the publication of the Wider Review of Regulation in 2006. In Health Reform in England, we promised to publish a document on the role of regulation within the context of revised arrangements for performance management in summer 2006.

8.26 The NHS reform rules for 2007 and 2008 will then set out how performance measures, including Public Service Agreements, developmental standards and Local Development Plan priorities, can better be integrated and streamlined to reflect these principles, and to reflect the new, stronger focus on prevention and well-being.

8.27 The GSCC and its devolved counterparts have a duty to develop codes of practice and they have worked together in developing these codes as part of their contribution to raising standards in social care services.

8.28 Comprehensive arrangements to improve quality, including better commissioning, national standards, best practice, and inspection were set out in A First Class Service. These have been very successful in driving the improvements in quality set out in Health Reform in England.
For me, the perfect social worker would be a caring person and understand the needs of the service user and follow them through with all the provisions and adaptations or whatever it is. They should go back to the service user and find out whether the service user is happy with what he or she has done so far.

**RESPONDENT TO INDEPENDENCE, WELL-BEING AND CHOICE**

**Patient safety**

8.29 For people, the clinical outcome of care – whether they get better, whether the complications of their illness are minimised, whether their health is maintained in the long term – matters greatly. So too does ensuring that they are not inadvertently harmed in the process of care.

8.30 For these reasons, we will continue to give a high priority to clinical governance and patient safety. The programme of patient safety launched by the Chief Medical Officer’s report *An organisation with a memory* is becoming integral to local services.

8.31 But there is more to do. It is important that the reporting of adverse events and near misses through the National Patient Safety Agency’s national reporting and learning system is fully extended into primary care and other out-of-hospital settings.

8.32 Worldwide most of the focus on patient safety has been within hospitals. The NHS has a unique opportunity to lead the world on developing reporting and learning for adverse events outside hospital so that safety can be improved and risks can be reduced for potentially hundreds of thousands of NHS patients over the years ahead.

**Developing the workforce**

8.33 The health and social care workforce is a huge army for good. There are now 1.3 million NHS staff engaging in hundreds of millions of contacts with patients each year, employed by over 10,000 practices, trusts and PCTs. There are 1.5 million employees in social care, with over 25,000 employers, providing a service to around 1.7 million adults at any one time.

8.34 This White Paper will mean changes for all staff, whether they are focusing more on prevention or working in new settings. These changes will be managed sensitively, made in full consultation with the staff involved and always with the interests of patients and professionals at their heart.

**Working across boundaries**

8.35 One fundamental change will be better integration between those working in the NHS and those working in social care. A better-integrated workforce – designed around the needs of people who use services and supported by common education frameworks, information systems, career frameworks and rewards – can deliver more personalised care, more effectively.

8.36 Key to closer integration will be joint service and workforce planning. The NHS and local authorities need to integrate workforce planning into
corporate and service planning. The Department of Health will consider and develop plans to achieve this in line with proposals to align service and budgetary planning across health and social care and in consultation with stakeholders. Workforce issues will also be fully integrated in service improvement planning by the Care Services Improvement Partnership and the NHS Integrated Service Improvement Programme (ISIP).

8.37 Integrating planning will facilitate joint working on the ground. The NHS Large-scale Workforce Change programme and the Skills for Care New Types of Worker pilots are providing significant learning to develop team-working across traditional agency boundaries. This will be complemented by the Partnerships for Older People projects developing prevention and well-being pilots that cut across the boundaries between health, social care, housing, benefits and other local services.

8.38 New health and social care multi-skilled teams will also be established to support people with ongoing needs (see Chapter 5). Underpinning the development of these teams will be common national competencies and occupational standards.

8.39 Increasingly, employers will plan around competence rather than staff group or profession. To encourage integration, we will bring skill development frameworks together and create career pathways across health and social care. Staff will increasingly be expected to have the skills to operate confidently in a multi-agency environment, using common tools and processes.

8.40 Skills for Care and Skills for Health, in partnership with other relevant organisations, will together lead this work so that staff can develop skills that are portable, based on shared values, recognised across the sectors and built around the needs of patients and service users.

Putting people in control
8.41 A further major change will be the shift to put people in control of their care. Professionals will work to support and empower people to make their own decisions, wherever possible.

8.42 Individuals, their families and other carers need to understand the services that are available in order to make good choices, and they need to receive maximum support in obtaining their chosen service – wherever it is provided. We will develop competencies for workers specifically trained to help individuals with health or social care needs to ‘navigate’ their way through the system, and ensure that the competencies are built into other key roles where people who use services require support.

8.43 Individual budgets, in particular, could have a considerable impact on workforce roles and ways of working, and we expect to see growth in the numbers of personal assistants,
employed directly by people who use services or their agents. A series of pilots managed by Skills for Care has begun to assess the nature of the personal assistant role, and this will also be explored through the individual budget pilots, seeking to devise and implement the best framework of training, support and regulation of this group of workers.

Working in the community

8.44 Both for the demonstration projects set out in Chapter 6, and for developing local care more broadly, we need to examine the workforce implications of receiving care closer to home and its associated regulations. A focus on care closer to home is likely to mean a different role for many specialist staff based in hospitals.

8.45 As care moves closer to people, many hospital-based staff will spend time working with multidisciplinary teams, with specialist nurses and with practitioners with special interests (PwSIs). There will be a need for full consultation with the staff affected by changing roles, and any new training needs will have to be appropriately addressed. Their role would be to provide oversight, training and patient consultations. We would encourage all
employers to use the job-planning process in the consultant contract, flexibilities in Agenda for Change and the incentives in new primary care contracts to facilitate the service changes laid out in this White Paper. New organisational or employment models that can be used by employers will be tested in the demonstrations described earlier and the Integrated Service Improvement Programme will provide a mechanism for sharing best practice.

**Investing in our greatest resource**

**8.46** The NHS and social care sectors spend more than £5 billion annually on training and developing staff. Only a small fraction is targeted at staff working in support roles – the least qualified don’t get the opportunity to participate in learning and development. None is spent in supporting informal carers. We will ensure the priorities of this White Paper are reflected in the way that money is spent.

**8.47** In particular, we need to build up skills, especially in basic communication, in social care – where only 25 per cent of employees have a qualification. It is not acceptable that some of the most dependent people in our communities are cared for by the least well trained. We envisage a much greater role for informal carers and people who use services in training staff – with ‘expert carers’ running courses for nurses, doctors, allied health professionals, social workers and other care staff.

**8.48** We will also continue to develop roles with greater responsibilities to encourage professional development. We will encourage the development of these roles – such as advanced practitioners in imaging – where they can make most difference to delivery. We will also place an increased emphasis on PwSIs. To this end, we will develop and pilot new PwSI roles, including a PwSI for adolescent health (likely to be particularly focused on disabled children and the transitional period from teenager to adult) and a PwSI for learning disability.

**Harnessing available potential**

**8.49** We must ensure that our workforce has the capacity to meet people’s needs. There are serious recruitment and retention problems to tackle in social care, where vacancy rates and turnover are often too high. Under the joint Department for Education and Skills and Department of Health Options for Excellence Review, there will be nationally co-ordinated action to improve recruitment and retention in social care.

**8.50** Supplementing the Options for Excellence Review will be research the GSCC is undertaking into the professional role of social workers. Together, these will lead to proposals for developing the social work profession. Initial findings emphasise their core role in working in the context of ambiguity, uncertainty and risk, taking a holistic view of
the lives of people who are often excluded or marginalised.

8.51 In the meantime, we will tap into the potential of groups of people who have, by and large, not been attracted into health and social care, and who have limited or no access to learning opportunities. We propose to extend recruitment to disadvantaged groups, young people, older people and volunteers, and people who have used services and can now make a new career in a caring role. The NHS Widening Participation in Learning programme and similar programmes in social care will be extended to support more diverse recruitment. We must also ensure that informal carers can move in and out of the paid workforce.

8.52 Health and social care organisations should also make good use of the many volunteers doing excellent work in the caring sector. To help with this, the Department of Health and the Home Office have funded a joint project led by Volunteering England to produce guidelines to encourage greater consistency in how volunteers are managed within the health service. This is scheduled for publication shortly.

8.53 Finally, we must ensure that health and social care employers are good employers. Evidence is growing that the highest-performing organisations have good employment practices. This includes local organisations fulfilling statutory duties on race, disability (from December 2006) and gender equality (from April 2007).

8.54 Yet, being a good employer is more than simply meeting legal requirements: supporting a good work–life balance, flexible working, childcare provision and healthy workplace policies are important to ensure that staff can perform to their full potential. The Department of Health will work with the Department for Work and Pensions and the Health and Safety Executive to promote healthy workplaces in health and social care, and model employment practices that attract and retain the best staff with the best skills.

References

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