Your health, Your care, Your say

Evidence base 3 (20 September 2005)

Health & social care needs, resources & services
Introduction

This slide pack provides a collation of information on services available outside hospital. We have tried to draw together information, not only about how services are used, but what service users and professionals currently feel about them. We have also tried to highlight key policy issues where these are known.

The pack has provided some context for the White Paper team, they do not suggest or answer policy questions. Their aim was to help all those leading this process have a similar core understanding of this diverse terrain.

The paper brings home how little we do know about many service areas, in particular community services, such as community hospitals and nursing. The consultation process offers an opportunity to fill some of those gaps.
Service & Policy Areas
Health and social care services provided outside hospital are diverse in nature and setting

Healthy communities
Healthy living centre
‘Sure start’
Workplace

Intermediate care
Rehabilitation services & stroke
Occupational therapy
Community hospitals
Community nurses
School nurses
Chiroprody
Palliative care
Physiotherapy
Speech and language therapy
Community mental health
Prison health services

Learning disability services
Home care
Nursing care
Residential care
Social care assessment

Informal carers
Self care
CAM

General Practice
Pharmacy and pharmacists
Optometry
Walk in centres
NHS Direct
OOH
Dentists
Ambulance services
Sexual health

Personal Care
Primary Care
Health Determinants
Social Care
Community Health
Life Style
User Groups
Health Promotion
Screening

Healthy Insight Unit
General Practice
Pharmacy and pharmacists
Optometry
Walk in centres
NHS Direct
OOH
Dentists
Ambulance services
Sexual health
Health Promotion
Health Promotion – lack of awareness of healthy living & little primary care support

- “There is some evidence that the public are less active than they say with regards to healthy living. Diet is not at the recommended levels for a healthy lifestyle (only 15% of people say they drink the recommended amount of seven glasses of water in an average day, and only 30% say that they eat the recommended 5 portions of fruit and vegetables). This highlights that the high self-ratings of self care are not necessarily accurate in terms of what may be considered desirable for healthy eating. This mismatch shows a potential lack of awareness and understanding of what people could be doing in terms of what may be considered desirable” [2].

- 72% respondents in UK said that in last 2 years doctor had not provided advice on weight, nutrition or exercise [27].

- 55% thought reason doctor didn’t mention was because not serious [27].

- “The problem is not the lack of information on what is good for you and what is not – people are getting new ‘facts’ from all sides. But messages about health are sometimes inconsistent or uncoordinated and out of step with the way people actually live their lives.” [27].

- 62% overweight & 48% obese don’t perceive serious health risk [148]

- Smoking: information played a very big role in 1970s and 1980s [149]

- Smokers and non-smokers now both estimate risks correctly on average but sizeable rump remain [150]

- Health promotion is often not directed towards older people [151]
Investments to tackle health inequalities may not be paying off

What is being offered?
- Spearhead PCTs will get funding for health trainers, improved smoking cessation services and school nurses [112]
- Spearhead PCTs are initiatives set up in the most deprived areas in England [112]
- Healthy Living Centres provide an opportunity to improve health and reduce inequalities in health through local community action; the programme will complement local Health Improvement Programmes [113]
- Healthy Living Centres are targeting deprived areas [113]
- Sure Start: Increasing availability of childcare for all children, improving health and emotional development for young children and supporting parents as parents and in their aspirations towards employment [111]

Who uses them?
- Sure Start: children and parents [111]

What are the key issues?
- An evaluation of the Sure Start program revealed uncertainty towards improvements in the targeted population [126]

What are the policy aspirations?
- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual groups and the population as a whole. [134]
- Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole [134]

Gap areas:
What does the public think?
What do the professionals think about them?
How is demand likely to change in the future?
Promoting health in the workplace influences health choices

**Choosing Health** [114]: Work is a key part of life and employers, employees, government and others can extend healthy choices by:
- Reducing barriers to work to improve health and reduce inequalities through employment
- Improve working conditions to reduce the causes of ill health related to work
- Promoting the work environment as a source of better health

**Health and Safety Commission** [115]: A strategy for workplace health and safety in Great Britain to 2010 and beyond
- Vision to see health and safety as a cornerstone of a civilised society
- Achieve a record of workplace health and safety that leads the world

**Workplace Health Direct** [116]: Model for occupational health, safety and return to work (OHSR) support
- Innovative ways of working
- Working with and through others
- Providing accessible advice and support
- Focus on small business

**Workplace Task Group** [152]: Task force is likely to reinforce the importance of primary care as a major local employer and the need for PCTs to actively promote health in the workforce
- Promotion of health living activities
- Recommending that GPs should have more training in occupational health issues
Choosing Health Consultation – Overview of responses relevant to Out of Hospital Care

- Call for clear messages from the NHS about health improvement and disease prevention
- Desire for more information particularly from GPs, NHS Direct and the Internet

Prevention
- Place priority on prevention
- Support for local screening programmes
- Weight

Patient Involvement
- Increase patient involvement and develop personal health programmes
- Strong demand for health MOTs

NHS
- Training for staff to be able to communicate health messages consistently
- Leading by example – helping staff to quit smoking, healthy food in waiting areas, help obese staff to lose

Mental Health
- Areas suggested for mental health promotion included healthy living centres, day centres, retirement homes, and young offenders institutions
- Recommended that particular groups should be targeted for mental health promotion

Access to Sexual Health Services
- Demand for easier access to primary care when needed for STIs and reductions in waiting times in genito-urinary medicine
- Better use of informal healthcare settings such as pharmacies, city centres and shopping centres for accessing information about STIs
- Demand for one-stop-shops for sexual health, mobile services and counsellors at times of the day that would suit target groups
- Outreach necessary to take services for STIs to rural areas

Source: Department of Health - Choosing Health Consultation, 2004
Prevention
# Screening services have the potential to save many lives

<table>
<thead>
<tr>
<th>Health Insight Unit</th>
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<tbody>
<tr>
<td>Breast Cancer Screening</td>
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<tr>
<td>- Method of detecting breast cancer at a very early stage by taking an X-ray of each breast (mammogram) which can detect small changes in breast tissue</td>
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<tr>
<td>- The NHS Breast Screening Programme provides free breast screening every 3 years for women in the UK aged 50 and above</td>
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<td>- Around 1.5 million women are screened each year in an attempt to decrease the death toll from breast cancer</td>
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<td>- Estimated that 1,250 lives are save per year</td>
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<td>- Programme has screened over 14 million women and has detected 80,000 cancers</td>
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<td>Cost approximately £52 million</td>
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| Prostate Cancer Screening |
| - Prostate cancer is the 2nd most common cause of cancer related deaths in men |
| - In 1997, 21,748 new cases were found and the incidence rate is 75 cases per 100,000 |
| In 1999, 9,491 men died from the disease |
| - Until there is clear evidence to show that a national screening programme will bring more benefit than harm, the NHS will not be inviting men who have no symptoms for prostate cancer screening |

| Cervical Cancer Screening |
| - Cervical screening is not a test for cancer; rather, it is a method of cancer prevention by detecting and then treating early abnormalities, which could lead to cancer if left untreated |
| - Early detection can prevent 75% of cancers |
| - Computer assisted detection of cervical abnormalities is a possibility in the future |
| - All women between 25 and 64 are eligible for free cervical smear test every 3 to 5 years |
| - 4 million women screened each year |
| Programme costs approximately £150 million a year |

| Colorectal (Bowel) Cancer Screening |
| - Phased in programme from April 2006 |
| - Men and women, aged 60-69 invited to be screened every 2 years |
| - The screening programme can detect cancer before symptoms develop |
| - In the UK, 35,000 people diagnosed each year |
| - In the UK, 16,000 die each year (2nd most common cause of cancer death in the UK) |
| - Programme will cost £37.5 million for the first 2 years [117] |

Source: NHS Cancer Screening Programs, http://cancerscreening.org.uk/index.html
Personal Care
More could be done to encourage self care – poor literacy is a major obstacle for some

- **80%** of health care episodes are handled by the self (2001)\(^1\). **87%** of people reported treating minor ailments themselves [4].
- Minor illness and injuries account for around **75%** of A&E attendances; around **15%** of these attendances have the potential to be dealt with by people themselves [5].
- **64%** of those who have been a hospital patient in the last 6 months say they often monitor their own illness following discharge [2].
- Of those who have a long-term health condition, **82%** say they play an active role in caring for their long-term health condition [2].
- **90%** of the English public appear very interested in wanting to do self-care [2].
- Least active in performing self care [2]: elderly, deprived, ethnic minority groups.
- **1/3** of respondents reported receiving conflicting information about their care from different health professionals, creating confusion and inefficiency in using health services [3].
- **20%** of people cited guidance from care professionals as an important factor that might better enable them to do self care [2].
- The *Public Attitudes to Self Care: Baseline Survey* (2005) stated that more than **1/2** of those who have seen a care professional in the last six months say they have not often been encouraged to do self care, and a **1/3** of respondents say they have never been encouraged by professionals [2].
- A survey of readability of patient information produced by hospices and palliative care units in the UK showed that **64%** of leaflets were readable only by an estimated **40%** of the population [27].
- There is a major Department of Health initiative to support and promote self care.
- The public possess a potential lack of awareness and understanding about performing self care (2005) [4].
- “People get information about health from a wide range of sources beyond the doctor’s surgery – friends and families, stories in the newspapers and magazines or on television, the internet, voluntary sector organisations, public advice centres and libraries, schools, sport centres, and shops [27].

A 2003 national research study for the DfES showed that [27]:
- **5.3** million adults could be described as lacking basic literacy
- More than **1/3** of people with poor or very poor health had literacy skills of entry level 3 or below
- Low levels of literacy and numeracy were found to be associated with socio-economic deprivation
Informal carers – are a critical part of care outside hospital but receive little dedicated support

What do they offer?
Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

Who are they?
12% adult population (6m) are carers - 2001 census
70% of those cared for are 65 years or over
174,995 young people under the age 18 provide care
1.9m people provide 20 or more hours care per week
1.25m provide over 50 hours care per week
58% of carers are women
20% people 50-59 provide some unpaid care
1/3 carers qualify for income support
More likely to be in poor health themselves
3m people combine caring with work – 1in 8 workers

Carers UK asking for carers to have:
- Rights to services and better rights for disabled people
- Information – about rights, benefits, services, medication etc
- Practical help and support
- Co-ordinated services – health, social care, housing etc
- Professionals who understand impact of caring and how to support carers
- Consultation – about decisions that might affect them

What are the key issues?
The number of elderly dependent people without informal care is projected to rise by 80,000 between 1996 and 2021. This may increase the demand for formal health care services, if informal care has a substitution or “preventative” effect on demand [124].
The number of elderly people with informal care is projected to rise by 530,000 over the same period [124].

What are the policy implications?
More research is needed on the extent, if any, of the substitution and preventive effects of informal care on formal care use

How is demand likely to change in the future?
Demand is likely to increase as the population ages
Capacity may dwindle as women become more integral members of the workforce

Gap areas:
What does the public think about them?
What do the professionals think about them?

Complementary and Alternative Medicine (CAM) – many using an add-on to conventional medicine not an alternative

What do they offer?
“CAM is defined as the diagnosis, treatment and/or prevention which compliments mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy, or by diversifying the conceptual frameworks of medicine” [72].

Who uses them?
- In UK rheumatology and dermatology clinics use of CAM is around 40% [69][70].
- 50% of patients in Britain with inflammatory bowel disease use some form of CAM [71].
- There are about 40,000 CAM practitioners in the UK [73].
- Most patients do not use CAM as an alternative to conventional medicine they use it as an add-on to orthodox health care [73].
- Half of all CAM users employ it for prevention rather than treatment [74].

What do professionals think about them?
- The medical profession’s attitude towards CAM has moved from a cynical and negative view to an uncritical, relaxed attitude. However this new conception of CAM has demoted it to the level of a ‘beauty therapy’ ignoring the high effectiveness of some CAM medicines and the adverse effects and complications other CAM modalities create [73].

What is the policy perspective?
- Unsure about the reasons people adopt CAM – disenchantment with mainstream medicine is not the most important role [73].
- The medical profession needs to be given sufficient knowledge about CAM in order to advice patients responsibly [73].

How is demand likely to change in the future?
- A recent survey of GPs by Sheffield University found that 49% of practices offered access to some form of complementary medicine in 2001, compared with 39% in 1995. Almost a third of practices now provide some form of complementary medicine in house [81].

Gap areas:
What does the public think about them?
Community Care
Community Nursing – a key role in managing long term conditions

What do they offer?
The NHS Improvement Plan (2004) described a new role for nurses, community matrons. These experienced, skilled nurses use case management techniques with patients who meet a criteria denoting very high intensity use of health care [96].

Community matrons will identify those whose health is at greatest need and work with patients and their carers to reduce the effects of disease and prevent accidents, dehydration, infections and other conditions that could result in an admission to hospital. Community matrons will also be able to put their patients in contact with NHS-accredited health trainers, who can provide additional practical support to the patient carers on changing their behaviour to prevent further ill health [97].

A difference between a community matron and a community nurse is that a community nurse discharges patients when an episode of care is complete where as community matrons’ caseloads will be there for life [96].

Who uses them?
- For community nurses, in 2003/04 there were 2m new episodes of care and 2.6m different people receiving care – little growth from previous years. The average length of an episode of care is 3 months. This has risen from 2 months in 1998/99 [66].
- General practitioners accounted for over half of referrals to District Nursing Services in 2003/04 and hospital staff accounted for about 1 in 5 [66].
- 68% of contacts are with the over 65’s. Only 2% are with children under the age of 16. 57% of those over 85 are receiving district nursing services [66].
- Data from the General Household Survey 2001/2 on self-reported receipt of services in the preceding month suggests around 425,000 older recipients of community nursing services in private households in England at any time [66].

How is demand likely to change in the future?
Demand is likely to increase with the ageing of the population and as care shifts closer to home

Gap areas:
- What does the public think about them?
- What do professionals think about them?
Occupational Therapy – high vacancy rate

What do they offer?
An occupational therapist engages with clients/patients to enable them to live as independently as possible. They work with a range of people including those who have physical, mental and/or social problems, either from birth or as a result of accident, illness or ageing and are aware of the impact that change in circumstances can have on individuals’ independence and confidence. OTs can either work in the NHS, or be directly employed by Social Services Departments (SSDs) – or jointly employed under the Health Act Flexibilities [125]

What are the key issues?
The main problem for Local Authorities is recruitment and retention – there is a very high vacancy rate (18.2% - England and Wales, April 2004) [125].

How is demand likely to change in the future?
Demand is likely to increase with the ageing of the population and as care shifts closer to home

Gaps:
Who uses them?
What does the public think about them?
What do professionals think about them?
What are the policy aspirations?
Rehabilitation & stroke services – drastic regional variation

What do they offer?
Rehabilitation following a stroke is an interdisciplinary process which provides interventions to reduce impairments, optimise abilities and increase participation. The aim is to improve quality of life by reducing the emotional, functional, cognitive, physical and communication disorders. Stroke rehabilitation includes specialist, detailed assessment, involving the patient and carer in goal planning, providing information, monitoring progress and implementing specific therapies at an intensity appropriate to the needs of the patient [98].

Who uses them?
Each year 130,000 people in England and Wales have a stroke – 10,000 of these are under retirement age [99]
Stroke is the largest single cause of severe disability in England and Wales, with over 250,000 people being affected at any one time [100]

What are the policy aspirations?
The National Audit Office is currently investigating stroke services in England to see whether the NHS is effectively using its resources to:
• prevent stroke
• Provide acute care
• Manage rehabilitation, and
• Integrate health and social care services for people who have suffered a stroke [144].

What are the key issues?
The needs of stroke patients are not being adequately met in the UK at present. Wide variation exists in the quality of services and, in many parts of the country, fewer than 25% of patients receive specialist care in a stroke unit [98].

Gap areas:
What does the public think about them?
What do professionals think about them?
How is demand likely to change in the future?
Demand for physiotherapy services is increasing

What do they offer?
Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being.

Who uses them?
Key drivers of use are being temporarily off sick from work and long-term illness
Around 20% of those who state they have used physiotherapy use it both in general practice and in other settings
Two-thirds of physiotherapy contacts with NHS occur in hospital and a third are provided by PCTs
Being older, female and divorced or widowed are associated with higher use

What are the key issues?
15-30% of physiotherapists work in private practice

How is demand likely to change in the future?
Is likely to increase as the population ages and arthritis increases in prevalence

Gap areas:
What does the public think about them?
What do professionals think about them?
What are the policy aspirations?

Source: Direct Referral to Therapies, David Buck
Speech & Language Therapy

What do they offer?
Speech and language therapists work to assess, diagnose and develop a programme of care to maximise the communication potential of the people under their care/referred to them. Speech and language therapists (S&LTs) also work to support people with swallowing, eating and drinking difficulties [101].

Who uses them?
- Around 2.5 million people in the UK have a speech or language difficulty [102].
- 5% of children enter school with difficulties in speech and language [102].
- 30% of stroke sufferers have a persisting speech and language disorder [102].

Gap areas:
What does the public think about them?
What do professionals think about them?
What are the key issues?
What are the policy aspirations?
How is demand likely to change in the future?
Prison health services are improving

What do they offer?
- Services are delivered in partnership with the local NHS to ensure that prisoners are given a service similar to that which they would receive if they were still living at home in the community [103]
- If the healthcare problem cannot be dealt with at the prison, a prisoner may be moved to another prison that has the facility needed; a specialist can also be called in if needed [103]
- Breast and cervical screening for women as well as family planning and sexual health services [104]
- Special arrangements are made for female prisoners who are pregnant [104]

What are the key issues?
- 66% of women in prison were assessed as having a neurotic disorder (in the community this figure is less than 20%) [104]

What are the policy aspirations?
- By 1 April 2005, all prisoner health care will be commissioned by local PCTs [105]
- Significant stage in the process to bring improvement to prisoner health services and ensure that the same quality and range of services as the general public [105]
- Effective healthcare can make a significant contribution to the health of individuals, as improve their capacity to benefit from education, drug treatment and other programmes [105]

How is demand likely to change in the future?
- Number of women in prisons is growing and they place a greater demand of medical services than men do [2]
  - Approximately 20% of women prisoners ask to see a doctor or nurse each day (this is twice as many as men) [104]

Gap areas:
What does the public think about them?
What do professionals think about them?
Chiropody/Podiatry – recruitment is difficult

What do they offer?
Chiropodists (now often called Podiatrists) diagnose and treat abnormalities of the lower limb. They give professional advice on the prevention of foot problems and on the proper care of the foot.

Who uses them?
2003/04: 788 000 (initial contacts)
3.5 % fewer than in 2002/03 [59].
High user groups: older people: 81 episodes per 1000 of the pop aged 80 + [59].
Low user groups: young people - 6% children aged 5 – 15
Initial contact rates vary widely across SHAs [59]

What are the key issues?
• Once accepted for treatment, patients are treated for life – demand is managed by ratcheting up the criteria for treatment, so that fewer patients are eligible for treatment [125].
• The profession has a large private sector (difficult to assess but probably something between 50% to 75% of staff, less activity), which carry out distinct functions to that of NHS podiatrists [125].
• Recruitment to the profession is difficult because of the perceived low status of podiatrists and the case mix, which are elderly, ill people [125].

How is demand likely to change in the future?
It is likely to increase as the population ages

Gap areas:
What does the public think about them?
What do professionals think about them?
What are the policy aspirations?
### Community Hospitals

**What do they offer?**
- Local hospitals, units or centres whose role is to provide accessible health care and associated services to meet the needs of clinically defined and local population [118]
- 480 community hospitals in the UK [89].
- 70% of these community hospitals offer a minor injuries or casualty service [89].
- These units tend to be staffed by nurses with increasing numbers of nurse practitioners and emergency nurse practitioners [89].
- Major role in rehabilitation, palliative care, health promotion, diagnostic, emergency, acute and therapeutic services [118]

**What does the public think about them?**
- Patient surveys have indicated consistently high levels of satisfaction with staffing by nurses [89].

**What do professionals think about them?**
- BMA fighting for better remuneration for community hospital support
  - GPs working in Community hospitals are underpaid and feel undervalued and exploited (2004) [42].
  - Community hospitals cause considerable disruption to GPs’ practices, not simply because it is work over and above that which is required for general practice, but because community hospital work can be disruptive in the running of daytime GP surgery activities (2004) [42].
  - A survey conducted by the BMA in 2004 highlighted that 85% of GPs deal with calls outside their normal community hospital sessions (2004) [42].

**Policy context:**
- Have a significant role in the evolution of intermediate care and in alleviating the pressures on larger specialist hospitals [118]
- Steady expansion in the number of both community hospital sites and beds across the UK [119]

**Gap areas:**
How is demand likely to increase in the future?
Community Mental Health Services – poor access to crisis care

What do they offer?
- A multi-disciplinary team offering specialist assessment, treatment and care to people in their own homes and the community [132]
- Team should involve nursing, psychiatric, social work, clinical psychology and occupational therapy membership, with ready access to other therapies and expertise [132]
- Work with other specialist teams covering early intervention [132]
- Provides the core of local specialist mental health services [132]
- Users are more likely to stay in contact with community services rather than hospital based services [132]

What does the public think about them?
- “In 2004, ¾ of service users rated the care they received as excellent, very good or good. Service users were most positive about communication and relationships with clinical staff, such as being treated with dignity and respect, being listened to, and having confidence and trust in psychiatrists, nurses and other clinical staff. The importance to service users of relationships with clinical staff was further highlighted by comments from respondents, and by the relatively more positive responses from those service users who had greater continuity of contact with an individual psychiatrist [33].
- 72% respondents in primary care were not asked about any emotional issues that may be affecting their health [29].
- In 2004 less than ½ of all service users had access to crisis care, for example, the phone number of someone in the mental health service that they could call out of hours. In some trusts only a quarter had access to crisis care [33].
- In 2004 only ½ users had been given (or offered) a written or printed copy of their care plan, and only a half had received a least one care review in the previous 12 months [33].
- In 2004 2/5 of respondents reported that they had at least one appointment cancelled or changed in the previous year [33].
- In 2004, 1/3 of people had not had help with finding accommodation, and more than ½ had not had help with finding work. However more than 2/3 of respondents reported receiving help with getting benefits. In other words, the findings from the survey suggest that mental health services could do more to address the social needs of service users [33].

What are the key issues?
Need stronger links between drug/alcohol services & community mental health services; suicide prevention strategy [132]

What are the policy perspective?
Action on mental health must be integrated into all local delivery systems [132]

Gap areas:
What do professionals think about them?
How is demand likely to increase in the future?
Sexual Health – a long wait for services

Who uses them?
The number of visits to genito-urinary medicine (GUM) Departments in England have doubled over the last decade – visits now stand at over a million a year [78]. There is a strong link between social deprivation and STIs, abortions and teenage conceptions [78].

Sexual ill health is not equally distributed among the population. The highest burden is borne by [78]
- Women
- Gay men
- Teenagers
- Young adults
- Black and minority ethnic groups

What do they offer?
The NHS provides a comprehensive range of sexual health services - including GUM clinics, community family planning clinics and services in primary care [78]

What the public think about them?
- 28% of people who need to be seen urgently are currently waiting more than 48 hours for an appointment at a clinic [86].
- 29% of people who have symptoms of sexual infection are waiting more than two weeks [86].

What are the policy aspirations?
By 2008, everyone referred to a GUM clinic should be able to have an appointment within 48 hours [145]

How is demand likely to change in the future?
Demand is likely to increase in the future as sexual risk-taking is increasing across the population [145]
Sexual Health – significant variations in the way services are provided, affecting the quality of services and access to them

What are the key issues?

- Pressure on sexual health services have led to **long delays** in accessing services [78].
- Sexual Health Services provided by the NHS are too often fragmented, **poorly advertised** and too narrowly focused [78].
- **Access** is a problem in some areas of the country, especially rural areas [78].
- Information about sexual health is often **out-of-date** or simply not available [78].
- Opening times for clinics cause difficulties for people, with about half of NHS clinics in the UK advertising opening times of **less than 21 hours** a week [78].

**Gap areas:**

What do professionals think about them?

Source: [78]
School Nursing – a potentially important role in health promotion but currently stretched thinly

What do they offer?
The role of the school nurse is to fulfil functions such as immunisation, providing health education, tackling bullying and promoting children’s emotional well being [106].

Who uses them?
Number of School Nurses – 2,500 [58]
Number of School Children – 8 million [58]
1 nurse per 3,200 children [58]

What do professionals think about them?
• Not enough school nurses - only 17% of respondents felt that there were enough school nurses in their area [58].
• Nearly two-thirds of the survey also thought that their workload was too heavy [58].
• Nearly two-thirds of respondents were unhappy with the resources available to them [58].
• Over half felt that they were ‘stretched too thinly’, and unable to provide a good enough service to pupils [58].
• More than three-quarters felt that they were not paid well enough for the demands and responsibilities of the job [58].
• The lack of career progression was an issue for 75% of people, and almost a quarter were unable to take time off to undergo further training. Many also faced difficulties getting funding for training [58].

Dr Beverly Malone, General Secretary of the RCN, said:
"It’s clear from our survey just how few school nurses we have. We know that in many parts of the UK children do not have access to an adequate school nurse service, and this is simply unacceptable. School nurses do a wonderful job under difficult circumstances.
"School nurses of today are not just about sick bays and nits. Their job covers a gamut of responsibilities from immunization, health promotion and child protection through to counseling, sexual health and drugs education. They also play an important role in social inclusion such as working with children with special needs, and promoting educational attainment.“ [58].

Gaps areas:
What does the public think about them?
What are the policy perspective?
What are the key issues?
Ophthalmic services

What do they offer?
- 17.2 million sight tests paid for in Great Britain (33.6% were private)
- Full time optometrists worked on average 38 hours, 21 minutes a week
- 8,594 practising optometrists in GB

How is demand likely to change in the future?
- Demand may be affected by the increase in NHS sight test fee, optical voucher values and supplements and the income threshold for entitlement to NHS sight tests and optical vouchers [146]

What is the policy perspective?
- The overall acceptability of General Ophthalmic Services (GOS) is to be taken over locally by those responsible for the quality of primary care service [147]

What are the key issues?
- There is an opportunity for optometrists to provide screening services for diabetes and for hypertension [152]
- Optometrists are in an excellent position to identify socially isolated older people and older people who are at risk in their own homes as a result of failing vision [152]

Gap areas:
Who uses them?
What does the public think about them?
What do professionals think about them?

Intermediate Care – number of beds rising

What do they offer?
Aim is to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living. Intermediate Care beds (beds for older people who would otherwise have to stay in hospital or move into a care home) continue to rise [87].
There are now 8,928 intermediate care beds in England up from 7,493 in 2002/03 [87].

Who uses them?
Primarily elderly people
Targeted at people who would otherwise face unnecessarily prolonged hospital stays or avoidable admission to acute in-patient care, long term residential care or continuing NHS inpatient care.

What does the public think about them?
Want care closer to home.

What are the key issues?
The gap between acute hospital and primary and community care needs to be closed; this is the rationale for intermediate care.

How is demand likely to change in the future?
Will likely increase as the population ages.

Gap areas:
What do professionals think about them?
What are the policy aspirations?

Source: Department of Health: National Service Framework – For Older People, March 2001
Health Insight Unit

Increases to palliative & end of life care are needed to fulfil patient requests

What do they offer?
“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” [60]

Who uses them?
Around 25% of the 520,000 annual deaths in England and Wales involve some form of palliative care [60].

What does the public think about them?
Most studies indicate up to 56% of people would prefer to die at home but only 20% actually do

What are the key issues?
“Many patients prefer to be able to die at home, but in practice only a quarter are able to do so, as a lack of community or specialist palliative care teams in some parts of the country conspires with inconsistent access to out-of-hours nursing care to prevent their wishes being met.” : NHS Cancer Plan (2000)

<table>
<thead>
<tr>
<th>Where people want to die (%)</th>
<th>Where people die (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>56</td>
</tr>
<tr>
<td>Hospice</td>
<td>24</td>
</tr>
<tr>
<td>Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Residential</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>


How is demand likely to change in the future?
Demand is likely to increase as cancer rates increases; yet, mortality rates are decreasing

Gap areas:
What do professionals think about them?
What are the policy aspirations?

Social Care
Vision from *Independence, Well-being and Choice*

The vision for the future of adult social care in England as identified in *Independence, Well-being and Choice*:

- Ensuring that, wherever possible, adults are treated as adults and that the provision of social care is not based upon the idea that a person’s need for care reduces them to total dependency [90].
- Ensuring that people using services, their families and carers are put at the centre of assessing their own needs and given real choice about how those needs are met [90].
- Improving access, not only to social care services, but to the full range of universal public services [90].
- Shifting the focus of delivery to a more proactive, preventive model of care [90].
- Recognising that carers also need support and that their well-being is central to the delivery of high quality care [90].
- Empowering the social care workforce to be more innovative and to take the risk of enabling people to make their own life choices, where it is appropriate to do so [90].
Resources

• In England during 2004/05, approximately £14.4 billion of public funds will be invested in social care [90]
• Of which £10.6 billion is for services for adults [90].
• Investment in personal social services will be £1.8 billion higher by 2007/08 representing an annual average increase of 2.7% in real terms above that of 2004/05 [90].
• Important contribution from those who pay for services themselves – an estimated 30% of adults pay for services themselves [90].
Social care statistics show moderate growth in activity and growth of direct payments

% change between most recent 2 years (%)

Source: DoH data – Non-residential Care for Adults in England, 2000-01 – 2003-04
Residential care places have grown while nursing home places have recently fallen

Source: Laing & Buisson
Residential and nursing care – concerns about quality and growth in extra care housing

What do they offer?
In 2004, 202,180 people were supported in residential and nursing care homes [10].
22,910 care homes for adults in England during 2003 [15].
13,455 care homes are for older people 2003 [15] providing 370,000 places in England – occupancy rate is around 91% [92].
Only 3 in 10 people who need personal care pay for some or all of the services [19].

Who uses them?
Older people, people with physical and learning disabilities, people with mental health problems.

What are the key issues?
Volatility in market. In some areas significant lack of choice – particularly for people with dementia. Poor information for residents. Poor recruitment and training. Poor physical environment. Poor medication management [89].

The private sector also provides the vast majority of the 538,000 places in residential and nursing homes. This sector is forecast to increase substantially in the longer term, given the current policy emphasis on expanding intermediate care services for the elderly and demographic changes. However, cost pressures such as the impact of the Care Standards Act have led to falling capacity in recent years and predictions of further closures in the short term [62].

How is demand likely to change in the future?
Likely to increase as the population ages.

Gap areas:
What does the public think about them?
What do professionals think about them?
What are the policy perspective?
Extra Care Housing – modern day alternative to residential care

What do they offer?
Extra Care Housing has been developed to give choice to very frail or disabled people whose care needs might traditionally have been met by residential care [90].
Extra Care Housing is a modern day alternative to residential care. Unlike residential care, extra care housing provides independence and choice, with the person having their own flat and able to choose the services they receive [14].
Extra Care Housing supports independent living and increases choice by providing older people with their own homes together with care and support that meets their own needs. Extra Care Housing schemes can provide 24-hour support, meals, domestic help, leisure and recreation facilities and a secure environment [91].
In 2003 there were 25,500 extra care housing places in England [14].
Allows people to live in their own homes with a range of facilities and support designed to meet their needs [90]
Range of intermediate care and outreach services, preventing older people from going into hospital or facilitating the discharge of those who have been in hospital [90]

Who uses them?
Elderly, frail and disabled

What are the key issues?
There is no single model or definition of Extra Care Housing. As a relatively recent innovation, models are still evolving. However, a code of practice is currently being developed by the Department of Health, Housing Corporation and the Office of the Deputy Prime Minister [14].

According to Laing and Buisson, it is still unclear whether extra-care housing is more or less expensive than residential care or dispersed home care. However they do assert that ‘there are early indications that very-sheltered housing may reduce the incidence and duration of admission to hospital’ [93].

Gap areas?
What are the policy aspirations?
How is demand likely to change in the future?
What does the public think about them?
What do professionals think about them?
Home care packages – increasingly supporting intensive home care

What do they offer?
3.38 m contact hours provided in 2004 [63]
Over 355,000 households received home help or home care in 2004 [63]
4121 Domiciliary Care Agencies registered in March 2005 [10]

Public and Private Provision:
- Between 1999 and 2003, the number of households receiving services has decreased by 11% [94]
- Since 1998 the number of households receiving intensive home care has risen by 43% [95]
- Between 1999 and 2003, the number of contact hours provided has increased by 16% [94]

Who uses them?
Older people are the greatest users of home care packages

What are the key issues?
Problems in staff recruitment. Changes of staff and inconsistent standards [92]

How is demand likely to change in the future?
Will likely increase as the population ages

Gap areas:
What does the public think about them?
What do professionals think about them?
What are the policy perspective?
Social care services for adults 18-64

An estimated 480,000, about 28%, of those receiving services were aged between 18 and 64. This means about 2% of people aged 18 to 64 in England received a service during 2003-04. The chart below shows the different primary client groups of the people aged 18 to 64 receiving a service [92].
Social care services for older people

An estimated 1.25 million, about 72%, of those receiving services during 2003-04 were aged 65 and over. This means about 16% of people aged 65 or over in England received a service during 2003-04. The chart below shows the different primary client groups of the people aged 65 and over receiving a service [92].
Services for adults with disabilities

Who uses them?

- It is estimated that as many as 800,000 people over the age of 20 have a learning disability [90].
- Predictions estimate that the number of people over the age of 20 who have learning disabilities will rise by 14% to over 900,000 by 2021 [90].
- The number of people with severe learning disabilities may increase by 1% per annum for the next 15 years, with growing numbers of children and young people with complex disabilities surviving into adulthood [90].

Gaps:

What do they offer?
What does the public think about them?
What do professionals think about them?
What are the key issues?
What are the policy aspirations?
How is demand likely to change in the future?
Social Care Users Experience – need for better co-ordination with health care

The most recent assessment of social care users experience is the report “All our lives: Social Care in England 2002-03”.

The report showed that in 2002/03:
72% - social care users said service received “excellent” or “good” (Joint review surveys)
57% - home care users – “extremely” or “very” satisfied with help from social services.

The report highlighted considerable inconsistencies between councils, some users having very poor experiences, and that satisfaction rates around race, culture or religion were consistently poor. Key message from user feedback was a desire for social services departments and other agencies to work together in users interests and co-ordinate services.

“Adult service users find it difficult to understand why the links between health and social services seem so difficult to achieve.”

Care of Older People The report highlighted a shift towards people being cared for in their own home, and in innovative extra care housing schemes. The numbers of delayed discharges from hospital had fallen, with improvements in services to support discharge. The report also highlighted the following problems:

• Older people are not well informed about their entitlements and can find it hard to make contact with the services that might help them.
• Weaknesses and delays in the arrangements for assessing people’s needs and organising services for them.
• Too few older people offered direct payments to purchase their care themselves
• Continuing closure of care homes creating a shortage of placements in some regions, and reducing choice
• Services for older people with mental health problems requires considerable further improvement
• Lack of small-scale support with transport, community activities and adaptations and equipment can reduce people’s ability to lead a full life.
Social Care Workforce – poor training levels

• Current national vacancy rate across the social care workforce is 11% - 110, 000 unfilled posts [90].
• The workforce in general still has a poor level of training. It is estimated that no more than 25% of the workforce has a relevant qualification [90].
• In February 2005, TOPSS England became Skills for Care, a constituent council of the new UK SSC for social care, children and families. One of the key tasks of this new council is to ensure improved workforce planning [90].
• Demographic changes will create pressures for a growing workforce if care continues to be delivered in traditional ways – important to develop and introduce different models of service delivery such as Telecare [90].
Telecare – huge potential to support individuals to live at home and complement traditional care

An example of Telecare:
The home is fitted with a small number of sensors that monitor movements and activities and are able to detect such things as the person not getting up in the morning, abnormal usage of the cooker or fridge, or whether the person has not moved for a long time. People can be reminded to take their medication, and if the automatic monitoring system detects a problem, a telephone call can be made to the person to check or to alert a carer [90].

- Early studies indicate that investment in telecare services can have a significant impact on reducing the need for residential care, unlocking resources to be directed elsewhere in the system [90].
- Telecare can give carers more personal freedom and more time to concentrate on the human aspects of care & support [90].
- Telecare will help to meet potential shortfalls in the workforce [90].
- The Government is currently planning to make £80 million available for two years from 2006 to local authorities to stimulate this transformation [90].
Improved Information Sharing & coordinated responses

*Independence, Well-being and Choice* identified that improvements with the early identification and response to people’s needs should be achieved through better assessment and information sharing between local councils and NHS services.

An example of the success of this approach can be sought from the single assessment process for older people. The single assessment process is based upon a locally-agreed approach to overview assessment when people come into contact with health or social services [10].
Primary Care
Pharmacy services are in high demand

What do they offer?
Dispensing of prescriptions, provision of pharmacy medicines, information and support/advice for preventative services, medicine management, chronic disease management, simple screening, promotion of self care, sexual health advice and support services [152]

Who uses them?
Evidence from the Health Survey for England shows some marked differences in rates of medication use amongst different groups

The elderly, those with long term conditions, and the more deprived are high user groups
  Taking prescribed medications
  • 86% **75+ year olds** vs 22% 16-25 year olds
  • 49% **women** vs 40% **men**
  • 43% bottom quintile **income** vs 30% top quintile
  • 49% those **without car** vs 35% those with a car
  • 56% **low exercise** vs 31% high exercise
  • 54% of those **obese** vs 33% not obese

What are the key issues?
• Poor adherence to medicine has significant economic and clinical consequences
• 30-50% of prescription medicines are not taken as directed and 20% don’t even make it out of the package [122]
• Each year unused medicines returned to pharmacies worth about £100 million [123]
• Estimated that 10,000 heart attacks, 5,000 deaths and 1,000 operations would have been avoided had those who had been prescribed statins (cholesterol-lowering drugs) been taken as directed [122]

Gap areas:
• What does the public think about them?
• What do professionals think about them?
Community pharmacies are extremely accessible

- 79% of people in Great Britain have a CP within 1 km of their home; 47% have a CP within 500 m
- 86% consider access to a CP easy to get to from their GP
- 98% of GPs have a CP within 1 km; 75% have one with 300 m
- Average independent pharmacies are open for around 50 hours a week whereas supermarket pharmacies tend to be open for 80 hours per week on average

Location of community pharmacies in Great Britain

Contractor pharmacies in the UK, 2002

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Number of outlets</th>
<th>Share of total outlets (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lloydspharmacy</td>
<td>1,321</td>
<td>10.9</td>
</tr>
<tr>
<td>Boots the Chemists</td>
<td>1,268</td>
<td>10.5</td>
</tr>
<tr>
<td>Moss Pharmacy</td>
<td>773</td>
<td>6.4</td>
</tr>
<tr>
<td>L. Rowland &amp; Co</td>
<td>300</td>
<td>2.5</td>
</tr>
<tr>
<td>National Co-operative Chemists</td>
<td>290</td>
<td>2.4</td>
</tr>
<tr>
<td>Superdrug</td>
<td>228</td>
<td>1.9</td>
</tr>
<tr>
<td>Tesco</td>
<td>210</td>
<td>1.7</td>
</tr>
<tr>
<td>Cohens Chemist Group</td>
<td>107</td>
<td>0.9</td>
</tr>
<tr>
<td>Sainsbury’s</td>
<td>107</td>
<td>0.9</td>
</tr>
<tr>
<td>Safeway</td>
<td>105</td>
<td>0.9</td>
</tr>
<tr>
<td>Asda</td>
<td>80</td>
<td>0.6</td>
</tr>
<tr>
<td>Others</td>
<td>7,335</td>
<td>60.4</td>
</tr>
<tr>
<td>Total</td>
<td>12,124</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Overall satisfaction with primary care is high - People under 45, those living in London, and from ethnic minority groups are less satisfied

- DH MORI polling shows net satisfaction consistently over 70%, though British Social Attitudes survey shows rating has fallen in last ten years 83% (1993) => 72% (2003) “very/quite satisfied with local GP” [52] & [48].
- The young are significantly less satisfied than the old. In 2003 63% 18-33 year olds vs 85% aged 65+ were “very/quite satisfied with local GP” [48].
- Londoners are markedly less satisfied than rest of England. In 2004 51% London vs 66% rest of England rated the care they received from their GP in past year as “excellent/very good” [29].
- Satisfaction amongst ethnic minority groups is lower data from 1998 & 2002 [56].
- Satisfaction in women slightly less than in men – 15% women vs 11% men had felt like making a complaint about the GP or other practice staff in past 12 months – 2002 [56].
- There were very few differences in views between patients from different social classes – data from 1998 & 2002 [56].
Access to GP services can be difficult – people want extended opening hours

- Patients want flexible appointment systems which give them rapid access, but which also allow them to book ahead [47].
- Patients want to be able to get through on the phone more easily, and to be able to get advice from a health professional – some patients would value newer methods of communication (eg. Email communications or the internet) [47].
- Patients are less satisfied with the availability of telephone contact with a clinician and simply the ability to contact the practice by telephone [93].
- In 2004, 43% felt they should have been seen “a bit/a lot” sooner [28].
- In the 2002, 53% of respondents said that their last visit to a GP was “urgent”. This figure +/- 2% was consistent across men and women, and between 1998 and 2002 [50] & [51].
- In 2004, 23% had to wait more than 2 working days to see the doctor [28].
- In December 2004, 25% of people felt that length of time to get a GP appointment was the issue that most needed improving in their local area [52].
- In 2004, 22% said that they had been put off going to the GP/health centre “completely/to some extent” because the opening times were inconvenient [28].
- In 2002, 21% had visited A&E because a GP was not available. When London is broken out the figure falls to 19%, but is 30% for London [29].
- Most common reasons for using alternatives to possible GP services were the perception that the GP may not be able to help, more convenient opening hour and wait at the surgery [National Patient Experience Survey]
- A people’s panel conducted by the Cabinet Office in 2000
  - 1/3 wanted surgeries to have extended opening hours during the week
  - 1/5 wanted surgeries open on Saturdays
  - 1/10 wanted surgeries to be open 24/7.
Continuity of care a key facet of general practice - 75% of people have been with their GP for more than 5 years

A survey about what patients think their health professionals and their practices was conducted by CFEP between April 2004 and March 2005. The results displayed that patients seeing their usual clinician rated communication skills higher than patients seeing someone else, thus emphasising the importance of the continuity of care [93].

Source: NHS General Practice Survey 2002, DH
Closed lists are a problem in some areas – particularly London. Access targets have reduced people’s choice of GP

Closed Lists
- In parts of London CHI found that 80% of general practices were not registering new patients. 2004 [30].
- 314 practices had closed lists in July 2005 covering 1.42 million people *

Choice of doctors
- 79% in England happy with choice of doctor, but when London broken out, rose to 81% compared to only 69% in London. 2004 data [29].
- 30% said “fair/lot of improvement” needed in choice of GP. Dec 2004 [52].

Choice of GP within a practice (92% people in a group practice)
- Rise from 26% (1993) to 43% (2003) in the % feeling that “choice of which GP to see” requires improvement. Those with children were markedly more likely to feel that improvements were needed in choice of GP than those without [48].
- The evidence suggests that speedy access to a GP is sometimes at the expense of patient choice; for example, patients wishing to see a particular doctor sometimes wait much longer (up to three weeks) for an appointment. CHI 2004 [30].
- 41% said they had waited to see a doctor of their choice. 2004 [28].
- Choice of GP is more important to women. 28% of women vs 18% of men said that “there is at least one GP in my GP practice that I do not like” 2002 [56].
- 58% of women and 30% of men feel it is “very/fairly important” to see a GP of their own sex. 2002 [56].

Better Information about Practices
- Patients want information about practices presented in a clear and concise way – providing background information, better information about staff, and the services available [47].
- Patients only want to see limited performance data and they do not like the idea of practice league tables [47].

* Capacity in primary care: Analysis of July 2005 data from Primary care access survey
Recommendations of the Choice Consultation on Primary Care – more personalised services

Health Promotion & Self Care
- Patients want to choose how much they self care and self manage.
- Patients want to staff and the NHS to provide the information and support they need to perform self care.

Communication
- Patients/users/carers want to be able to choose appropriate means of communication (e.g., languages including sign and Braille)
- Access to an interpreter should be available alongside a choice of interpreter by race and gender
- Health records should clearly display the individual’s communication/cultural needs
- A culturally sensitive service should be available to meet the needs of a multicultural society

Location and Professional
- Patients want a choice of access to, and location of primary care services
- Patients want to access a health care professional at a time and place that suits their need and preference to reflect their working patterns
- Patients want information about the performance and effectiveness of practitioners to enable the individual to have a sense of ‘being in control’
- Patients are looking for primary care service where you don’t need to book ahead, short waiting times when you get there and face to face contact with a health professional* 

Continuity
- Have equal opportunity to choose a provider that offers the continuity of care that best suits their needs
- Relative to other groups, people with children and people with long-term condition tend to value continuity of care above choice of providers

Medicines
- Choice of access to prescriptions and medicines to respect housebound, working patterns, locations near work and home

* MORI data on patient choice
Primary care currently offers variable access to GPs – some data suggests high numbers of closed lists or “open-but full” lists

- At least 14% of GP lists nationwide are closed to new registrants.
- PCTs are able to override closed lists and allocate people to practices: one large urban PCT allocated 30% of registrants in 2004.
- Areas experiencing significant population growth also tend to suffer from actual GP shortages.
- Vacancy and distribution indicators from General Practice reveal aspects of a complex system progressively less able to provide GPs in needy areas.
- Increasing the numbers of GPs has not altered their fundamental maldistribution in England.
- In parts of London 80% of general practices had closed or ‘open but full’ lists in 2004.

For choice in healthcare to work, the public will need better information and support

- I would like to make the decision with advice: 60%
- The GP should be making the choices: 22%
- I would like to be able to make the decision myself: 13%
- Don't know: 3%
9.6 million people would want to exercise choice quickly

Factors associated with wanting choice:
• Be from a minority ethnic group
• Be aged under 30
• No have children
• Have difficulties getting to their current GP
• Be registered with a surgery with a single GP
• Be trying to exercise choice under the current system because of worries over quality of their current provision

Factors not associated with wanting choice:
• Whether someone had a long-term condition
• Their gender
• Whether they were working and their social class
• The frequency with which they visit GPs

Patient dissatisfaction is likely to be the key driver of whether people exercise choice in primary care

Source: Analysis of recent MORI data on patient choice
Many quality of care indicators in primary care are high.

2004 NHS PCT Survey Responses

- Did you have confidence and trust in the doctor?
- Did the doctor treat you with respect and dignity?
- Were you involved as much as you wanted to in decisions about your care and treatment?
- Did the doctor explain the reasons for any treatment or action in a way that you could understand?

DH MORI Polling December 2004

- The friendliness of staff
- The length of time staff spent with you
- The quality of care provided
- The explanations that staff gave you about your illness and its treatment

- Yes, to some extent
- Yes, completely/definitely/all of the time

- Fairly satisfied
- Very satisfied
Involvement in treatment decisions and review of medications in primary care require improvement

- Overall ratings of key quality indicators are generally high but concerns about quality of care may be rising. In 2003, 34% felt the quality of GP medical treatment needed improvement vs 23% in 1993 [48]. This finding is at variance with DH MORI polling (conducted with smaller sample) which suggests no change in level of concern [52].

- The 2004 Commonwealth Fund survey [29] showed lower ratings than MORI for involvement in treatment choices. 50% said they were “sometimes, rarely or never” told “about treatment choices or asked their opinion”.

- Medication explanation and review requires improvement. 24% had not had their long term medications reviewed (in last year). (2004 [28]) The Commonwealth Fund [29] showed the UK to be the worst amongst Aus/Can/NZ/USA.

- 39% wanted more information about medication side effects. (2004 [28])
Nurses in primary care – high satisfaction ratings in the public

The 2002 General Practice Survey [51] indicated that the proportion of patients seeing a nurse was rising. In the last 12 months 55% of respondents had seen a nurse vs 52% in 1998.

As in 1998, the survey showed that patients experience of nurses was very positive (and echoes other qualitative research).

- 88% felt that nurses had answered all their questions
- 92% felt the nurse knew enough about their condition
- 98% felt all the nurses action were appropriate
- 97% said that nurses were easy to understand
- 99% felt that nurses had treated them with dignity and respect.
More needs to be done to support continuity across the whole care pathway

There are significant delays between primary and secondary care
- 11% of respondents said they had been referred too late.
- 20% of respondents had not been given a clear explanation of why they had been referred.
- 25% of respondents had to wait more than three months to be seen by a specialist.
- 38% of respondents said their condition got a “little/a lot worse” while waiting.
- 14% of respondents were in “a lot” and 39% “some pain” while waiting to be seen by a specialist.

Source: 2002 General Practice survey [51]

There is a lack of communication between hospital and GP.
- 32% of respondents said GP had not been informed after they had visited A&E. 2004 [29].
- 27% of respondents said the GP had not been informed after their admission to hospital 2004 [29].
- 12% of respondents said the specialist to whom they had been referred did not have the necessary information. 2002 [51]
Outreach schemes for specialist consultations improve access

A study performed in 1997 compared specialist outreach clinics (hospital based consultant clinics in non-hospital settings) with outpatient clinics.

**Patient views from the results showed:**
- Greater satisfaction for the outreach patients with the clinic process in terms of convenience, location, environment and staff attitudes
- Outreach patients had significantly lower mean waits, 6.8 weeks less, for clinic appointments than out-patients
- Outreach patients had shorter distances to travel, 12 miles less
- Outreach patients had shorter travel times, 36.7 minutes less
- Outreach patients had shorter waiting times at the clinic of 15.5 minutes less

**Professional’s views of outreach services:**
- Outreach improves patient access and convenience
- Considered worthwhile by 88% of specialists and 96% of GPs
- Broadening of skills as a result of outreach was reported by 40% of GPs
- Specialists reported conducting educational sessions for the GPs at 65% of the outreach practices

**Policy Perspective**
- Decrease in referral to out-patients since the establishment of outreach

**Issues**
- Introduce a two-tier system with outreach patients having preferential treatment – 56% of the specialists put outreach patients on the normal waiting lists

Source [83]
Quality of the environment in primary care requires improvement

- No national statistics on the quality of GP premises, other than NHS owned premises, or information via Healthcare Commission PCT inspections.

- In all but three reviews, CHI found problems in the physical suitability of some premises. *Too often the clinical environments are old and outdated or not designed for the needs of the modern healthcare.* …*In some general practices CHI saw cramped reception areas, poor access for disabled patients and space restrictions.* 2004 [30]

- 75% said surgery health centre “very clean”, 25% fairly clean – 2004 [28].

- Privacy is an issue – One in five CHI reviews [30] found that private conversations can be overheard in general practice reception areas.
Qualitative Research on the emotional experience within primary care

In 2003 Opinion Leader Research undertook some qualitative research for the Department of Health to help develop a “patient experience statement” which encapsulates how patients would like to experience the NHS, with a focus on the emotional responses rather than the physical aspects of the experience. The research involved a mixture of workshops, focus groups and one to one interviews. The total sample size was not large but drawn from a mix of urban and rural areas. The key findings are shown below. Some, but not all the findings match the quantitative data.

<table>
<thead>
<tr>
<th>What hoped would happen</th>
<th>What actually happened</th>
<th>What would need to change</th>
</tr>
</thead>
</table>
| **Arranging an appointment**
  Fast appointment
  See own GP
  Friendly service & understanding receptionist | **Arranging an appointment**
  Some waits
  Mixed response
  Too many questions from receptionist | **Arranging an appointment**
  24 hour service
  Choice of GP
  Welcoming receptionist |
| **Waiting room/reception**
  Nice facilities
  Quick response
  No waiting/delays | **Waiting room/reception**
  Mixed experience
  Judged by receptionist
  Long waiting/delays | **Waiting room/reception**
  Improved modern facilities
  Seen on time |
| **GP consultation**
  Analysis of problem & answer
  Sufficient time to explain symptoms
  Taken seriously
  Treatment there and then | **GP consultation**
  Mixed experience
  Insufficient time | **GP consultation**
  Advice on health issues more generally
  Not rushed – more than 5 minute consultation |
| | Good nursing treatment
  Referrals | |
GP Summit 09/06/05 – Key Elements Of Family Medicine to Keep

- Community Base
- Registration of patients
- Continuity of Care
- Maintain the GP as advocate and navigator of registered patient list
- Generalist base for family medicine
- Holistic approach
- Practice team
- Systems promoting therapeutic practice
- Payments for Equality
- Practice Base Commissioning
GP Summit 09/06/05 – Key Elements Of Family Medicine to Change

- Integration and expansion of services (e.g., social care and diagnostics) alongside extending GPs ability to manage patients in Primary Care
- Improve access and increase responsiveness to patients
- Improve patient empowerment, education and responsibility
- More obligations to visit registered patients at home or use other means
- Professionalise receptions, have interpreters and information for patients at their fingertips
- Improve GP premises
- Increase E-communication
- New patient/doctor relationship having the right to say if the list is open/closed
- GPs more valued
- Address the poor skill mix
- Reduce Inequalities
- Commissioning
- Change PCT Focus
Some primary care professionals perspectives

- There are still too few GPs (2005*)[37]
- There is a problem with the under-funding of GP trainers and training (2005*) [37]
- “Many single handed and small practices will find it very difficult to compete in providing an extended range of services or in replacing retired partners in future unless they actively co-operate with other practices under the umbrella of a primary care group or primary care trust.” (2005*)[35]
- “Need to improve primary care in hard hit areas where recruitment can be difficult. First class primary care to support under-served and marginalised communities will be critical to tackling health inequality.” (2005)[36]
- Reducing the variations in quality between GPs, upwards rather than towards lowest common standards, is one of the most urgent problems facing the profession. “There is a considerable gap between the very best and the least good in general practice.” (2005*)[38]
Doctors need to be better engaged in the choice agenda

GPs think patients already have choice

GPs think choice will increase their workload

- Information about treatment
- Choice of medication/treatment
- Choice of hospital for operation
- Choice of surgeon

% Polled - MORI/BBCHA 20000

GPs polled by MORI/BBCHA 2003

<table>
<thead>
<tr>
<th>Decrease</th>
<th>Increase</th>
<th>Stay the same</th>
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<tr>
<td>10%</td>
<td>88%</td>
<td>2%</td>
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GPs think patients already have choice:
- Information about treatment: 2%
- Choice of medication/treatment: 88%
- Choice of hospital for operation: 10%
- Choice of surgeon: Decrease

GPs think choice will increase their workload:
- 88% Increase
- 10% Stay the same
- 2% Decrease
Quality of care in General Practice is highly variable and rarely meets accepted standards

Variations in appropriate prescribing identified by medical literature reviews...

Reporting of prevalence rates for some chronic conditions across General Practice is highly variable

Birmingham & the Black Country SHA: GP-reported prevalence of mental illness

This variability is reinforced by comparison with alternative epidemiological techniques. BBC SHA PCTs report Diabetes prevalence rates in a range 70-90% of that predicted by the Sheffield University ScHARR population model

Out Of Hours Care (OOH) – Care at home has fallen, satisfaction is low

- On average only 14% of people use out of hours services in any one year [50] & [51].
- In 2004, 43% said it was difficult to get GP out-of-hours care, the figure for London was 55% [29].
- Net satisfaction with after hours care is currently 0% (Dec, 2004), fallen from 18% in 2001 [52].
- In 2002, 17% felt the doctor did not know enough about their case OOH, and 6% “little or nothing”.
- Home visits Out Of Hours have fallen markedly – 47% 1998 to 34% in 2002 [50] & [51].
- 19% of people are not sure what they should call their GP OOH service for [75].
- Working patients especially want flexible access to practices [47].
- There is a particular demand for general practices to be open at weekends [47].
- To increase patient satisfaction, OOH centres should focus on improving doctor-patient communication skills for GPs, specifically listening [82].
- People who use OOH services for the first time may have high expectations about the doctor listening and waiting times. Patient education should target people who have not used the service before to lower unrealistic expectations [82].
Experience of NHS Direct & Walk In Centres – big perception gap between users and non-users

% respondents using services in last year -DH MORI

% respondents very/quite satisfied - DH MORI Dec 2004
Walk-In Centres – improving access for younger people and hard to reach groups

What do they offer?
NHS Direct operates a 24-hour nurse advice and health information service, providing information on:
- What to do if you or your family are feeling ill [143];
- Particular health conditions [143];
- Local healthcare services, such as doctors, dentists or late night opening pharmacies [143].

Who uses them?
- The NHS Walk-In Centres have seen 6 million people since opening in 2000 [12]. Each centre averages 114 patients a day, which results in 42,000 patients a year [12].
- During March 2005, 197,470 people attended the walk in centres [12].
- Often accessed to bypass GP waiting times and opening areas [National Patient Experience Survey 2002]

What the public think about them?
- There is a big perception gap between users and non users of these new services. Those using the service are have high satisfaction while the general public as a whole has much lower levels of satisfaction.
- In 2003 only 9% of respondents had used NHS Walk-In Centres [34].

What are the policy perspectives?
- Walk-In Centres are improving access for young people, homeless people, students, refugees and asylum seekers [12].

Gap areas:
What do professionals think about them?
What are the key issues?
How is demand likely to change in the future?
NHS Direct: 24/7 services, high satisfaction ratings, low uptake by older people

Who uses them?
- 6.5 m calls in 2004/05 [88].
- According to the Developing NHS Direct (2003) document, the phone service handles over 500,000 calls a month [17].
- Call volumes have been growing by an average of 20% per year since the service started [17].
- 7 million people have used the service since 2000 [27].
- Fewer people use either NHS Direct or Walk In Centres rather than their GP, but the numbers are growing while the % visiting A&E and their GP is falling slightly.
- Use NHS Direct to bypass GP waiting time and opening hours [National Patient Experience Survey 2002]

High User Groups: Young Adults (2001)[44] & Parents on behalf of children (2001)[44]
Low User Groups: Older Adults (2001)[44]

What do they offer?
Most NHS walk-in centres are open from 7am to 10pm Monday to Friday and 9am to 10pm Saturday and Sunday.
The centres are nurse-led, they may occasionally include a GP at certain times of the day, and other professional staff. No appointment is necessary and quick access to a range of NHS services is offered including health information, advice and treatment for a range of minor illnesses and minor injuries [12].
- There are 64 existing walk-in centres with a further 18 developing.
- The current walk-in centres offer a service to 11 million people [12].
- Mainstream centres are open 365 days a year early until late [12].
- NHS Walk-In Centres are situated in convenient locations that allow the local population quick and easy access to a range of NHS services [12].

What does the public think about them?
- Satisfaction ratings with the service from respondents were 95% or higher (2003)[17].
- 90% of respondents who had used the service were either 'completely satisfied' or 'satisfied to some extent' by the way their call was dealt with [8].
- 72% of those surveyed had heard of NHS Direct [8].
- Difficulty getting through to the service (2001) [46].
- Delays in being able to speak to a nurse (2001) [46].

What do professionals think about them?
Poor integration with rest of system
Full potential not realised
There is little or no evidence available about the quality of self care advice (2003) [45].

What is the policy perspective?
A high proportion of callers, in the region of 90%, follow most or all of the advice given by NHS Direct (2001) [44].
Low uptake amongst older adults could be a sign of increasing marginalisation from accessing services through "new technologies" such as the telephone, email, the web or digital TV (2001) [44].

Gap areas:
What are the key issues?
How is demand likely to change in the future?
Ambulance Services – high satisfaction ratings but more services needed

What do they offer?
Traditionally ambulance services have been primarily perceived as an emergency service. Training and service provision have been organised around the needs of patients with life threatening emergencies, with severe breathing difficulties, acute coronary syndrome or suffering major trauma [91]. However Ambulance services have changed their traditional approach and are now more embedded in urgent care as a whole, for instance providing out-of-hours primary care and making referrals to other healthcare professionals [90].

Assisting these changes is an increase in the number of Emergency Care Practitioners (ECPs) across the country. ECPs are a new type of health professional who have greater assessment and examination skills and more training for the treatment of minor injuries and illnesses. ECPs are also trained in the management of long-term conditions [92].

Who uses them?
- 5.3 million emergency calls were made to the ambulance service in 2002/03, an increase of 8% upon the previous year [23].
- Ambulance service attended 4.3 million incidents in 2002/03 [23].
- Between 1993/94 and 2003/04 there was an 80% increase in the number of emergency incidents attended. The number of emergency incidents attended rose from 2.4 million to 4.3 million [23].
- Nationally, ambulance services demand is rising by 6-7% a year; an extra 250,000 responses a year [90].

What the public think about them?
- In 2004 98% of patients rated their overall care as excellent, very good, or good [33].
- In 2004, 1/5 of respondents said that ambulance staff could have done more to help control pain [33].
- In 2004 1/5 of respondents reported that they did not fully understand the ambulance crew’s explanations of care and treatment [33].
- 72% of people think they would be seen more quickly at A&E if they arrived by ambulance, regardless of their problem [75].

What is the policy perspective?
- Only 10% of patients ringing 999 have a life-threatening emergency. Many patients have an urgent primary (or social) care need [90].
- Ambulance services have a wider role to play as mobile providers & co-ordinators of out of hospital patient care & diagnosis, working as part of the PC team, for the NHS as a whole, not just emergency care [90].
- With revised education and training of ambulance clinicians, the number of patients taken to A&E departments by ambulance can be significantly reduced (potentially 1 million patients [90]). Ambulance clinicians need to be competent, trained and empowered to do this and supported in making decisions for themselves – rather than feeling they have to get a second opinion [90].

Gap areas:
What do professionals think about them?
What are the key issues?
How is demand likely to change in the future?
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