Discussion Brief 4/2013
Local Health

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Jeremy Hunt, Secretary of State for Health, has outlined four key priorities in health between now and the 2015 General Election:

1. Improve the standard of care throughout the system
2. Bring the technology revolution to the NHS
3. Improve treatment and care of dementia and other long term conditions
4. Improve mortality rates for the big killer diseases to be the best in Europe[1]

This month's paper focuses on the local elements of health identified by the CPF Sectoral Group on Public Services and Infrastructure but through our work run these same four themes. As we investigate your views on dentistry we must consider the health inequalities and different levels of care experienced across our health system; local doctors remain the front line in improving treatment for dementia; and integration will be aided by the new technology that the Secretary of State has pledged to introduce before 2018.

Health is an area in which huge strides are being made already. Indeed, as this paper goes to press, the Government has just published a Care Bill capping social care costs and addressing some of the failings identified by the Francis Review.[2] The Health Secretary has also just announced a vulnerable older people plan that aims to prevent the hospitalisation of frail older people and those with dementia. This is an area that will require work from general practitioners, commissioners, and emergency services and will see elderly patients allocated a single named point of contact to manage their care needs.[3]

So, as always, this paper will focus on the underlying principles of our topic: local health – the doctors, dentists and other systems that deliver us the day-to-day care that is our primary experience of the NHS.

1. Dentistry

Good dental health is an essential part of overall good health. Poor oral health has been linked to a number of other diseases, such as heart disease and respiratory diseases.[4]

Access. The Office for Fair Trading (OFT) has raised concerns about patient access to dentistry being limited, either by a lack of information about entitlements to NHS services or through structural barriers. For example, dental patients are currently unable to access hygienists, dental therapists and clinical dental technicians without first receiving a referral from a dentist.[5]

The OFT also cites the current NHS dental contract (the terms under which NHS dentists operate) as a barrier to access, as the majority of these contracts are not time-limited and only a very small volume of new contracts are put out to competitive tender each year. This has had the effect of insulating dental practices with NHS dental contracts from competition, which can be seen to be detrimental to the service delivered to the patient.[6]

Targeting need. The most deprived communities in the UK experience the highest levels of oral disease, and yet it is this group that does not currently access dental treatment. According to a report by the Office for National Statistics in 2004, 60 per cent of 5 year olds and 70 per cent of 8 year olds attending 'deprived' schools (schools where 30 per cent or more children are eligible for free school meals) showed obvious decay in their milk teeth. At non-deprived schools the figures were 40 per cent for 5 year olds and 55 per cent for 8 year olds.[7]

There are a number of different ways to target need within a community; for example health visitors in schools, or national campaigns targeting school children. 'Child Smile' is a campaign operating in Scotland, which provides education on dental care to nursery, primary and secondary age children. Each child is provided with a dental pack containing a toothbrush, tube of 1000ppm fluoride toothpaste and an information leaflet.[8] In addition, every three and four year old child attending nursery is offered free, daily, supervised toothbrushing.[9]

Preventative dentistry. Although most health campaigns target the individual, central or local government can have a role to play in preventing tooth decay.

One of the ways in which government can help with oral health is through fluoridisation. Currently around 10 per cent of the population of England live in areas where there is enough fluoride naturally in the water or it has been added to the extent that it is medically sufficient. In 2003 the law was changed to enable local commissioners to require water companies to fluoridise their water, provided that there is local support following consultation.[10]

According to the University of York, a reduction of 40 per cent in tooth decay can be found in children in fluoridised areas and fluoridisation increases the percentage of children totally disease free by 14.6 per cent. In addition, the greater the average level of tooth decay before the scheme the greater the average reduction in decay achieved.[11]

Other forms of preventative heath include the application of Fluoride Varnish twice a year, the prescription of high fluoride toothpaste or fluoride tablets.[12] In addition, there are a number of benefits that can be gained by launching public health campaigns around diet and improving existing dental public health infrastructure.[13]

What Conservatives in Government have done so far:

- **More funding for NHS dentistry.** Providing a £30 million cash boost for NHS dentistry. This follows the decision to provide an extra £28 million for NHS dentistry the year before. Since May 2010 more than a million new patients have received access to an NHS dentist.[14]
- **Reforming the dental contract.** Taking steps to remedy issues with the 2006 dental contract by introducing a new dental contract based on registration, capitation and quality. This is currently the subject of several pilots.[15]

Question one: In dentistry and in general healthcare, the highest demand for services is often not in the areas of greatest need. Which of the following statements best reflects the opinion of your Group? [ONE VOTE PER PERSON]

	Mark number of votes here
Areas of highest health need should receive the most money in order to prevent higher healthcare demand later.....	
High demand indicates people taking responsibility for their own health and they should be rewarded with the most money.....	

Question two: NHS dentistry is funded differently from other health services: core services are subsidised while advanced or cosmetic procedures are fully chargeable.

a) Is this system clear? If no, how could it be made more clear?

b) Is this system fair? If no, how could it be made more fair?

2. Local doctors' surgeries

The majority of most individuals' interactions with the health service come through visits to their local General Practitioner (GP), who also acts as a gateway to the rest of the health service. This relationship is essential for a functioning NHS.

However, some GP surgeries are stretched due to an expanding older population. The estimated number of consultations for a typical practice in England rose from 21,100 in 1995 to 34,200 in 2008. In 2008, the highest overall consultation rate occurred in the age band 85 to 89 years for both sexes, at approximately 13 consultations per year. This is in comparison to 5.5 consultations per year for the average patient.[16] GPs surgeries must find ways to expand or change the way their service is delivered in order to meet demand.

Federations. GP federations are a group of GP surgeries working together over a large area. There are currently a number of federations in the UK, operating in both rural and urban locations.

According to the think tank The Kings Fund, general practice can - in many parts of the country - resemble a 'cottage industry' in which family doctors run small businesses that are isolated from each other and consequently only able to provide a limited number of services. There is often a lack of adequate premises and infrastructure and it is difficult for practices to extend the scope of the services they deliver or extend opening hours.[17]

In contrast to the relatively limited services that most GP surgeries provide, federations may offer services such as specialist consultations, access to some diagnostic facilities and minor surgery, as well as hosting minor-injury clinics. There is also the potential to align with a local integrated health and social care team.

Federations can also have the advantage of being more efficient to run due to economies of scale, and greater capacity for training and teaching.[18]

Out of hours/setting work. One of the major criticisms often levelled at primary care is the inability for working people to access it in a convenient manner. Providing GP surgeries in more convenient settings and during extended opening hours are two ways to tackle this.

In 2012, the supermarket chain Sainsbury's began offering GPs the option of setting up branch surgeries free of charge in its stores. There are currently 13 in-store surgeries, and another 24 on the supermarket's property, such as in car parks.[19] This was a move that was recommended by the Kings Fund, in their report 'Transforming the Delivery of Health and Social Care', as a way to deliver care in more convenient settings.[20]

Many GP surgeries are also beginning to use technology such as Skype (phone or video calls on the internet) to cut down on the number of face to face consultations needed. This brings the patient the advantage of having a consultation in a setting of their choosing.[21]

Telehealth and Telecare. With advances in technology it is now possible to monitor some aspects of patients' healthcare in their own home. This technology can include alarms, or motion sensors to reduce the risk of falls by turning on lights if a patient wakes during the night reduce harm by alerting help quickly if the patient has had a fall.

Specialist equipment can also be installed in the home of the patient, so that their blood pressure, blood glucose levels, or weight can be remotely monitored. Patients are taught how to do the tests themselves and the measurements are automatically transmitted to their doctor or nurse.[22] Tools like these can cut down on the number of doctors appointments needed and reduce unexpected hospital visits.

Examples from other countries. Many countries in Europe have taken the step of defining in law the 'core services' that local healthcare providers are obliged to provide in order to provide clarity and streamline the system.

Case Study: Switzerland

In 1996 a new law was passed that defined the level of healthcare patients could expect as the 'basic package' through statutory health insurance. Competition between insurance companies has driven down premiums and driven up quality of care. Insurance companies are not allowed to make a profit on basic package plans and 'Open Enrolment' ensures that all applicants must be accepted by insurance companies. Although slightly more is spent on healthcare in Switzerland as a proportion of GDP than in the UK, health outcomes are amongst the best in Europe.[20]

Case Study: Netherlands

A 'basic package' of healthcare has been defined and is the minimum health insurance deal that must be offered by insurers. It includes:

- Medical care: GP appointments, hospital care, prescribed specialist care;
- Dentistry for under 18 year olds; specialist dentistry and dentures for those over 18;
- Ambulance services;
- Post-natal care and midwifery services;
- Certain medications;
- Rehabilitation care: for example, diet advice;
- Stop smoking schemes.

The Netherlands came top of the Euro Health Consumer Index and also came top of a Commonwealth Fund survey which compared the healthcare systems of seven countries including America and Germany.[21]

What Conservatives in Government have done so far:

- **Putting GPs in charge of commissioning care.** On 1 April 2013 England's 211 Clinical Commissioning Groups took control of the NHS budget for local health communities. This put GPs in charge of commissioning care for their patients allowing them to shape local NHS services without interference from Whitehall.[25]
- **Encouraging extended GP opening hours.** The Coalition Government published updated guidelines on extended opening hours for GP practices in 2011, including advice on how to best match patients' preferences for extended hours access at that practice, based on the most recent GP Patient Survey results.[26]
- **Extending Telehealth services to 100,000 people.** On 14 November 2012 the Health Secretary, Jeremy Hunt, announced that 7 'pathfinders' - NHS and

local authority organisations including clinical commissioning groups - would agree contracts with industry suppliers that will mean 100,000 people being able to benefit from telehealth in 2013. Leading technology companies will be supplying the NHS with the technologies and services at no upfront cost. This followed the publication of the NHS mandate on 13 November 2012 where the Health Secretary announced the intent that 3 million people will benefit from telehealth by 2017.[27]

- **A new GP contract to improve services for patients.** This April, changes to the GP contract, saw £164 million redirected from bureaucratic box ticking exercises into better care. Under the changes GPs will be expected to offer the best standards of care in 20 key areas that have an impact on avoidable deaths. The changes could mean up to 3.5 million more patients will get better care by 2014-15. The Government are also phasing out the minimum income guarantee to stop some GPs earning more than others offering the same services.[28]

Question three: What would your Groups describe as the 'core' or 'essential' services offered by General Practitioners? Should these be better defined as they have been in Switzerland and The Netherlands so that patients know what they can expect from their GP?

3. Better integration

Health and Social Care integration. Integration between health and social care services is at the heart of the Coalition Government's programme for health reform.[29]

Older people are over represented in NHS hospitals. About 60 per cent of people in hospital are over the age of 65 (who represent around 17 per cent of the UK population), and the number of admissions for people aged 75 and over is rising faster than for any other age group. Moreover, the average length of hospital stay for patients over 75 years of age is more than 10 days, compared with just over 4 days for those aged 15-59.[30]

There is a growing consensus that a hospital setting is not the best place to treat older patients. The design of an acute ward is often not fit for purpose, with physical hazards, poor signage, and a majority of staff without age-specific training.[31] This is especially problematic given that around a quarter of older people on acute wards in hospitals are estimated to have dementia, much of it undiagnosed.[32]

Moreover, a concentration on reducing lengths of stay - found in some parts of the NHS - means that patients can be continually moving through environments that are not conductive to rest or recovery.[33]

In order to ensure that the complex health needs of an ageing population are met, health and social care must work more closely together. Indeed, the Department of Health estimates around 25 per cent of hospital patients, many of them older people, could be cared for at home or in the community.[34]

There are two major models for health and social care integration. Organisational integration, which is achieved either by pooling resources and aligning goals and standards or by establishing new units or organisations, or 'virtual' integration, achieved through cross organisational support and communication.

Case Study: Torbay Care Trust

Created in 2005, Torbay Care Trust brings together PCT and adult social care services into one organisation, joining together social care teams from Torbay Council and Community Health teams in the NHS Trust.

Torbay Care Trust provides:

- Community healthcare services, including Brixham Hospital and Paignton Hospital;
- Adult social care (previously provided by Torbay Council);
- Disability Information Service;
- Learning Disability Services;
- Mental Health Directory.[30]

The key benefits that have been identified from the integration of services in Torbay are:

- £250,000 in savings in the first year due to integrated management structure, which was used to develop services;
- A new IT system for all staff to enable better sharing of information;
- Improved access to intermediate care;
- A 24 per cent fall in emergency bed day use for people aged 75 and over;[31]
- Lowest use of hospital beds in the region.[32]

The fall in emergency bed use for people aged 75 and over is particularly relevant for dealing with the health needs of an aging population in an intelligent manner.

Case Study: Knowsley Health and Wellbeing

Knowsley Health and Wellbeing is an example of how health service and social care integration can work without the need to consolidate organisations. It is a partnership between NHS Knowsley and Knowsley Council's Directorate of Wellbeing Services, incorporating Social Care, Leisure and Culture. Formal partnership arrangements were put in place in 2004, originally between health and social care services and subsequently extended to cover leisure and cultural services.

Services provided are:

- Community teams, providing a range of nursing, therapy and social care services;
- Primary care contractors: dentists, family doctors (GPs), optometrists (eye care and pharmacists (chemists);
- NHS trusts and foundation trusts (hospital and mental health services);
- Voluntary and independent sector organisations.[33]

The partnership has allowed greater flexibility in the use of resources. For example NHS funding has been used to support projects tackling the social concerns which can have an effect on health, such as worklessness. It has also enabled the PCT and local authority to work together by using shared sites and buildings. This has saved on rental and running costs as well as helping to deliver integrated services.[34]

Integration between Primary and Secondary Care. As with the integration of health and social care, there are benefits to the patient that can be gained from a closer relationship between primary (family or local) and secondary (specialist or hospital) care. As with health and social care, this integration can take the form of organisational mergers, or cross organisational support and communication.

Case Study: London Ambulance Service

The London Ambulance Service is a good example of how primary and secondary care can work together without merging organisations, to the benefit of the patient.

Under the system operated by London Ambulance Service all urgent and unscheduled calls are received by one call-handling centre. Including calls to 999, urgent requests from GPs, GP out-of-hours calls and calls transferred from the Metropolitan Police. NHS Direct also transfers urgent calls to the centre.

Special emergency care practitioners (ECPs) are often used as an initial response for 999 patients and are more effective than a traditional ambulance, as they are familiar with all the local care pathways available in their area and can refer or transfer patients to the most appropriate service. As a result, ECPs take fewer patients to Accident and Emergency and offer better patient care at a lower cost.[35]

What Conservatives in Government have done so far:

- **The Health and Social Care Act 2012** creates a duty for clinical commissioning groups, the NHS Commissioning Board, and Monitor to promote integrated services for patients between the NHS and social care and other local services. In addition, under the new legislation local authorities will

have a much larger role in the integration of health and social care services and will be responsible for promoting partnership working, joint strategic needs assessments, some aspects of public health and health improvement. Health and wellbeing boards will also be expected to promote integration across the NHS and social care.[41]

- **Removing barriers to integrated care.** On 14 May 2013 the government announced its aim for joined up and integrated health and social care by 2018 – with projects across the country by 2015. 'Pioneer' areas will be chosen by September 2013 to look at practical ways to make this happen. To ensure that success is measurable the government is introducing the first agreed definition of joined up integrated care and new measures of patient experience to ensure people feel they are getting this.
- **Improving support for people moving from one service to another.** Developing a new assessment process for people from birth to 25 that will include education, health and social care needs, planning to change the law to allow adult social care services to assess young people under 18 and spending £1 billion between 2010 and 2015 on making sure that old people returning home after hospital have a temporary care plan.[42]
- **A paperless NHS.** On 16 January 2013 the Health Secretary announced his intention to make the NHS go paperless by 2018 allowing everyone who wishes to get online access to their own health records held by their GP by March 2015, allowing GPs to send referrals by email, and putting plans in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system.[43]
- **Vulnerable Older People Plan.** On 13 May 2013 the Health Secretary, Jeremy Hunt, announced the government's 'vulnerable older people plan' aimed at making sure that elderly people with long-term health needs are getting access to the care they need from their GPs and hospitals. This will ensure that the health service is geared towards prevention and reducing the number of people being admitted to hospital and receiving treatment that does not best suit their needs.[44]

Question four: Treating people in hospital is often more expensive and less effective than treating them within or close to home. How can we encourage more General Practices to offer advanced treatments usually administered by hospitals (for example, scans or hernia operations)?

4. The role of non-NHS organisations

Charities. Charities have a very important role to play in the NHS. Currently the NHS is supported by a number of so called 'NHS charities'; a charity that has been established for charitable purposes relating to the NHS and in its operation is linked directly to an NHS body.[45] For example, The Leeds Teaching Hospitals Charitable Foundation explain on its website that:

- *'It raises funds through various appeals as well as providing support and encouragement for NHS staff and members of the general public in efforts at fundraising.*

- *'It receives donations, legacies and grants for the benefit of the NHS Trust.'*[46]

While Imperial College London has recently partnered with the Imperial College Healthcare trust to set up a charitable 'Academic Health Science Centre', to focus on the translation of outstanding research into treatments that will benefit patients and the wider health sector.[47] NHS charities receive money donated by members of the public to NHS bodies (normally hospitals), and have the power to raise money through activities such as public appeals or competitions. Around 300 NHS charities support the NHS with around £300 million each year, and hold charitable assets in excess of £2 billion. A very small number of NHS charities account for most of these assets and income.[48]

Private provision. The NHS has welcomed private providers within its structure for many years. In 2003, the Labour government introduced Independent Sector Treatment Centres (ISTCs). ISTCs are owned and run by organisations outside the NHS but they provide planned operations, outpatient care, and diagnostic tests to NHS patients only. They are funded by the Department of Health on five year budgets.

ISTCs were introduced in order to help the NHS reduce waiting times, primarily by separating planned operations from emergency care, but also as a way to introduce competition and patient choice into the NHS.[49]

The role of private providers in the NHS was expanded in 2008, when patients being referred for routine care were given the right to be seen by any provider (NHS or independent sector) that is registered to provide the service they need, willing to accept NHS prices, and either holds a contract with their local PCT or is listed on a national 'choice network'.[50]

What Conservatives in Government have done so far:

- **Launching a review into changing NHS charities regulations** in order to create more freedom for by allowing them to establish a new 'independent' charity to transfer current charitable assets into, in order to free themselves from government interference and control. These proposals are in response to concerns raised by a number of NHS charities about difficulties in operating, such as the inability to transfer funds without ministerial action and direct involvement.[51]
- **Enabling patients to be able to choose services** which best meet their needs, including from charity or independent sector providers, as long. Providers, including NHS foundation trusts, will be free to innovate to deliver quality services. Monitor will be established as a specialist regulator to protect patients' interests.[52]

Question five: As the NHS becomes more advanced and innovative, and welcomes a variety of providers from all backgrounds, how can we help patients to choose the most appropriate options for their health and social care?

5. Quick fire round! Some controversial food for thought to get debate going…

For each statement record the number of Members in you Group who strongly agree; agree; disagree; or strongly disagree. [ONE VOTE PER PERSON]

	Strongly agree	Agree	Disagree	Strongly Disagree	DON'T KNOW
GPs should take greater responsibility for out of hours care in their area					
The ability to see your GP or consultant for a routine appointment in the evening or at the weekend is a luxury the country cannot afford					
The ability to see your GP or consultant for a routine appointment in the evening or at the weekend is important to keep the economy moving					
Families should be responsible for the care of their infirm relatives					
Families should be financially incentivised to take responsibility for the care of their infirm relatives					
Patients who repeatedly miss NHS appointments without good reason should have action taken against them					
There should be no annual limit to the number of appointments patients can book to see their GP					
It is right that all NHS treatment is provided on the basis of need – including for those illnesses worsened by lifestyle choices such as alcohol intoxication and obesity					
Britain cannot afford to fulfil all the health expectations of all the population all of the time					
Open competition within the NHS is unnecessary					
Open competition within the NHS is undesirable					
Other comments:					

6. Endnotes

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