Transforming Primary Care

Personalised, proactive care for people who need it most

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FOREWORD

When the NHS was set up over 60 years ago life expectancy was 65 for women and 70 for men. This year a third of babies born can expect to live beyond 100. The NHS should be congratulated for the part it has played in driving these improvements. However, an ageing population also brings new challenges, and as the population it serves changes so must the NHS.

There are now 4.2 million people aged over 75 in England and by 2026 there will be more than 6.3 million. Advances in medicine also mean that people of all ages, not just the over 75s, are living with complex health needs – it is estimated that by 2026 three million people will have three or more long-term conditions, whether physical, mental, or both.

People with complex health needs are not properly supported. More than a quarter of people who have long-term conditions say that they are not well cared for by the NHS, and two fifths expect their care to get worse over the coming years. People are frustrated by using different services that did not speak to each other, and felt that their conditions were treated in isolation. This must change; we must focus on whole person care rather than seeing people as a series of conditions.

If the NHS is to continue to deliver high quality, sustainable care it needs to shift away from providing 20th century solutions that are based on a fix and treat model. A system that waits until crisis and then forgets about them once treated. One that is based around treatment in hospitals rather than support in the community. At present, people are too often enduring rather than enjoying their longer lives. We must make prevention as important as cure.

This change is not only for good for patients and carers but vital for the future of the NHS. Over the past 10 years ago, emergency admissions per head have risen by a quarter and for people over 75 by nearly a third At least a fifth of these emergency admissions are estimated to be directly avoidable in some way. Every preventable admission represents a failure of the system. Being admitted to hospital when it could have been avoided is not only distressing for people and their families but can also trigger further health problems. It is a waste of NHS resources, and one that we cannot afford..

Change is what patients want and the NHS needs In many areas it is already happening. Local clinicians have been empowered through the creation of Clinical Commissioning Groups and Health and Wellbeing Boards to bring together health and social care and focus on whole person care – a system with the patients and carers at its heart. Integration Pioneers up and down the country are breaking out of the traditional mould to develop new services. NHS England developing more responsive primary care learning from international best practice. The appetite and will is there and this document sets out the first of a series of initiatives to support local areas in making this change a reality across the country.

The Proactive Care programme is the first major step towards personalised and joined-up care for all. We will move from a system where the NHS simply fixes problems when they occur to one where it provides regular, on-going support to identify and tackle issues before people reach crisis point.

To do this we need to see a step-change in out-of-hospital care, transforming the experience of patients across the country so that they are supported to stay well. The transformation will be built around one of the NHS' greatest assets – the GP practice, building on existing relationships that often span over many years.

This means a change in ways of working. People will receive holistic care, with all their physical, mental and social needs taken into account, rather than being treated separately for each condition. Instead of people being pushed from pillar to post, repeating information countless times, services will be organised around the patient. We are starting with the 800,000 patients with the most complex health and care needs who will be given personal care and support plan, a named accountable GP, a professional to coordinate their care and same day telephone consultations if needed.

These changes to primary care will mean freeing up staff to focus on the needs of patients and carers. We are working to reduce bureaucracy, equip staff with the right skills and to improve communication between GP practices and other services.

We will also be supporting commissioners to make joined up care the norm. CCGs will invest £250m to support the shift to more primary and community care, and next year the Better Care Fund will provide £3.5bn for integration of services. And recognising this is the first step on a long journey we will ensure that 10,000 primary and community care professionals will be trained by 2020.

Over the next two years these changes have the potential to achieve savings of £0.5bn a year in hospital costs. Over the longer-term, improving primary and community services for people with long-term conditions will not only improve quality but also has the potential to achieve further savings.

This transformation is a vital step towards achieving a financially sustainable NHS that delivers high quality care to an ageing population. Working together, we can achieve these changes and ensure that we have a NHS ready to face the challenges of the 21st Century.

Jeremy Hunt

Secretary of State, Department of Health

PREFACE

How well can the NHS serve older people? In my view, the future of the Health Service largely depends on the answer to this question. Listening to their views, respecting their dignity, supporting their choices, helping them stay healthy and independent, meeting their distinctive health needs – these are some of the expectations our fellow citizens rightly have of those of us working in the NHS and social care.

Fortunately, standards of care are generally high, and our patients say that the vast majority of the time they feel very well looked after. But we all know relatives or friends for whom that has not always been the case, and we're determined to do better. An ageing nation with more chronic health conditions – but with the possibilities offered by new treatments and technologies – means that how we care for people with the highest needs can now improve.

For about a decade, there has been broad consensus in this country about much of what will this will require. Numerous well-reasoned White Papers, plans and initiatives attest to that consensus – but over the years, resulting action has been diffuse, and the impact marginal. This challenge is not unique to us in England. Many other countries have had mixed results from their efforts to move beyond health and social care which is often reactive, sometimes poorly coordinated, and not always tailored to the particular needs and preferences of diverse individuals.

However, there is now good evidence that effective personalisation and care coordination improves patients' experience of care – which is a critical goal in its own right. Ensuring that people are also able to avoid unnecessary emergency hospital stays is in principle entirely possible too, but in practice has been harder to achieve. Why is that? And how can we now do better?

Part of the answer lies in getting three things right. First, build on and support the work of GPs and the wider primary care team, rather than purely relying on separate and disconnected new programmes. Second, recognise that real word impact requires a number of services and new processes to work in combination. Every link in the chain has to be in place. Third, however good the ideas and plans are, nothing will change without rigorous implementation. The good news is that there are some inspiring examples both here and internationally showing how to get these things right.

It is in that context that the new national GP contract – agreed between GPs and NHS England – and which takes effect this month, has the potential to make a real difference to the care of our most vulnerable older patients. This document explains how. By freeing up time and redirecting several hundred million pounds of public funding for hard pressed family doctors and other primary care staff, the aim is to bring about broad-based improvement in care for our highest need patients. The onus is now on all of us to actually bring that about.

Simon Stevens

CEO, NHS England

EXECUTIVE SUMMARY

1. The NHS needs to change to meet the challenges of an ageing population and to better serve those living with complex health and care needs. This means providing personalised, proactive care to keep people healthy, independent and out of hospital.

2. This document sets out the actions we are taking towards our vision of personalised, proactive care. Our initial focus is on the role of primary care, but providing personalised, proactive care relies on the support of a wide range of NHS and other staff, working together around the needs of patients and their carers.

HOW SERVICES WILL CHANGE FOR PATIENTS AND CARERS

3. People feel that services are disjointed and the system isn't meeting their needs. The immediate priority is people with the most complex needs. From September 2014, over 800,000 people with the most complex needs will experience a step-change in their care, with GPs developing a proactive and personalised programme of care and support tailored to their needs and views – the Proactive Care Programme.

4. In addition, to improve continuity of care, by the end of June 2014, all people aged 75 and over will have a named GP with overall responsibility for and oversight of their care.

5. This accountability will help coordination of services around the patient, ensuring personalised, proactive care regardless of the setting. Coordination will be supported by improvements in communication between GP practices and other services, including A&E, ambulance services, care homes, mental health and social care teams.

6. These changes will be supported by CQC's new approach to regulating, inspecting and rating NHS GP practices, along with patient feedback and the NHS Choices service, providing assurance and information on the quality of services.

7. Improvements in information and technology will support people to take control their own care, providing people with easier access to their own medical information, online booking of appointments and ordering repeat prescriptions. GPs will be supported to enable this, working with other services including district nurses or community nurses.

8. Finally, people caring for family or friends will also be given greater support and information, both to help them care for others and to support their own health and wellbeing.

HOW STAFF WORKING IN HEALTH AND CARE WILL BE SUPPORTED

9. Staff need to be given the time to focus on proactively caring for people. The Government and NHS England are working with the profession to free up time for GPs to provide proactive care and have already removed a number of task-based payments which have become overly bureaucratic.

10. NHS England is working with the professions, patients and carers to further reduce bureaucracy and provide a a clearer focus on outcomes and patient experience.

11. Staff will also be given the right training to ensure they can improve their skills to meet people's changing needs and work across traditional boundaries. Health Education England will work

with employers, professional bodies and education providers to ensure the workforce has the necessary skills to care for older people and those with complex needs and to support joint working.

12. New ways of working also mean moving away from traditional professional boundaries and ensuring that staff are able to take on different roles where it benefits patients. Joint working will be further supported by improved information sharing, enabling staff to take decisions more effectively, and by timely access to GPs for staff in other care settings.

13. Finally, the Government will be working with NHS England, Health Education England and other system partners to embed the values and behaviours of the NHS Constitution.

HOW HEALTH AND CARE SERVICES WILL SUPPORT THE VISION

14. The system needs to enable, rather than restrict, the changes required, and organisational barriers must be removed.

15. To support better joined up working this year, CCGs will provide £250 million to commission services to support GPs to improve quality of care for older people and people with the most complex needs. From next year, the £3.8bn Better Care Fund will support the integration of health and care services. In addition, the 14 Integrated Care Pioneers are demonstrating new ways of delivering coordinated care.

16. Building on best practice, Monitor and NHS England are working with local commissioners to provide national support, tools and guidance to further support innovation and new ways of working.

17. Ensuring access to and availability of primary care will be essential. Over the coming year, local pilots will be exploring new ways to improve access to GP services, supported by a £50m challenge fund.

18. We are making a number of changes, starting in April 2014, to make clear the need for general practice to securely share records with other services, where patients are content for them to do so. These changes will benefit all patients, ensuring that those caring for them have access to the most up-to-date information about their needs and treatment.

19. To ensure that we have a workforce ready to meet the challenges of the future, we are planning to make available around 10,000 primary and community health and care professionals by 2020, in support of the shift in how care will be provided.

20. To meet short-term pressures, the Government will be working with NHS England, HEE and the professions to consider how to improve recruitment, retention and return to practice in primary and community care.

IMPLEMENTING THE VISION

21. Improving care out of hospital has been a common theme of successive Governments, with varied success. Achieving this change will need clear focus and support for local leaders to implement the plan.

22. GPs, commissioners and the wider system will be supported through guidance, support and clear standards so that people are clear about what needs to change. Success will be celebrated and shared so that others can learn from this and support will be provided to those that need to improve their performance.

23. We will also measure the success of the Proactive Care Programme, both nationally and locally, to ensure that lessons are learned and improvements can be made. These measures will include cost, outcomes, process and experience data to help build up a picture of how the changes are working.

24. The focus on people with complex needs is the first step in a wider vision for transforming care out of hospital. The Government will explore how the core principles of this plan can be extended beyond people with the most complex needs.

HOW SERVICES WILL CHANGE FOR PATIENTS AND CARERS

- From September 2014, over 800,000 people with the most complex needs will experience a step-change in care, with GPs developing a proactive and personalised programme of care and support – the Proactive Care Programme - tailored to their needs and views.
- In addition, by the end of June 2014, all people aged 75 and over will have a named GP with overall responsibility for their care, providing continuity and oversight of their care.
- This accountability will help coordination of services around the patient, ensuring personalised, proactive care regardless of the setting. This coordination will be supported by improvements in communication between GP practices and other services, including A&E, ambulance services, care homes, mental health and social care teams.
- This step-change in care will be supported by CQC's new approach to regulating, inspecting and rating NHS GP practices, patient feedback and the NHS Choices service, providing assurance and information on the quality of services.
- Improvements in information and technology will support people to take control their own care, providing people with easier access to their own medical information, online booking of appointments and ordering repeat prescriptions. GPs will be supported to enable this, working with other services including district nurses and other community nurses.
- Finally, people caring for family or friends will also be given greater support and information, both to help them care for others and to support their own health and wellbeing.

What needs to change?

1. People are rightly proud of the NHS and appreciate the hard work that health and care staff do on a daily basis. Many people's experiences of the NHS and social care are positive. 66% of the public report being satisfied with the NHS. This figure rises to 78% of people believing that their local NHS provides a good service.[1]

2. However, in too many cases, patients face frustration and confusion when they feel the system isn't meeting their needs. The Department and NHS England have heard that people often feel they are pushed from pillar to post by disjointed services. People often need to repeat the same information time after time and feel they are viewed in terms of their medical condition, not as an individual.

3. People want a clearer path from one service to another and expect services to work together across the NHS, local councils and voluntary organisations. More than a quarter of people who have long-term conditions say that they are not well cared for by the NHS, and two fifths expect their care to get worse over the coming years.[2]

4. People want to set goals for their care and to be supported to understand the care proposed for them. Ultimately, people told us that they want to focus on keeping well and maintaining their independence and dignity: staying close to their families and friends and playing an active part in their communities.

5. Services need to improve for all people, but we have consistently heard that the priority is people with complex needs. Advances in medicine also mean that people of all ages, not just the over 75s, are living with complex health needs. It is estimated that by 2018 three million people will have three or more long-term conditions, whether physical, mental, or both.[3] Services need to change to meet this challenge.

6. This failure to respond is reflected by the numbers of people being admitted to hospital in an emergency. For people over 75, the number of emergency admissions has increased by 31%.[4] At least a fifth of these emergency admissions are estimated to be directly avoidable in some way.[5] Every preventable admission represents a failure of the system to care for the people it serves – and can trigger further health problems.

Providing proactive, personalised care

7. For many people, the starting point will be care out of hospital, which can prevent illness and help people to avoid reaching crisis point. We need to see a step-change in how primary and community services are provided, with a renewed focus on the individual needs of people with complex needs. **From July 2014, over 800,000 people with the most complex health and care needs will benefit from the Proactive Care Programme, receiving personalised, joined-up care and support, tailored to their needs.**

8. The basis for this step change will be a new enhanced service to the GP contract that will support GPs, together with general practice nurses and their wider practice team, to build on their existing good work and provide the Proactive Care Programme for at least two per cent of adults on their practice list with the most complex needs. GPs will use one of a number of established tools to help identify which patients are most likely to benefit from this proactive approach to managing care. Practices will inform patients enrolled on the Proactive Care Programme of the changes they can expect to see. In identifying people for the Programme, practices will give equal consideration to mental health and physical health needs, and should include children who would benefit.

9. People on the Proactive Care Programme will have:

    - **A personalised, proactive care and support plan –** informed by their expectations and goals, but also the views of their carers. The plan should reflect the totality of mental and physical health needs, social needs, and wider factors affecting their health.[6] The plan will be shared and regularly reviewed with the individual and their carers.

    - **A named, accountable GP –** who will proactively oversee their care and support.

    - **A care coordinator –** who will provide advice and help them to navigate the system. The care coordinator may be the GP, but might be another professional, such as a general practice nurse, community nurse, allied health professional or mental health professional.

    - **Same day telephone consultations –** with a professional in the GP surgery where necessary.

    - **Timely follow up after hospital discharge** – and advance knowledge of what care they can expect, providing confidence that appropriate arrangements will be made for them.

[PLACEHOLDER – Overview of programme infographic]

10. Even if a person is diagnosed with exactly the same condition or disability as someone else, what that means for those two people can be very different. The care and support plan should truly reflect the full range of individuals' needs and goals, bringing together the knowledge and expertise of both the professional and the person. It should give parity of esteem to mental and physical health needs and services, ensuring that any person receiving mental health support from the Care Programme Approach receives coordinated, coherent care.[7,8]

11. The Proactive Care Programme, and the wider programme of action set out in this document, are designed to provide a major stimulus to develop person-centred care and support plans that address holistically both mental and physical health needs. At least 30% of people with long-term conditions are estimated to have mental health conditions, and the proportion is likely to be greater for people with the most complex health needs identified through risk stratification. Local commissioners and practices will need to work effectively with mental health professionals to ensure that they play an integral part in helping assess and plan care for all patients with mental health needs on the programme. This will complement the new enhanced service to improve diagnosis and care for people with dementia, now in its second year.

12. The care and support plan should also take account of a person's social needs, such as whether they are a carer, and wider factors that may affect their health, such as their housing situation. Professionals should also strive to ensure that people are able to use services in an environment in which they feel comfortable and respected.

13. National Voices has worked with people to understand what matters when planning their care, and we would encourage professionals to use their guide to support them in care and support planning.[9] Volunteers may also be able to support people in ensuring they get the best out of the care planning process – for example, Age UK is piloting a programme that actively involves volunteers in care and support planning, acting as an advocate for people with complex needs.[10]

14. GPs, practice nurses and the wider practice team will not be able to provide this step-change on their own. They will work as part of multi-disciplinary teams including community nurses, pharmacists, allied health professionals, care assistants, social workers, mental health workers, volunteers and others able to provide high quality care. These teams will work with individuals, their families and carers, recognising that not all care is provided by formal health and care services.

15. For instance, pharmacists can help prevent avoidable hospital admissions that result from inappropriate use of medicines, currently estimated to be around 5-8% of all admissions.[11] Similarly other professionals can help identify and tackle risk directly. Dietitians may see the early signs of deteriorating health arising from dietary problems; orthoptists may be able to identify where poor eye care is increasing risk of falls; and dentists can help to ensure that dental problems are dealt with early and do not lead to pain and discomfort when eating, which could contribute to nutritional problems. To ensure these services reach those at greatest need, they may be provided in people's homes or care homes. Providing good quality continence services can also be invaluable, improving the quality of life of older people and reducing the risk of infections.

Healthy Homes on Prescription

Many areas are taking innovative steps to address issues around the wider determinants of health. One such example is the Healthy Homes on Prescription scheme set up by Liverpool City Council in partnership with 55 GPs surgeries. A software system identifies those patients vulnerable to cold weather and GPs can then refer these patients, with their consent, to the Healthy Homes Programme and other partners, where they can get help and advice on a range of issues, including energy efficiency. An evaluation carried out by the Building Research Establishment in 2011 estimated ongoing NHS savings from the whole Healthy Homes Programme of £440,000 per year.[12]

Wider determinants of health

Many determinants of health have traditionally sat outside of health and care responsibilities, such as living in a cold home, or the impact of loneliness on people's health. GPs and care coordinators should be taking a wider view of individual's needs, using a social rather than just a medical model of health, identifying any risks and either involving the necessary services directly or signposting people to local services available to them.

Loneliness

According to research identified by the Campaign to End Loneliness, there are estimated to be 800,000 people in England who are chronically lonely.[13] The impact of loneliness and isolation on people's health is demonstrated by the fact that lonely people are more likely to undergo early admission into residential or nursing care.

Malnutrition

Three million people in the UK suffer from or are at risk of malnutrition.[14] As many as 33% of older people are already malnourished or at risk of admission to hospital and 37% of older people who have recently moved into care homes are at risk too.15 Nationally, malnutrition costs an estimated £7billion to the NHS and social care per annum.[16] As well as the negative impact of poor nutrition or dehydration on health, they can also lead to people, particularly older people, becoming confused, potentially increasing the risk of falls.

Cold Homes

Living in cold homes is known to negatively impact on physical and mental health, particularly for people under 5, over 75 or with pre-existing health conditions. Key problems include:

- **Cold related mortality**: Excess Winter Deaths (EWDs), claimed an estimated 31,000 lives in England and Wales in 2012/13. Estimates suggest that around a fifth of Excess Winter Deaths can be attributed to living in cold homes.[17]
- **Cold related morbidity**: living in cold homes can result in or exacerbate poor physical health including cardiovascular and respiratory problems.
- **Mental health impacts**: There are also links between living at low temperatures and mental wellbeing in adults with links to common mental disorders. The stress of living in a cold home can increase the risk of anxiety and depression.[18]

Improving continuity of care

16. Regularly seeing the same GP may help reduce emergency admissions. In one study, a 5% increase in numbers of patients with regular access to the same GP was associated with a

decrease in emergency admissions of around 3%.[19] The GP Patient Survey has also shown that older people are more likely to have a preferred GP and to trust their GP's advice more than others.[20]

17. Knowing that someone is responsible for overseeing their care should give people confidence that the right decisions are being made in every setting. GPs' expertise and training, their responsibility to patients and their role as commissioners mean they are well placed to oversee the totality of people's care. 79% of people believe that GPs are best placed to understand what services their patients need. This rises to 90% for over 75s. [21] **By the end of June 2014, all people aged 75 and over will have a named GP with overall responsibility for their care.** The named GP will support improved care and work with general practice nurses and district nurses to meet the needs of those aged 75 or over.

18. We will consult on whether this specific right should be added to the NHS Constitution, and we expect GPs to honour the longstanding constitutional right of patients to express a preference for a particular doctor within their GP practice, and take a person's preferences into account in choosing named GPs.

19. Continuity of care should include providing confidence about the quality of care available at all times of the day, including when GP surgeries are closed. Since 2004, GP practices have been able to opt out of the responsibility for arranging provision of out-of-hours care for their patients, with services instead commissioned from other provider organisations. This change has allowed more innovative approaches to delivering urgent care in many places.

20. However, the changes also meant that people have not always been clear who is responsible for out-of-hours care. **Through the GP contract, from April 2014, GPs will have responsibility for helping to assure the quality of out-of-hours services through regular monitoring and reporting.**

Case study: proactive support to people aged 75 and over

At Gnossal Surgery in Stafford, people are sent a birthday card on their 75th birthday, inviting them to complete a self-assessment of their health and care needs. The surgery employs 'Eldercare Facilitators', who are responsible for reviewing these assessments and, where necessary, organising follow up visits, and overseeing and coordinating people's care in conjunction with the person themselves, their family, and the GP. The patients are visited at home and an initial assessment is completed, taking note of their wider social needs, and the needs of their carer. The Facilitator takes on a befriending role and becomes the single point of contact for the person and their carer, if they have one, with the practice offering a 24-hour telephone support line. A trained GP then completes a comprehensive geriatric assessment with the person, taking into account their wishes and goals, and sets out triggers for accessing urgent care. A copy of this individualised care and support plan is kept on the patient's fridge**.**

Improving coordination

21. Ultimately, people want to know that they have access to the best services and care for their needs at all times. For example, people should expect the same standards from NHS services and providers regardless of whether they are in their own home or in a care home. The Social Care

Institute for Excellence published a guide for care home managers in December last year to support them in their work with GPs. [22] The Government welcomes this guidance as establishing better links between GPs and care homes that will help to address problems at an earlier stage, improve people's health and care outcomes and reduce unnecessary frustration for residents and their families.

22. People in care homes will often need staff to act on their behalf, for example ordering repeat prescriptions or organising treatment. We encourage secure sharing of information across service providers to benefit people's care, where they consent. GP practices will also be asked to ensure that care homes and nursing homes can easily contact the practice by telephone.

23. In instances where individuals need to be admitted to hospital, they should expect personalised, proactive care. For instance, many of the best A&Es have tailored processes for identifying and prioritising the care of the most vulnerable older people. This includes the provision of comprehensive geriatric assessments with specially trained health professionals. Following this assessment, older people are sent quickly to the most appropriate place for treatment, resulting in more efficient, better care.

24. Finally, coordination and continuity are particular issues when people are discharged from hospital. 23% of older people discharged after an overnight stay said they felt very vulnerable when they came home.[23] Proactive follow up after discharge will provide reassurance that someone is looking out for them at a crucial time. We expect local commissioners to build plans for effective discharge into care plans, and local hospitals to work closely with GPs and nurses each time a person comes home. These plans may draw on intermediate care – reablement or rehabilitation – which can be crucial in bridging the gap between home and hospital. It is also important that the suitability of a person's housing is considered as part of discharge planning. The *Hospital to Home* Resource Pack contains essential information for all the professional sectors that have a role in hospital discharge for older people in England.[24]

Case study: Age Concern Luton Meet and Greet Service

Working with the local clinical commissioning group, Luton & Dunstable Hospital, and local health services, Age Concern Luton has developed a Meet & Greet service for people returning home after a stay in hospital or respite care. The service ensures that someone is there to receive the older person at home where discharge is unexpected and takes the pressure off carers, who may be at work or living at some distance

Meet & Greet helps people settle back in at home, and supports them to return to independence. Age Concern workers make sure that the cupboards are full, beds are made, and everything is in place for the best possible recovery. They provide information to carers to help them think through the process of a safe discharge and can also help with practical tasks that may be difficult for them, such as moving furniture to allow for disability equipment. This service lasts for up to six weeks and is designed to help older people and their carers resolve any issues, practical or emotional, that come up in that time. Age Concern also helps to ensure future appointments are kept and everything else in the care and support plan is working properly.

These interventions have led to a 20% reduction in readmissions for over 75s, and a 32% reduction in falls**.**

Inspecting standards and improving information

25. People need to know that their local services are safe and how well they are performing. The Government is therefore strengthening the inspection regime for health and care services and increasing the transparency of information. The inspection regime will be led by the Chief Inspectors of General Practice, Social Care and Hospitals, who have all already begun their work and will drive up quality by highlighting failings, encouraging improvement and championing best practice.

26. One of the Chief Inspector of General Practice's most important roles is to oversee the regulation and inspection of how well services work together within sectors but also across different sectors. This will look at how well people's care is organised when more than one type of service is involved.

27. In future NHS GP practices and community care services will receive published ratings of the quality of services. **From October 2014, CQC will begin to rate community care practices and NHS GP practices. This will include specific ratings on the quality of general practice services for older people and those with long-term conditions.** These ratings will help people to know that the quality of their care is being assessed, poor performance is being tackled and good performance celebrated.

28. As well as the ratings, another important test of the quality of services is whether you would recommend them to your friends and family. **We will extend the 'Friends and Family Test' to General Practice from December 2014 and the results will be published.**

29. People will not only know what other people thought about local services, but they can also feedback their own views to their practice. The Friends and Family Test should also stimulate practices to reflect on patient feedback and consider what they can do to improve.

30. People need easily accessible, reliable sources of information. NHS Choices will be core to providing patients, users of care services and families with information on quality of services in an easily accessible format. **NHS Choices will provide an important service for patients, carers and the public, acting as a 'front door' to the best quality information on health and care available on the internet.**

Supporting people to take control of their own care

31. Many individuals and their families want more control over their own care, and the NHS should support this. Important changes are being made to how patients access their own care records and support their own care. **From April 2014, people will increasingly be able to book appointments with their GP practice online and order repeat prescriptions online.**

32. As set out in the NHS Constitution, patients already have the right of access to their health

records. **To ensure greater ease of access, their GP practice will also need to provide people with access to their own care records online, or have published plans for how they will do so by March 2015.**

33. Technological advances mean that technology has a major role to play in improving the health care system of the future. New technology is being used more and more within community care to enable people to live independently and care for themselves at home. Telecare includes innovations such as motion sensors that switch on lights to make falls less likely and alarm systems that can alert others if something goes wrong, giving people the confidence to remain in their own homes. Telehealth refers to the use of technologies that allow people to monitor their health in their own home and automatically send the results through to their GP or nurse. This gives people peace of mind that their health is stable without having to make regular visits to a GP surgery and ensures that any changes in their condition are picked up quickly by a professional, such as the district nurse of community matron..

34. Through the Technology Enabled Care Services programme, three million people with long-term conditions will benefit from these services by 2017, helping them and their families to manage and monitor their condition at home.

35. Community pharmacy teams also have a vital role in supporting the 1.25 million people who visit them every day to manage their own health, or the health of their family or friends. Supporting people to manage their own care – for instance through educating people about the medicines they're taking, or supporting them to consider how they can live healthier lives - is therefore embedded as an essential service in the community pharmacy contractual framework. All 11,500 community pharmacies are required to either provide this support themselves, or signpost people to other health and care services where they are not able to provide the support themselves.

36. Effective care and support planning needs to actively involve individuals, to help them identify their own priorities and goals, and to develop their own action plans based on their wishes. People delivering care have an important role to play in supporting patients and carers to engage in this process. **The Government's mandate to Health Education England (HEE) therefore includes a specific requirement for training to enable staff to help individuals and their families to manage their own conditions.**

37. Personal health budgets build on personalised care and support planning, allowing people to meet their needs in ways that work for them. **The Government has committed that all people receiving NHS Continuing Healthcare will have a right to have a Personal Health Budget from October 2014** and we will consult on whether the NHS Constitution should be updated to reflect this right.

38. Local commissioners can also offer personal health budgets to others who they feel may benefit from additional flexibility and control. NHS England is working to promote integration of personal budgets across health and social care.

Supporting Carers

39. Many people rely on family members, friends and neighbours to look after them. Caring for a

family member or friend can be demanding, as well as rewarding. Just as people need to understand their conditions, and be involved in decision making, so too do their carers. It is therefore important to help people's carers and families continue to support them.

40. GPs need to identify as a matter of course in the care and support plan whether a person has a carer or carers, and understand the contribution that carer can make. GPs should also consider the support carers themselves need to remain healthy, and continue caring, for example carers' breaks or a referral to a local carers organisation. Staff need to be supported to engage carers in this way. **We are therefore funding the *Supporting Carers in General Practice Programme* up to April 2015.**

41. Through this programme, the Royal College of General Practitioners (RCGP), the Royal College of Nursing, the Queen's Nursing Institute, Carers Trust and Carers UK are providing support to GPs, General Practice Nurses and Community Nurses to develop their ability to support carers. The programme includes development of an interactive, online 'carer roadmap' to embed carers' needs in care and support planning and management processes from the beginning.[25]

42. NHS England will shortly publish its *Commitments for Carers.* This will respond to the clear messages NHS England has heard about what carers want from the NHS, including respect for and recognition of their role and expertise; signposting to information and advice; and more flexibility to support the carer and the person they care for. In response, NHS England will publish its *Commitments for Carers* shortly.

43. To further reinforce the need for health and social care to recognise, value and support the important role that carers play, **the Care Bill[26] will introduce a legal duty on local authorities from April 2015 to undertake a carer's assessment where it appears a carer may have needs for support; meet carers' eligible needs for support, putting them on an equal footing with the people they support; and provide information on services available and how to access them to everybody in their area, including both carers and the people for whom they care.**

44. These legal duties will be underpinned by new funding for local authorities. In 2015/16, they will receive £15m for carers' assessments and £30m for carers' support.

Case study: Supporting of Carers in Worcestershire

The 'Engaging GP Practices in the Support of Carers' initiative in Worcestershire provides an excellent example of general practice working with the voluntary sector to improve support for carers. Through this initiative the local carers' centre, Worcestershire Association of Carers (part of the Carers Trust network) , supported local practices by delivering training to GPs and other practice-based staff to develop an action plan to increase the number of registered carers in their surgery; signpost or refer carers to local statutory and voluntary services; encourage practice staff to support the healthcare of carers; and encourage clinicians to involve carers as 'expert partners in care'.

As a result, an effective pathway was developed for GPs within the sixty-eight GP practices across Worcestershire to refer their patient carers directly to the countywide GP Carer Support Service, for comprehensive 1-2-1 support by a team of dedicated Carer Support Advisers. This is currently

funded by three clinical commissioning groups.

Participating practices have seen a definite and measurable improvement in identification of and support for carers. Practices involved also reported increased understanding of and confidence in dealing with carers' issues, improved knowledge of carer support services, and improved willingness to involve carers in patient consultations. Furthermore, with dedicated carer support and empowerment to manage their caring role, evaluations suggest that carers' physical and emotional health have improved as a result, providing a better patient experience and allowing GPs more time to concentrate on clinical matters.

HOW STAFF WORKING IN HEALTH AND CARE WILL BE SUPPORTED

- The Government and NHS England are working with family doctors to free up time for GPs to provide proactive care, and have already removed a number of task-based payments which have become overly bureaucratic.
- To further reduce burdens and support innovation, NHS England is working with the health professions, patients and carers to provide a clear focus on outcomes and patient experience.
- Health Education England will work with employers, professional bodies and education providers to ensure the workforce has the necessary skills to care for older people and those with complex needs and to support joint working.
- New ways of working also mean moving away from traditional professional boundaries and ensuring that staff are able to take on different roles where it benefits patients. Joint working will be further supported by improved information sharing, enabling staff to take decisions more effectively, and by timely access to GPs for staff in other care settings.
- Finally, the Government will be working with NHS England to embed the values and behaviours of the NHS Constitution.

What needs to change?

1. We know that people working in health and care are overwhelmingly committed to providing high quality compassionate care, working with their colleagues in other professions. However, all too often, they find barriers that prevent them from doing so.
2. For example, GPs have said they want more time to care for patients rather than feeling like they are merely reacting to day-to-day pressures.
3. With more people needing care in their own homes or in community settings, community nurses, mental health professionals and allied health professionals are all increasingly called upon too. People become frustrated if they feel they are working in silos and spending too much time on unnecessary bureaucracy, without seeing the link to improved care.
4. There are much greater opportunities for professionals to take on additional roles and skills, but people can still feel that traditional assumptions about roles remain. In addition, the old professional boundaries need to be broken down in favour of more of team relationships, sharing ideas, and learning from what each person can bring to the discussion.
5. Staff express frustration with the barriers that a lack of information sharing or technology creates for their ability to communicate effectively with each other and to care for people. They want to be able to share information securely; to all be working off a shared and agreed plan; and to make use of technology and innovations where they speed up processes and improve care.

Reducing Bureaucracy

6. Incentives introduced in the 2004 GP contract were important in providing clear direction for GPs to drive up standards. However, increasingly these incentives are seen as out of date and often not appropriate for treating complex needs.

7. To provide greater flexibility, NHS England is streamlining the Quality and Outcomes Framework, the measures against which GPs operate, to free up GPs and general practice nurses to provide proactive care and support for older people and those with complex needs. **Based on clinical advice, from April 2014, 40% of indicators currently included in the Quality and Outcomes Framework will be retired.**

8. This change will give GPs increased freedom to use their clinical judgement to provide more personalised care to patients. We will continue to work with the profession to explore how their roles could be 'de-cluttered' of unnecessary burdens.

9. In addition, we will continue to consider how technology can reduce burdens. For example, the Nursing Technology Fund supports nurses, midwives and health visitors to make better use of digital technology in all care settings, to deliver safer, more effective and more efficient care. In addition, technology can lead to improvements in care through improved access and promotion of self-management.

Focussing on outcomes

10. "Retiring" some of the Quality and Outcomes Framework indicators is part of a broader move towards focussing on outcomes. Local commissioners are already developing new outcome measures across primary care, community services and hospital services to provide this focus. **NHS England will be working closely with the health professions, patients and carers to consider how best to provide a clear focus for quality and patient experience, while also giving professionals space to innovate.**

11. At GP practice level, regular review of outcomes will be fundamental to improving quality. A new Enhanced Service will require GPs to review all emergency admissions to consider how the admission might have been avoided. This review will support practices to work with hospitals and other providers to improve processes for hospital admissions and discharges. The role of the care coordinator will be pivotal, as they will have oversight of all the care a person receives and will be able to work to ensure transfers between settings are as seamless as possible.

12. GPs should also consider other times where a review would be appropriate, for instance after a fall, an unexpected relapse, or when a patient dies. This review will support improvements in their own practice and also identify where wider service improvements are needed, providing feedback for their clinical commissioning group (CCG).

Equipping staff with the right skills

13. The health and social care workforce is crucial to our vision of care. People need to be equipped with the skills to perform their roles effectively. They need to be able to respond to the needs of older people and those with complex needs – including understanding mental and physical

health needs and wider social determinants – and understand how they can meet these needs through new ways of working in joint teams. **The Government has set Health Education England (HEE) objectives that will ensure the workforce has the necessary skills to care for older people and those with complex needs and support joint working.**

14. As a result, HEE plans to work with employers, professional bodies and education providers to:

    - Develop evidence-based approaches to recruitment and continuing professional development based on values and behaviours.

    - Work with the General Medical Council, the four UK Health Departments and the RCGP to agree a revised training programme for GPs. This programme will include emphasis on working in teams to provide support to specific groups including on care of older people

    - Ensure new nurses have the skills to work with older people in all settings, including by developing post-graduate training for nurses. Starting with pilots, all NHS-funded nursing students will first serve up to a year as a healthcare assistant. This scheme will prompt frontline caring experience and values, as well as academic strength.

    - Ensure that nurses have appropriate and easy access to training to ensure they can improve their skills to meet people's changing needs, undertake new ways of working and be confident in moving from the acute sector to give care effectively in the community.

15. HEE is also working with Skills for Health and Skills for Care, leading the development of the Care Certificate, recommended by Camilla Cavendish in her review.[27] The Care Certificate will provide assurance that healthcare assistants and social care support workers can receive the high quality and consistent training and support they need to do their jobs.

Case study: Tackling malnutrition in the community

Two dietitians from South Essex Partnership NHS Foundation Trust Community Health Services, working on the Bedfordshire Food First Project, won an award for their work in provide nutritionally balanced meals. This ambitious project, with the overall aim of managing malnutrition in the community, includes an award scheme for care homes to encourage them to screen regularly for malnutrition and to encourage residents to eat nutritious food rather than relying on oral supplements.

The Food First team has spanned both health and social care by working with care home staff, community nurses, GPs and hospital doctors to develop resources and training to meet the needs of patients and staff. Social care staff have been trained to identify people at risk and 95% of care homes said their practice had changed since working with the team.[28] Tackling malnutrition in long-term care settings will improve people's experience of care and will help to address the estimated £2.6billion cost of malnutrition for this part of the system.[29]

16. Supporting parity is a key objective of Health Education England. The Mandate to HEE recognises the importance of professional culture to achieving parity. It tasks HEE with ensuring the mental health workforce has the skills and values to improve services and to promote a culture of

recovery and aspiration for their patients. It also notes the importance of mental health awareness in the wider health workforce.

17. We are asking Health Education England to make sure a wide range of clinical staff are up to speed in recognising the signs of mental illness and developing skills and expertise:

    - Putting in place leadership: HEE will shortly be appointing a senior national clinical lead for mental health to co-ordinate education, training and workforce development.
    - Compulsory training for GPs: HEE are working with the Royal College of General Practitioners (RCGP), to explore including compulsory work-based training modules in mental health - including dementia - in GP training.
    - Mental/Physical Health awareness training: HEE are being asked to develop training programmes to build an awareness of the link between mental and physical health – particularly in people with long-term conditions.
    - Numbers: We also want HEE to have a strong focus on making sure the mental health workforce has sufficient numbers of psychiatrists, care staff and GPs with a special interest in mental health.

Supporting joint working

18. We need to break away from outdated assumptions of who can do what. Where traditionally a particular issue might have involved a visit to a GP or specialist doctors, needs are now being addressed by other community staff in a more convenient way for patients. For example, many pharmacists and practice nurses are now able to undertake further training to allow them to prescribe medicines, and this has been extended to other professional groups including physiotherapists and podiatrists.

19. NHS England's Call to Action for Community Pharmacy highlighted, for example, how pharmacists could: manage repeat medicines through repeat dispensing, freeing GP practice time; support GPs with medicines optimisation; help older people take their medicines as intended; and provide first response for minor ailments, lifestyle advice and support for self-management. [30]

Case study: secure information sharing between care homes and GP practices

Donisthorpe Hall Care Home in Leeds is utilising innovative technology to improve care for their elderly residents. They have implemented a software system that gives them online access to the electronic medical records of their 183 residents in the relevant local GP practices, ensuring the home is securely connected within the wider health care system. The software has been designed with the GPs' IT provider to provide a customised solution that can be deployed easily, with minimum training required.

The care home works with close support from local GP practices and the clinical commissioning group and is beginning to establish closer links with hospitals and other healthcare providers, for example hospices. Staff at the care home are enthusiastic about the benefits of this joined up system - the automatic, electronic link facilitates information flow and more informed, better planned care. Staff can identify quickly the support needs of residents, personalising care to need. Improved information sharing also means staff can more easily pass on their own expertise, which is especially useful when referring a resident for onward care.

Care workers' access to the most up-to-date medical records has already had a remarkable impact on residents and their families, improving their quality of life. For example, a resident with complex needs was admitted to the home over a weekend, when GP practices and other care services were closed. Family members were unable to inform staff about the resident's medication. However, as staff could access the full medical history on the person's behalf, they could identify the correct and current medication, ensuring continuity of care for the resident and valued support to the family at a difficult time.

20. Staff need to be able to communicate effectively to provide high quality care. They should be able to spend more time looking after patients rather than chasing their records, and be able to make decisions about a person's care based on accurate and up to date information.

21. For staff working in care homes, urgent care and emergency settings, and mental health, we are supporting greater communication and access to GP practices, to support better care for people with complex needs, particularly at points where there is a risk of crisis. **Through the Enhanced Service, GP practices will also need to provide dedicated phone lines and timely access for staff in other care settings to contact them for advice**.

Reinforcing the NHS Constitution values

22. The NHS Constitution is a powerful expression of the values and principles which underpin the NHS, and sets out what people can expect from the NHS. We are currently working to increase the Constitution's impact in a number of ways. For instance, Health Education England and NHS Employers are working with professional bodies, education providers and employers to ensure that the values and behaviours embedded in the NHS Constitution feed through into the NHS's approaches to recruiting and developing staff.

23. NHS England is also working to define what the rights set out in the NHS Constitution mean in practice. This approach, which has been pioneered by Macmillan Cancer Support as well as a number of NHS providers such as London's Guy's and St Thomas', will make the rights clear and understandable to staff by defining the specific behaviours expected of them. This work will ensure that people with the right motivations are recruited to the NHS, and then that those staff have the support needed to ensure patents come first in everything they do.

HOW HEALTH AND CARE SERVICES WILL SUPPORT THE VISION

- To support better joined up working this year, CCGs will provide £250 million to commission services to support GPs to improve quality of care for older people and people with the most complex needs. From next year, the £3.8bn Better Care Fund will support the integration of health and care services. In addition, 14 integration pioneers are demonstrating new ways of delivering coordinated care as part of the Integrated Care Pioneers programme.

- Building on best practice, Monitor and NHS England are working with local commissioners and professionals to provide national support, tools and guidance to support innovation and new ways of working.

- Ensuring access and availability of primary care will be essential. Over the coming year, local pilots will be exploring new ways to improve access to GP services, supported by a £50m challenge fund.

- We are making a number of changes, starting in April 2014, to make clear the need for general practice to securely share records with other services, where patients are content for them to do so. These changes will benefit all patients, ensuring that those caring for them have access to the most up-to-date information about their needs and treatment.

- To ensure that we have a workforce ready to meet the challenges of the future, we are planning to make available around 10,000 primary and community health and care professionals by 2020, in support of the shift in how care will be provided.

- To meet short-term pressures, the Government will be working with NHS England, HEE and the professions to consider how to improve recruitment, retention and return to practice in primary and community care.

What needs to change?

1. The vision for more proactive, personalised care needs to be engrained in how services operate. Too often, staff want to work collaboratively around the needs of the people they are caring for, but find organisational or system barriers which stop them.

2. High quality care involves a wide range of services, reflecting the wide range of needs individuals have. Coordination between these services is therefore crucial. However, in too many areas, services are fragmented.

3. Organisations want to innovate or implement known best practice, and individuals want to find out what has worked for others and use these models to shape their own work.

4. Information sharing between organisations needs to be improved, ensuring people can securely access the vital information they need about a patient in order to care for them more effectively.

Supporting integration of care

5. We recognise that GPs cannot achieve these changes on their own and need to be supported by the wider health and care system. To support joined-up working between services for people

with complex needs, **CCGs will provide £250 million to commission additional services which will support the GPs to improve quality of care for older people and those with complex needs.**

6. This investment should support practices and CCGs, working in partnership, to deliver better care for older people and those with complex needs, and improve coordination of the services they receive. The services commissioned will be those that that practices have themselves, either individually or collectively, identified as being of most value.

7. CCG plans will need to specify how this pump-priming investment will be used. NHS England's recent planning guidance, 'Everyone Counts', set out an expectation that CCGs will develop clear plans for how they intend to improve quality of care for vulnerable older people. [31]

8. Central to support of joined up services over the longer term will be the Better Care Fund, which will help the NHS and local authorities commission joined-up services for their local populations. **From next year, the £3.8bn Better Care Fund will support better integration between health and care services.**

9. Each area will develop local plans that set out how across health and social care there will be better data sharing, seven day services, and joint assessments. All local plans will be required to have an accountable professional, or care coordinator, able to join up services around the individual. We will also measure how well areas are succeeding in integrated services, using locally agreed outcome measures such as patient experience and reductions in emergency admissions, and will provide hands on support where this is required. This fund will be a major step forward in achieving our vision for integrated, person-centred care.

10. The oldest and most vulnerable patients are likely to also be receiving social care support. They should receive seamless care across health and social care services. Earlier in the year, the Department of Health therefore announced the establishment of 14 integrated care pioneers to provide better support at home and earlier treatment in the community, and to prevent people needing emergency care in hospital or care homes. The learning from these sites will be spread and promoted for wider, rapid adoption.

Box: Integrated Care Pioneers

In May 2013, a collaboration of national health and care partners, including the Department of Health and NHS England, announced the 'integrated care pioneers' programme, inviting pioneering local areas to demonstrate the use of ambitious and innovative approaches to delivering person-centred, coordinated care and support.

Fourteen pioneers were selected, and they are now implementing a range of new approaches to developing seamless systems of care and support. For instance, in Islington the clinical commissioning group, local authority and voluntary sector are working together to ensure local patients have a single person with overall responsibility for their health and care services. The Islington pioneer is also developing and implementing progressive models of integrated support across the health and social care system and introducing new IT infrastructure that will support this

ambition.

In Leeds, twelve joint health and social care teams are working to coordinate care for older people and those with long-term conditions. The NHS and local authority have opened a new joint recovery centre offering rehabilitation, in order to prevent hospital admission, facilitate earlier discharge and promote independence. In the centre's first month of operation, it saw a 50% reduction in length of stay at hospital.

The pioneer in Worcestershire is developing a fully integrated service delivery model in primary and community care that comprehensively supports the frail and elderly and people with long-term physical and mental health conditions. Services will be delivered by 'clusters' of different services, including primary, community and social care, and voluntary sector services. These clusters will be centred on GP practices.

Taken together, the fourteen pioneers are supporting the rapid dissemination, promotion and uptake of new approaches to delivering health and care services across the country.

Promoting Innovation

11. Making the NHS financially sustainable whilst providing proactive, person-centred, integrated care will require bold approaches to commissioning and providing services. The Government and its partners are committed to promoting more integrated out-of-hospital care. **NHS England is developing a range of practical tools in order to support local leaders to implement innovative approaches to delivering out-of-hospital care.**

12. In a number of local communities, including the integrated care pioneer sites, commissioners and providers are already working together to develop new models of care and new forms of commissioning and contracting, with the aim of providing more integrated and cost-effective services, particularly for people with the most complex health and care needs. NHS will ensure that there is a consistent set of measures that can be used to track the impact of these different service and commissioning models to help accelerate the spread of innovation.

13. We need the right incentives for providers to offer integrated, coordinated care. Some areas have started designing different payment approaches including 'capitation payments', with providers taking overall responsibility for the care of a person, or group of people, rather than for providing specific services. The 2014/15 National Tariff[32] published by Monitor and NHS England will provide clearer rules to support variation of national prices and currencies, as long as the new payment approach is in the best interests of patients, is agreed constructively, and is transparently reported.

14. Monitor and NHS England are exploring different options for promoting the delivery of proactive and coordinated care. In so doing, we will learn from good practice both in this country and abroad, in order to build an evidence base for what works best. **Monitor and NHS England will publish alongside the 2015/16 national tariff a series of tools and guidance to support local areas in designing and implementing innovative approaches to paying for services.**

Case Study: Whitstable Integrated Care Pilot

This pilot was a two year study of integrating community health and social care services, led by Whitstable Medical Practice, a large NHS GP partnership of 19 GPs serving 34,000 patients (97% of the local population). The pilot aimed to provide high-quality general practice alongside a range of services that would normally be associated with a hospital visit, in order to improve patient experience and reduce costs. The three work streams of the pilot were long-term conditions, urgent care, and elective care including diagnostics. In each instance, healthcare services were brought into the community, and joined up to reduce the number of attendances. This was achieved by:

- Establishing teams of multidisciplinary professionals, including GPs, community providers and, where necessary, secondary providers, to ensure organisational integration.
- Commissioning services in ways that enabled them to be delivered in primary care settings.

The result was better healthcare, closer to home and at substantially less cost to the system. The model has reduced the cost of local health care provision at Whitstable Medical Practice compared to national tariff by more than £1.6m over the 2 years of the study. The pilot also found that patient experience was markedly improved by the changes introduced: 94% of patients receiving community services reported that they had received 'excellent or very good' services.

Extending access to services

15. People should expect access to high quality services at times and in ways that are convenient to them. To support them, the Prime Minister announced in September a **£50m challenge fund to look at ways of improving access in general practice across the country for at least half a million people**.

16. There was strong interest in the challenge fund. As a result, from this year, more than 1,100 GP practices will offer improved services, covering 7.5 million people.

17. Improving access is not just about longer opening hours, although evening and weekend opening may be beneficial for some people. For some practices it is about a more integrated approach with out-of-hours services, while for others it may be about offering greater flexibility over consultation lengths.

18. The pilot sites will also explore a range of options to offer flexibility to people over when and how they access care, and will support the development and dissemination of best practice. The pilots will be testing a range of options for improving access including consultations via telephone, Skype, email and instant messaging, and better use of apps linked to your GP to manage your own health. These pilots will give more choice to hardworking families who find it hard to find time to see their GP.

CCGs leading change

Since their inception in April 2013, the 211 clinical commissioning groups (CCGs) have led improvement and innovation in the NHS[33]. Many CCGs are working together to ensure that services work effectively around patients, rather than the other way round. In Staffordshire five CCGs are working with Macmillan Cancer Support to commission end-of-life and cancer care as packages that reflect people's experiences of care, rather than in chunks that don't relate to how patients actually use the NHS. This means ensuring there's a single organisation with overall responsibility for the entire 'patient journey', which includes prevention, diagnosis, treatment, and end-of-life care.

In other areas, CCGs are adopting approaches to commissioning services that reflect the full variety of factors affecting people's health. For instance, people's health suffers if their homes are too cold. Consequently, in Oldham the CCG has launched a joint initiative with the local council and a social housing provider to help lift people out of fuel poverty. The partners have invested a total of £200,000 in 1,000 homes this winter, installing new boilers and insulation and helping people with multiple conditions remain healthy at home.

Taken together, the past year has shown how CCGs can transform healthcare at a local level, delivering higher quality care that is better value for money.

Sharing information

19. The Government remains strongly committed to improving information sharing between health and care providers. The NHS already commits in the NHS Constitution to ensure those involved in an individual's care and treatment have access to that individual's health information so that they can care for them safely and effectively, but we believe this needs to go further. **We are therefore making key changes to the GP contract, starting in April 2014, to make clear the need for general practice to securely share records with other services, where patients are content for them to do so.** These changes will benefit all patients, but will be of particular benefit to older people and those with the most complex health needs.

20. Specific agreed changes now require GP practices to:

    - Include the NHS number on all communications relating to the patient to allow secure information sharing across care settings.

    - Update the Summary Care Record with relevant patient information, at least on a daily basis, ensuring that other providers are able to access up-to-date information.

    - Provide for electronic transfer of records between GP practices, or at least have plans in place for achieving this, by 31 March 2015.

    - Provide information securely to the Health and Social Care Information Centre.

21. The BMA General Practitioners Committee has also committed to working with NHS England to make progress in permitting access to patient records from other care settings, so that patient

care can be seamless and joined up, and making referrals electronically from April 2015 or having plans in place to do so.

22. To further improve care, we want all ambulance services, NHS111 services and A&E departments to be able to access GP patient records. **NHS England is in discussion with GPs to make progress to achieve coverage of at least a third of providers by 2015 and full coverage by the end of 2016.**

Case study: integrated services working around people's needs

Torbay and Southern Devon Health and Care NHS Trust is an organisation within one of the fourteen integrated care pioneer sites and provides an excellent example of the importance of different services working effectively together. It was formed in Torbay in 2005 with responsibility for both health and social care. A single assessment process was implemented for health and social care, and integrated health and social care teams were established that were able to deliver effectively coordinated, patient-centred care. These teams work closely with general practices to provide care to older people in need and to help them live independently in the community.
The vision was for local people to only have to tell their story once. Single health and social care coordinators became the main point of contact for referrals and liaised with other team members to decide who should handle these referrals and how. They also worked closely with nurses, allied health professionals and social care staff to put in place appropriate care packages and support. The work of coordinators was underpinned by a commitment to sharing data, enabling coordinators to access information about users from the hospital, general practices and from within the Trust.

Health and social care integration has had a significant impact on the quality of services available to the local population and the Trust's scope has now widened with integrated services being provided across South Devon. Success is reflected across a wide range of indicators - delayed transfers of care fell to just 32 in December 2013 and the daily average number of occupied beds in the area fell from 439 in January 2005 to 375 in January 2013. Building on their successes, the focus has now widened to better integrate primary care and mental health care within this joint health and social care model. The Trust is working closely with GPs, Torbay Hospital, Torbay Council, Devon Partnership NHS Trust,Devon County Council and Rowcroft Hospice to achieve ambitious plans of joining up the whole health and care system in Torbay and South Devon.

Planning for the future workforce

23. The primary and community workforce is crucial to our vision of care. As ways of working shift more care into local communities, we need to ensure that the workforce is available and capable to support this change. More GPs will be needed to provide oversight and leadership of care to people with the most complex needs. More community nurses will be needed to manage chronic conditions, support self-care and to tackle social isolation. We also need to harness the opportunities of pharmacists and allied health professionals in community settings who are skilled to support people across a range of areas.

24. As a greater number of services are made available in the community and unnecessary hospital activity is avoided, we need to ensure that staff can follow the shift in activity from hospitals to primary and community services. To ensure that we have a workforce ready to meet the challenges of the future, **we are planning to make available around 10,000 primary and community health and care professionals by 2020, in support of the shift in how care will be provided.**

    [PLACEHOLDER – Workforce infographic]

25. This planning assumption needs to be responsive to changing requirements to ensure the appropriate mix of GPs, community nurses, allied health professionals and other frontline staff. It should not be an end in itself, but be a plan to drive our focus for the coming years. To support this aim, **HEE will continue to increase the number of placements in primary care, community health services and integrated care settings for undergraduate trainees so that more graduates consider moving into community and primary careers.**

26. HEE is developing a 15-year strategic view of the NHS workforce. Building on this, and NHS England's strategic framework for commissioning primary care services, the Department will work with HEE and other stakeholders to inform detailed planning for the future primary care workforce including the required skills.

Meeting current pressures

27. As well as planning for the future, we need to address the pressures that practices are facing in recruiting and retaining staff. There are long-standing inequalities in numbers of GPs and general practice nurses, particularly in deprived areas and rural or remote areas.

28. Within the community workforce, there is also a pressing need to improve capacity in certain sectors including general practice nursing and district nursing. HEE and NHS England are therefore working with the RCGP, RCN, the Queen's Nursing Institute and other professional representatives to address these challenges. This work will include action to:

    - Improve the recruitment of GPs, general practice nurses and community nurses where this has been challenging, including in deprived rural and remote areas.

    - Promote safe, effective and proportionate routes for GPs and nurses wishing to return to practice, and supporting the retention of the existing workforce.

    - Support the development of community, district and general practice nurses through the Community Nursing Strategy Programme.

    - Encourage more effective use of skill mix in general practice and encouraging practices to work with the wider community workforce and with communities themselves to allow best use of community assets.

IMPLEMENTING THE VISION

- We will provide guidance, and clear standards so that people are clear about what needs to change. Success will be celebrated and shared with others to learn from and support will be provided to those that need to improve performance.
- We will also measure success of the plan, both nationally and locally, to ensure that lessons are learned and improvements can be made. These measures will include outcomes, process and experience data to help build up a picture of how the changes are working.
- The focus on people with complex needs is the first step in a wider vision for transforming care out of hospital. The Government will explore how the core principles of this plan can be extended beyond people with the most complex needs.

Implementing the plan

1. Improving care out of hospital has been a common theme of successive Governments, with varied success. Achieving this change will need clear focus, but also support for local leaders to implement the plan.
2. General practice, commissioners and the wider system will need to work together to achieve the ambitions for primary and community care for those who need them most, and we will support them in reaching these goals. This includes:
    - **Sharing best practice** – and celebrating examples of successes, both locally and nationally.
    - **Guidance for GPs** – from NHS England on the implementation of the Proactive Care Programme.
    - **Inspection of practices** – by CQC to ensure services provide people with safe, effective, compassionate and high quality care, including specific ratings on the delivery of services for older people and those with long-term conditions.
3. NHS England is working with professional bodies to provide additional direct support to CCGs that will build on the guidance it has issued on the implementation of the Proactive Care Programme. Taken together, we are confident that this suite of support will ensure GPs have the help they need, both nationally and locally, to lead the transformation of change envisaged in this plan.

Case study: Greater Manchester Health and Wellbeing Board

The Greater Manchester Health and Wellbeing Board provides overarching leadership for a health and social care reform programme across the NHS and Local Authorities in Greater Manchester. A key strand of this reform is out-of-hospital care and health and social care integration, and as part of this the Board is driving forward an approach to reducing the number of older people who are taken into hospital. The Northwest Ambulance Service are working in partnership with adult social

care to pilot the paramedic pathfinder tool[34]. Paramedics conduct a face to face assessment when they arrive at the scene and, using a flow chart of specific symptoms, determine the most appropriate care pathway for that patient. Depending on the assessment, the next step for the patient could be that they are taken to either a community based specialist service, an Urgent Care Centre or to an Emergency Department. This ensures that people get the care most suitable for their individual needs and prevent avoidable hospital admission.

Measuring progress

4. In order to ensure that the ambitions set out in this document are delivered effectively and to learn how this could be improved in future years, we will need clear measures of success.

5. Central to the plan will be the impact of the Enhanced Service, which NHS England and CCGs will monitor. Practices will be required to demonstrate that they have implemented the Enhanced Service for at least the 2% of adult patients with the most complex health and care needs. This monitoring will include measuring the numbers of people who have a patient care review on at least a quarterly basis. This reflects the importance of managing risks to health, preventing people reaching crisis point.

6. NHS England and CCGs will also monitor the impact on emergency admissions and length of stay, as key measures of the quality and cost of service. Of course, the most important feedback on this plan will come from the people it is intended to benefit. We will therefore conduct a survey of these patients at regular intervals, to understand how the Proactive Care Programme has changed their experience of care.

7. More widely, there are a number of measures that we will use to assess progress against our overall plan for the transformation of out-of-hospital care. These include measures of the quality of patient experience of care, including how easily they have been able to access the services they need and the amount of time they spend in hospital. We will also consider measures of activity within the system, including for example the number of readmissions to hospital after discharge and the overall cost to the system of supporting these patients

8. Our assessment of the impact of innovations and good practice needs to be based on clinical outcomes, experience and costs. When assessments consider costs or savings to the system, they can often be conducted in silos so the benefits realised in a different part of the system aren't taken in to account. We need to improve our understanding of whole system costs of care so that those who commission services can understand how individuals are using services. We will work with CCGs to help commissioners and providers understand better the overall costs of care for patients with more complex needs and thereby help them organise services better".

Transforming out-of-hospital care

9. Many of the changes proposed on personalised care, on support for staff and on wider system changes will have benefits beyond people with the most complex needs. The immediate focus

on this group is the first step in changing the way in which services should provide care in primary care settings.

[PLACEHOLDER: Long term conditions infographic]

10. Over the coming months, we will be considering how the principles of proactive, personalised and joined-up care can be extended beyond people with complex needs, in particular to a greater number of people with long-term conditions. This work will build on the work being taken forward by NHS England and a range of partners on the House of Care Model to deliver proactive, holistic and patient-centred care for people with long-term conditions.[35]

11. Our next steps will be informed by our progress on this plan and the feedback we receive from those benefitting from and implementing the actions it contains.

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