

**Their Patients, Our Clients**  
**Our Patients, Their Clients:**  
Developing effective partnerships between the  
NHS & the Advice Sector in England  
The Evidence Report for *advice*<sup>UK</sup>

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June 2009



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## FOREWORD

This is the second of two reports which explore the potential for developing effective partnerships between the NHS and the advice sector in England.

This report provides the evidence base for the companion Discussion & Guidance document. It is hoped that the information here will provide further detailed information and background support for those taking forward the ideas contained in the discussion paper.

It comprises:

- A somewhat fuller guide to NHS bodies and their functions than that included in the Discussion and Guidance paper.
- A more detailed look at the shared objectives, particularly a more in depth statutory background a closer look at significant parts of future NHS plans.
- Summary research findings from the review of twenty PCT Commissioning Strategic plans. These aim to raise some of the issues health and advice partners may wish to consider before embarking on developing a funding / commissioning relationship.
- A literature review of studies of the health impacts of advice.
- Summaries of the key elements of twenty PCT Commissioning Strategy Plans.
- A list of the “Spearhead” PCTs
- Recommended further reading.

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## WORKING TOGETHER

### 1 FINDING YOUR WAY AROUND THE NHS

As with all large institutions the NHS can seem a daunting a complex world to outsiders with impenetrable structures and unique processes. In this section we provide a quick guide to the key bodies, their principal functions and some hints on finding the right people to talk to. In all cases this refers only to the NHS in England; the NHS is differently structured in each of the home nations with the national parliaments or assemblies in those areas setting their own priorities.

The last major structural reconfiguration of the NHS took place in 2002 with the establishment of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). However in 2006 these were reconfigured reducing the number of SHAs to 10 across England and merging PCTs into larger bodies in most parts of England (except London) into larger bodies. Since that time there continue to be changes and reform, however the basic shape remains the same.

#### 1.1 THE DEPARTMENT OF HEALTH AND THE NHS EXECUTIVE

The Department of Health is the department of state charged with “improving the health and wellbeing of the people of England”<sup>1</sup>. Under the Secretary of State are a Minister of Health Services and a Minister of Public Health and a number of Ministers of State and Undersecretaries. They are advised by Chief Officers (Medical, Nursing, Dental, Health Professional, Pharmaceutical and Scientific). Implementation of policy emanating from the Department is in the hands of National Clinical Directors covering fields such as Emergency Access, Pandemic Influenza Preparedness, Mental Health, Health and Work, etc.. The former NHS Executive ceased to exist in 2002.

The Secretary of State discharges his responsibilities through the NHS Chief Executive for England.

#### 1.2 STRATEGIC HEALTH AUTHORITIES

The NHS Chief Executive is responsible for a network of 10 Strategic Health Authorities across England. They are known by the name of their respective region e.g. NHS North West, NHS London etc. The NHS description of the role is:

*“Strategic health authorities are responsible for:*

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<sup>1</sup> [www.dh.gov.uk](http://www.dh.gov.uk)

- *developing plans for improving health services in their local area,*
- *making sure local health services are of a high quality and are performing well,*
- *increasing the capacity of local health services - so they can provide more services, and*
- *making sure national priorities - for example, programmes for improving cancer services - are integrated into local health service plans.*

*Strategic health authorities manage the NHS locally and are a key link between the Department of Health and the NHS.”<sup>2</sup>*

### 1.3 PRIMARY CARE TRUSTS

Every local authority or group of local authorities is covered by a Primary Care Trust or PCT. From 1<sup>st</sup> April they stopped using the term PCT in their name but this is still the legal term for these bodies but their trading names have changed from , for example Manchester PCT to NHS Manchester, etc. This can be confusing but they are one and the same body.

The role of Primary Care Trusts (PCTs) is to improve the health of their local community. They are pivotal to the planning and delivery of local NHS services. They work closely with patients, service users, carers, GPs, other health professionals and local healthcare providers to assess local health needs and then to develop or commission suitable services. PCTs receive most of their budget directly from the DH and use this to commission hospital and other services from NHS trusts and other healthcare providers. This includes commissioning services from independent primary care contractors such as GPs and dentists, and from the independent sector, which includes voluntary and private sector providers.

At present, a few PCTs still also directly provide a range of community-based health services, including those relating to sexual health in some areas. Future changes in the NHS system will mean that these services are relocated to other providers over the next two years, which may lead to an increase in NHS-funded provision by the private and/or voluntary sectors.

PCTs are responsible for assessing the health needs of their communities and develop plans for meeting these needs and plans for ensuring that NHS providers can meet any national or regional priorities (e.g. maximum waiting times). PCTs put in place services to meet their obligations and implement their plans. To do this they *commission* services. Commissioning can

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<sup>2</sup> [www.nhs.uk](http://www.nhs.uk)

mean buying services from other parts of the NHS such as GPs or hospitals or buying in services from other bodies in the private, public or voluntary or community sectors. They will commission, for instance, accident and emergency services from a hospital but may commission a mental health support service from a charity. Understanding the commissioning function and making contact with the commissioning part of the service is critical to being able to offer services and be paid for delivering them.

PCTs are not simply charged with ensuring treatment services are available locally. They are charged with providing health and as such should be pro-active in tackling health inequalities within the communities they serve and in the prevention of illness and injury.

Very much after the fashion of the commissioner provider split which has been seen in local authority social service departments, the PCTs are separating their commissioning and providing arms. The commissioners are responsible for buying a service from someone to see that a need identified in their planning is met. The providers will tender for services and must demonstrate that they are competitive with independent providers of similar services and when the split is complete will have to tender directly against competition. The divorce of these services and the erection of a firewall between them is proceeding at very different speeds across the country. It will be most keenly felt in the provision of community based services as there are, obviously, a limited number of providers of acute hospital services. Trusts now talk of managing the market place and the “provider landscape” which are terms new to healthcare but which need to be understood as to work with them you have you a provider in that managed market.

PCTs do not necessarily commission alone. They may commission collaboratively where a group of trusts over an expanded geographical area commission a specific medical service - for instance the renal care service under the South West London Collaborative Commissioning Initiative. Within London the 31 PCTs have set up arrangements where all acute (hospital) services are commissioned by just six “sectors”. They may also commission jointly with other partners - typically local authorities - to jointly commission, say, a mental health service to provide both health and social care.

### **1.3.1 RELATIONSHIP WITH LOCAL GOVERNMENT**

Primary Care Trust boundaries are, where possible, shared with local authorities responsible for social services (unitary authorities and counties) though there are examples where a PCT covers a number of unitary authorities or part of a county or exceptionally both such as

Tameside and Glossop PCT. There is strong expectation that they will co-operate to deliver a seamless service to residents and deal with their conflicting financial imperatives for the benefit of patients. In many cases joint trusts have been set up using pooled budgets to provide both health and social care services - mental health services are commissioned in this way over much of the country.

PCTs are now under a legal duty to participate in Local Strategic Partnerships (LSP) led by local authorities. As part of these LSP arrangements PCTs and local authorities now undertake periodic Joint Strategic Needs Assessments to determine the health needs of their local communities. In recent years there has been a growing tendency for joint appointments at senior levels, most often joint Directors of Public Health but in some cases joint chief executives.

From next April the regulators (see below) will be assessing PCTs on the quality of their relationship with local government with top marks reserved for those that can demonstrate the closest relationship.

#### **1.4 PROVIDER TRUSTS**

Alongside the SHAs who are the system managers and the PCTs who are the local commissioners the other key part of the NHS are the provider trusts. Trusts provide hospital, mental health, ambulance services and some community-based health services.

These can be NHS Trusts, directly accountable to their local SHA or Foundation Trusts (FT) which have considerable autonomy whilst still being part of the NHS. Over time the government aims for all trusts to attain FT status (except for a few specialist trusts such as Broadmoor that are prohibited from acquiring this status).

Funding, as well as the types of treatment and services that the trust will provide, is determined with the PCTs through service agreements.

#### **1.5 THE REGULATORS**

##### **1.5.1 CARE QUALITY COMMISSION**

At the end of March 2009 the Healthcare Commission was replaced by a new body, the Care Quality Commission (CQC). The CQC, for the first time, brings together regulation of the health sector with the social care sector. It is currently developing its assurance process and framework; however, on the basis of public comments from its Chairman Baroness Young, it

will mark a radical departure from the approach taken by the Healthcare Commission. Its quality assessment is likely to include five key domains:

1. Safety
2. Clinical Outcomes
  - Patient experience (in two parts):
  - Satisfaction
3. Patient Reported Outcome Measures (PROMs)
4. Access
  - Societal Contribution including potentially links to Local Area Agreements, value for money etc.

Of additional relevance to this review is that from April 2010 the CQC registration requirements will include the extent to which health and social care services are integrated or provide a seamless service.

#### **1.6 NATIONAL OR REGIONAL PROGRAMMES**

Whilst the vast majority of NHS funding is distributed to other parts of the NHS through PCT commissioning there are some national and regional programmes where money is provided from the centre. This includes ongoing programmes such as research and development or workforce training to one-offs such as the high profile programme of “deep cleaning” in every hospital.

Occasionally such programmes can relate closely to the work of advice agencies. For example in 2007 the Government announced that it was making substantial funds available for “Increasing Access to Psychological Therapies” (IAPT). As the IAPT programme has been rolled out it has increasingly focussed on the mental health issues arising from the recession and as part of this work in some regions IAPT has begun to develop much closer links with debt advice agencies.

## 2 IDENTIFYING SHARED OBJECTIVES

### 2.1 OVERVIEW

The radical changes facing the NHS at a national level from a model where people became ill and went to hospital to get better to one striving to prevent illness and to maintain those who are ill in their own homes hugely expands the opportunity to develop the naturally symbiotic relationship between health and advice provision. The specific provisions of the commissioning plans of many of the PCT's further emphasise this. Advice can undoubtedly assist the PCTs in achieving their targets and in turn funding from PCT's can help advice services deliver services to more of the communities they serve. It is a relationship which should have only winners, most particularly the public, but it is a relationship which needs understanding and action to develop. This report and its supporting papers hope to contribute to that understanding.

For advice agencies to develop effective partnerships with the NHS there is a need to identify shared objectives. We suggest that there are three key areas for advice agencies to examine locally:

#### 1. Understanding the NHS Policy Drivers

Are there parts of the national or regional NHS agenda that your service could contribute to? For example what is or could your service do to advance the goals of the NHS Operating Framework Priority Three in relation to?

- Smoking reduction
- Tackling obesity
- Improving Sexual Health
- Treating drug addiction
- Improving Mental Health
- Reducing alcohol harm

Is there a role for your agency to advance the goals of the NHS Operating Framework Priority Four in relation to improving patient experience, staff satisfaction and engagement?

#### 2. Contribution to tackling health inequalities

Are there specific targets that your PCT has set around health inequalities that you could assist with? Are you in a spearhead PCT area? If so, they have additional responsibilities in tackling health inequalities.

#### 3. Focus on Client Groups

National priority groups include older people and carers. Locally other priority groups may

have been identified. Do these priority groups match the profile of your service users? Are there ways you could work with them that would provide benefit to the NHS or things that NHS could do that would provide benefit to you?

## **2.2 LEVELS OF POLICY AND FUNDING DECISIONS**

The key fact is that 80% of the NHS budget is spent by the 152 local Primary Care Trusts<sup>3</sup>. Accordingly this report looks primarily at the spending plans of a sample of those trusts. The Trusts however do not have total freedom, being bound by Department of Health's national policies and the ten regional Strategic Health Authorities (SHAs)

The purpose of this section is to identify which are the areas all trusts must give priority to and thus will require the commissioning of services throughout the Country and those areas which are left to SHAs and PCTs to determine.

## **2.3 UNDERSTANDING THE NHS POLICY DRIVERS**

### **2.3.1 THE OPERATING FRAMEWORK AND PRIORITY TIERS**

The Operating Framework for the NHS in England 2009/10 sets out the national framework<sup>4</sup>. Themed "High Quality Care For All", this was published on 8 December 2008.

It sets out three levels of priority.

- Tier 1 priorities identified as "must do" and subject to central (i.e. Department of Health) control,
- Tier 2 "national priorities for local delivery" where "strongly performing organizations" will be allowed to deliver without interference from the centre.
- Tier 3 indicators which can be selected locally for targeting action. And are not centrally monitored.<sup>5</sup>

The following is not a complete summary but is a highly selective survey of the parts of the framework which could be effectively supported or delivered by advice agencies. It aims to show what can be seen as applying everywhere in England and areas where significant local flexibility exists.

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<sup>3</sup> [www.nhs.uk](http://www.nhs.uk)

<sup>4</sup> Downloadable from

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091445](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445)

<sup>5</sup> Operating Framework for the NHS in England 2009/10 p10

### **2.3.2 OVERALL FINANCE**

The framework asserts that “NHS finances are now much healthier with a surplus in the system as a whole and the vast majority of NHS organizations maintaining financial balance.”<sup>6</sup>

### **2.3.3 THE FIVE PRIORITIES**

The five national priority areas are (summarized):

1. improving cleanliness
2. improving treatment times
3. “keeping adults and children well, improving their health and reducing health inequalities”
4. improving patient experience, staff satisfaction and engagement
5. preparing to respond to emergencies

There would seem to be a very strong role for advice and information in delivering priority 3 and possibly significant roles in 4 and 5.

### **2.3.4 PRIORITY 3; KEEPING ADULTS AND CHILDREN WELL**

The preventative thrust of this accords well with the aims and established effectiveness of advice.

“for the NHS to be sustainable in the 21<sup>st</sup> century, it needs to focus on improving health as well as treating sickness”

Improving life expectancy in the “Spearhead” PCTs and tackling high infant mortality rates in disadvantaged groups are priorities. A full list of the 70 local authorities and 62 PCTs identified as high inequality “Spearhead” areas is included as appendix 1. Spearhead PCTs have submitted all age, all cause mortality plans (AACM) which seek partnership in tackling health inequality.

Six key goals to be pursued following local identification of need are

- Smoking reduction
- Tackling obesity
- Improving Sexual Health
- Treating drug addiction
- Improving Mental Health
- Reducing alcohol harm

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<sup>6</sup> Operating Framework for the NHS in England 2009/10 p8

Specific within these are

- prevention packages for older people
- joint plans with local authorities for a carer's strategy including breaks for carers.

All PCTs are required to consider action on cancer, stroke, maternity and children. Of specific interest to advice agencies will be the requirement to “demonstrate improvements in the experience of women and their families” in maternity and neonatal services and the child obesity and teenage pregnancy targets. There are issues around housing, debt, and income maximization, timely and confidential advice in all of these.

#### **2.3.5 PRIORITY 4; EXPERIENCE, SATISFACTION AND ENGAGEMENT**

The agenda for advice agencies will rightly be dominated by priority 3 but in seeking to develop a service, impact on other priorities should not be forgotten - particularly on satisfaction. The more advice can be accessed as a seamless part of the overall package, the more satisfied patients will be - benefit advice available at maternity and neonatal clinics being an obvious example.

#### **2.3.6 PRIORITY 5; EMERGENCY PREPAREDNESS**

A close relationship with advice agencies should enable health providers to improve communication, particularly with vulnerable communities in times of local or national health scares such as e-coli outbreaks or flu pandemics. There is also a role for advice in the aftermath of disasters, man made or natural. These are not pivotal roles but an awareness of them and their inclusion on in service level agreements may assist in a small way in securing funds for an overall package.

#### **2.3.7 PRIORITIES TO BE SET LOCALLY**

Programmes to be developed locally and included in Local Area Agreements include:

- Alcohol
- Dementia
- End of life care
- Mental health
- Military personnel, dependants and veterans
- People living in vulnerable circumstances
- People with learning disabilities

Reflecting diversity and seeking out those most at risk are part of the agenda for vulnerable

people.

## **2.4 POLYCLINICS**

Although not always referred to by the term in plans, PCTs are expected to look at the development of polyclinics, 150 of which are expected to be developed in London. Described by the BBC as “super GP surgeries”<sup>7</sup> these are expected to provide a much greater range of services than traditional GP surgeries. Proposed by Health Minister Lord Darzi<sup>8</sup> these proposals have generated considerable controversy. What is clear is that these developments provide a level of opportunity to embed appropriate advice services in centres delivering medical and community care services in a way which has not previously been possible. This underlies all the plans for London and will be highlighted below where proposed outside London.

## **2.5 COMMISSIONING STRATEGY PLANS (CSP)**

Each PCT has to produce a have approved a CSP for the coming five years detailing its goals and the initiatives it will undertake to achieve them. These detail the strategic approach to Primary Care and the changes needed in types of service and delivery of those services. These often involve significant changes in the geographic and structural arrangements of services and in who is commissioned to provide the services - “the provider landscape”. Joint commissioning of health and community care services is often envisaged. These are substantial documents, typically upwards of 85 pages and some up to three times that. Much of the content is, naturally, medical and the Parts 4 and 5 of this report below seek to distil from them the areas where access to high quality advice services could significantly enhance the patient outcomes.

## **2.6 A CHANGING CONTEXT FOR COMMISSIONING**

### **2.6.1 HEALTHCARE FOR LONDON & THE NEXT STAGE REVIEW**

The NHS has embarked upon a major process of change. Within London, the NHS commissioned Professor Sir Ara Darzi (now Lord Darzi) to develop plans to reconfigure services across the capital. All PCTs in London have consulted on the principles behind these changes and outline ideas and have established a central *Healthcare for London* (H4L) team to carry forward this work. Of particular importance to this review are the proposals within H4L to:

- Shift resources and activity from the acute sector to the primary care sector
- Establish of poly clinics
- Reshape the education and training to support the shift to primary care

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<sup>7</sup> <http://news.bbc.co.uk/1/hi/health/6288366.stm>

<sup>8</sup> NHS Next Stage Review: final Report NHS June 2008

- Provide greater resources to health promotion and illness prevention work.

Following the success of Lord Darzi's H4L review he was appointed as a Minister within the Department of Health in 2007 and charged with undertaking what was termed the Next Stage Review (NSR) across the rest of England. The NSR has now been completed with its final report, "High Quality Care for All" published at the end of June 2008. Much of the NSR reflects thinking already contained in H4L including a commitment to shift resources from the acute sector into primary care and greater emphasis on health promotion work. In a number of key areas of relevance to this review it does go further than H4L, most notably:

- The development of personalised care plans for *all* patients with long-term conditions, and the piloting of personalised budgets for patients
- A greater emphasis on the measurement and publication of information about the quality of care including the requirement for providers to develop "Quality Accounts" to be published alongside their financial accounts and the establishment of regional Quality Observatories. This quality agenda may also see adjustment to tariffs on the basis of emerging best practices. Patient experience and Patient Reported Outcome Measures (PROMs) will be a key part of the assessment of quality.

The NSR also commits the NHS to the development of an NHS Constitution (see above).

#### 2.6.2 NHS CONSTITUTION

As part of the NSR the DH also launched its consultation on the first constitution for the NHS. It is envisaged that this will underpin all work by the NHS and will be reviewed every ten years. We consider the proposed clauses on involvement in healthcare and in the NHS of particular significance. This provides for two key rights and two pledges:

- *"You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this.*
- *You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.*
- *The NHS will strive to provide you with the information you need to participate effectively to influence the planning and delivery of NHS services. (pledge)*
- *The NHS will strive to work in partnership with you, your family and carers. (pledge)"*

### **2.6.3 “CHOOSING HEALTH”: THE WHITE PAPER ON PUBLIC HEALTH**

In 2004, the Government published a White Paper, *Choosing Health*, which laid out strategies for promoting health through campaigns, changes in service provision, and, most importantly, actions to tackle health inequalities.

### **2.6.4 WORLD CLASS COMMISSIONING**

The Department of Health has committed itself to an ambitious programme to raise the quality of commissioning across England under the heading of World Class Commissioning (WCC). As part of this agenda all PCTs have undergone an assurance exercise to assess how far their current systems comply with the eleven competences required under WCC.

### **2.6.5 PAYMENT BY RESULTS**

As part of its NHS reform programme, the Department of Health (DH) has begun to progressively introduce a new system of funding for NHS services, known as “Payment by Results”. The principle is that a fixed sum of money follows each patient, and that the fixed sum of money is sufficient to cover the costs of care to the accepted standard in an average provider. PbR aims to:

- Incentivise better health and health care
- Drive innovation, productivity and responsiveness
- Maintain a clinically sound, transparent and sustainable framework for commissioning

The majority of out-patient services are now covered by PbR with a national tariff which can be adjusted by a local Market Force Factor (MFF). PbR is currently under-review to increase the flexibilities and the Next Stage Review proposes to pilot quality enhancements to tariffs.

### **2.6.6 PERSONALISED HEALTH BUDGETS**

Other initiatives are also on the horizon. The NSR has committed the NHS to develop personalised budgets for patients with long term conditions such as diabetes, paralleling developments in social care.

## **2.7 PATIENT AND PUBLIC ENGAGEMENT**

Community engagement in the development of public policy has been an increasingly important part of the agenda for health and social care services over the past decade. This has developed into systematic consultation processes underpinning the development of local strategic plans (led by local authorities) and was given particular prominence in the 2002 NHS re-organisations

set out in “Shifting the Balance”<sup>9</sup>. The current round of NHS changes envisaged in “Commissioning a Patient Led NHS” and the Next Stage Review place further emphasis on strengthening mechanisms for the NHS to consult with local communities.

Within the health and social care settings the drive to greater community consultation and engagement has been reinforced by legislation. This section provides a summary of the basic requirements of Sections 7 and 11 of the Health & Social Care Act, 2001.

### **2.7.1 SECTION 11 OF THE HEALTH AND SOCIAL CARE ACT 2001**

This Section places a duty on all NHS organisations<sup>10</sup> to make arrangements to involve and consult patients and the public on changes to services they are responsible<sup>11</sup> for. This means the NHS must involve and consult patients and the public:

- Not just when a major change is proposed, but in the on-going planning of services;
- Not just when considering a proposal but in developing that proposal; and
- In decisions that may affect the operation of services.

Engagement needs to begin right at the beginning and continue throughout the process to:

- Gain a joint understanding and set a joint agenda
- Work together to develop a vision.

The guidance for Section 11 includes best practice baseline measures; these will be used by various agencies/organisations as a guide to whether the requirements of the legislation have been met, for example Patient & Public Engagement Forums, Overview & Scrutiny Committees (OSCs), Independent Reconfiguration Panel.

### **2.7.2 SECTION 7 OF THE HEALTH & SOCIAL CARE ACT 2001**

Section 7 of the Health & Social Care Act 2001 requires Overview and Scrutiny Committees (OSCs) to be consulted on ‘substantial variation or development to health services’. OSCs are drawn from elected members of local authorities and may call other witnesses, including community organisations and individuals, to assist in their deliberations.

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<sup>9</sup> Department of Health, 2001.

<sup>10</sup> Strategic Health Authorities, PCTs and NHS Trusts

<sup>11</sup> This is defined as the organisation that either provides the service or arranges for another organisation, person or people to provide the service for it.

### 2.7.3 OTHER GENERIC ENGAGEMENT FORA

The NHS re-organisation in 2002 envisioned by “Shifting the Balance” saw the abolition of Community Health Councils and their replacement by Patient & Public Engagement Forums (PPIF) in December 2003. Under that system each Trust (including hospitals, primary care trusts, mental health trusts etc.).

These forums were seen as largely unsuccessful and from April 2008 responsibility for public engagement was shifted to local authorities who were funded to commission Local Engagement Networks (LINKs)<sup>12</sup>. Each local authority with a social services department has a budget for commissioning a local LINKs.

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<sup>12</sup> These were established under the Local Government & Public Engagement in Health Act 2007. The aspirations for the LINKs were set out in the Department of Health’s “*A Stronger Local Voice: A Framework for creating a Stronger Local Voice in the Development of Health and Social Services*” (2006)

### 3 RESEARCH FINDINGS AND RECOMMENDATIONS FOR ACTION

The following are drawn from the study of Commissioning Strategy Plans of nine Primary Care Trusts in London and eleven outside London. The detailed summaries of those Plans are below.

- The plans vary enormously in detail, in scope, in the level of resources already committed and the amount still at a planning stage. While they all reflect the NHS's national priorities, local priorities do differ. Some set very specific challenges to which the advice sector can easily respond. There is no substitute for studying the plan or plans for the area within an agency's remit.
- Trusts' financial positions vary enormously, with some carrying a surplus and some struggling to clear debt. Overall, the position appears to be quite positive.
- What research has been done clearly identifies the health benefits of social welfare advice particularly debt advice, income maximization / welfare rights advice and housing advice. A review of some of that literature is available as a supporting paper.
- Key themes in the changing health service are prevention of the need for treatment and high quality community based treatment. Advice agencies are uniquely able to contribute to this agenda of keeping people well and at home for longer both by addressing long term needs for a sustainable income and dealing with crises such as threatened repossession of homes.
- To be commissioned to contribute to this agenda, agencies need to be flexible and need to consider a range of issues, some of which will be challenging and are detailed below. The benefits to agencies in terms of resources, to PCTs in achieving their goals, particularly to removing health inequalities are clear.
- This is a major time of change; new structures and new post such as Primary Care Development Officers are being set up. Agencies are advised to identify contacts both in the service provision and commissioning areas.
- These are rolling five year plans and different part of plans and different PCTs are at very different stages and some are keen to develop the "provider landscape" - the range of potential providers of services from public, private and voluntary and community sectors. In some cases very high level decisions have yet to be made and the opportunity is clearly there to ensure that the role of advice and the potential providers is included and to be involved in projects at design stage.
- Many trusts already value their relationship with voluntary and community sector and some contract with the sector for the provision of services. In some cases the breadth of the role envisaged or its absence may need to be challenged. Plans may not wholly reflect a PCT's view of the relationship and there is no substitute for personal contact.

- Some plans are clearly targeted at health inequalities and already detail a specific role for advice but most do not.
- Collaborative Commissioning. Some services are provided jointly over a number of PCT areas and it is important that advice providers appreciate that. This raises the issue of agencies bidding as a consortium to deliver services across such a jointly commissioned area. It also opens up the possibility of agencies bidding outside their normal areas of remit, potentially in competition with agencies who normally serve that area. Agency management committees may wish to consider the implications of this.
- Joint Commissioning. Many services are jointly commissioned by partners operating within a single area - usually including the local authority and the PCT. Again agencies need to know who the commissioner is.
- Practice Based Commissioning. At the other end of the scale individual practices or polyclinics will have their own budget for some services and it is useful to know what is commissioned at this wholly local level.
- Agencies may wish consider bids with non advice partners - for instance to provide benefit screening for users of long term nursing care service. Some of these bids will be made by public services, some by voluntary and community sector agencies and some by private companies. Management committees may want to consider their attitudes to potential partners.
- Agencies should be prepared to evidence the value for money they provide and consider what performance measures should be in a contract. Determining the outcomes and outputs expected and making their own view of these form part of the bid should lead to more satisfactory contract for both parties.
- Agencies should consider whether they could work on a price per case basis rather than an annual fee basis. This is likely to form a growing part of the health economy.
- Agencies currently providing service from health premises need to be aware of any plans to move clinics and services to community settings and be ready to re-appraise how they deliver their services.
- A number of developments which offer potential for partnerships between advice agencies and PCTs are widespread through most PCT plans. These include:
  - ➔ Polyclinics the development of large community based facilities offers a more realistic scale on which to offer services than a single GP practice and from the user's point of view can assist by grouping advice with a range of other services. They will also offer contemporary accessible premises.
  - ➔ Long term care and end of life care at home. Changes in financial circumstances, care needs and indeed advice on the material aspects of

- dealing with a death may all call for effective advice to ensure the success of the package of care.
  - ➔ Separate communities - these may be prisons or isolated ethnic or religious communities and may either be communities where advice input would be valuable or communities where an advice agency has a level of contact and trust which is not shared by the NHS and could assist access for preventative services such as vaccinations.
  - ➔ Health inequalities - Trusts' targeting health inequalities are generally targeting the same communities that advice agencies are - especially those which are part of or linked to specific communities. They can have an important role in supporting the tackling of those inequalities.
- There are number of non-advice roles agencies may be uniquely equipped to fulfill, including:
  - ➔ Training - if services are embedded in the development of health provision, training on, say, NHS costs, basic debt and benefits and how to refer patients to local services can be provided for staff of GP's, Dentists, pharmacists, community nursing staff, etc. - all within the walls of a polyclinic.
  - ➔ Community access for some health services. Some communities are resistant to major strands of the Trusts' prevention work. Non health premises such as an advice centre may provide opportunities for, say, Chlamydia screening to people who would be hesitant going to a health centre or GP's.
  - ➔ At least one PCT has a specific target of developing community infrastructure where none exists a function in which advice services could certainly contribute.
  - ➔ The patient experience. Agencies could contribute enormously to the collection of feedback form patients.
  - ➔ Legal advice in preparing care packages. Some agencies may be able to advise on the consequences of the design of care packages on individual's income and thus on the likely success of the package.
- The authors would encourage agencies to contribute to academic research on the impact of advice where there is a possibility to do this. Several PCT's have partnership with academic institutions and are keen to establish the impact of new models of prevention and treatment.

## THE EVIDENCE

### 4 A NATIONAL CONTEXT

#### 4.1 LITERATURE REVIEW

##### 4.1.1 INTRODUCTION

A number of studies which have taken place over recent years suggest that welfare rights advice, through improving take-up of entitlements, can have a positive impact on health and social well being. Furthermore, placing advisory services in a primary care context could be a particularly effective method for reaching eligible non-recipients. References towards this literature are presented in this section.

For young people a reduction in financial worry may contribute to long term reduction in ill-health which has proven to be associated with anxiety and stress. In contrast, older patients have found that the impact is mostly felt on immediate improvements in quality of life and reduction in financial difficulties.

##### 4.1.2 LINKS BETWEEN ADVICE AND GENERAL HEALTH

Evidence to reinforce these observations can be found in the document *An Evaluation of the Health and Social Welfare Support Service*, which was developed as a pilot project by Ellesmere Port and Neston Primary Care Trust in 2004. It conducted a 'before and after' study and followed this up with a second questionnaire one year later and found that prior to intervention, participants' physical and mental health had a below average status however following the intervention mental health had significantly improved.

There is also literature<sup>13</sup> to support the emerging findings that welfare advice within GP surgeries and hospital settings draws attention to the common gains for patients and primary care staff, the benefits of which include:

- Placing advice workers in GP surgeries improves access for traditionally hard-to-reach groups in danger of exclusion because of age, poor health, lack of transport and psychological barriers to accessing mainstream advice services;

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Greasley, P. & Small, N. (2005b) 'Establishing a welfare advice service in family practices: views of advice workers and primary care staff', *Family Practice*, pp 513- 519, 22

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- Health workers develop a greater awareness and knowledge of benefits and relevant 'rights' advice enabling them to take a more holistic approach to patient (socio-economic) needs;
- The service can improve the health and quality of life enjoyed by patients;
- Improvements in health and well being of patients can lead to reduction in use of NHS resources.

Another advantage of welfare rights provision within general practice is that it may improve the access to welfare right advice of mental health service users and people from minority ethnic community. Services provided in this context give access to patients who might not use mainstream advice centres, particularly:

1. People with mental health problems;
2. Some members of the female South Asian population.<sup>14</sup>

The 2004 report *A Review of Research into the Impact of Debt Advice* by Tom Williams highlights a number of studies which were undertaken between 1997 and 2004 which provide evidence that there are positive links between advice and general health. For example, one study concluded that a CAB project giving advice to HIV sufferers led to reported improvements in both mental and physical health. Another study by researchers Abbott & Hobby in Liverpool looked at the impact of welfare benefits advice on the health of patients from seven GP practices and found that these welfare benefits which came about from engaging in advice services led to reported lower levels of stress, worry and depression and reduced their requests for GP consultations and prescriptions. They also decreased their visits to Accident & Emergency departments.<sup>15</sup>

In contrast, the group whose income did not increase following advice, the number of GP consultations, visits to the practice nurse, repeat and new prescriptions and referrals to secondary care all increased over the twelve month period. These results allowed Abbott & Hobby's study to become the first to show a measurable, statistically significant health gain associated with welfare benefits advice in a registered general practice population.<sup>16</sup>

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<sup>14</sup> Greasley, P. & Small, N. (2005b) 'Establishing a welfare advice service in family practices: views of advice workers and primary care staff', Family Practice

<sup>15</sup> Welfare benefits advice in primary care: Evidence of improvements in health.' *Public Health*, 2000

<sup>16</sup> Welfare benefits advice in primary care: Evidence of improvements in health.' *Public*

An example of good practice between the NHS and the advice sector include those found in the 2006 report *Prescribing advice: Improving health through CAB advice services* by the National Association of Citizens Advice Bureaux. They report that since 2003, the Department of Health has funded Citizens Advice to provide ICAS (Independent Complaints Advocacy Service) services in six of the nine health regions in England, helping people with concerns about NHS services and treatments.

This report makes a strong case for further joint working between the NHS and the Advice sector. The report states that “CAB advice services free up time spent by health professionals on patients’ social problems, leaving them to concentrate on medical matters. Doctors have found that patients who had received CAB advice visited them less often and needed fewer prescriptions, saving on local health budgets.”

They state that good advice to tackle non-clinical problems, like low income and debt, relieves the stress and anxiety that often underscore a patient’s clinical symptoms.

#### **4.1.3 MENTAL HEALTH AND DEBT**

Published evidence such as the article “a meeting of minds” present evidence which suggests that people with mental health problems “*are more likely to be in debt; more likely to borrow, especially of suffering from depression, and will have trouble managing their money and coping with the paperwork*”.<sup>17</sup>

In their report *Final Demand: Debt and Mental Health*, the Royal College of Psychiatrists state that: “*...spending can be exacerbated by the mental; health problems (e.g. mania and spending sprees), whilst debts can pile-up if individuals withdraw or find communication difficult...*”<sup>18</sup>

Furthermore, the stress of tackling debt problems is particularly amplified among people with mental health problems, who often:

- Experience memory problems on some psychiatric medications, which may make it difficult to keep track of finances;

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*Health, 2000*

<sup>17</sup> *A meeting of minds*. Article about debt advice and mental health. *Quarterly Account* Summer 2005.

<sup>18</sup> *Final Demand. Debt and Mental Health*. Royal College of Psychiatrists

- Find that some psychiatric medications make them feel lethargic and lacking in motivation to control their finances.<sup>19</sup>

Research by the Mental Health Foundation and the National Association of Citizens Advice Bureau have pointed out that mental health users have particular problems with the complexity of the benefits system, exacerbated by rapid and ongoing changes in their circumstance and compounded by a lack of awareness about how to access appropriate advice. A study by Sharpe and Bostock (2002) of debt, access to welfare and money advice, and the role of psychological therapists, found that while many referred mental health users to advice service some felt they lacked adequate training or knowledge of who the appropriate agency would be and/or were concerned that advice services for the general public did not necessarily suit clients with mental health problems (crowded waiting rooms and lengthy waiting times could prove particular problems).<sup>20</sup>

Therefore there is evidence to suggest that the importance of welfare rights advice for service users should not be underestimated, particularly the contribution it can make to improvements in psychological status amongst those benefiting from increased incomes.

#### 4.1.4 OLDER PEOPLE

A recent report by Age Concern<sup>21</sup> states the case for additional to deal appropriately with the increasing ageing population across England. This report states that any additional investment would *“start to improve the quality and scope of services and ... the first priority for extra spending must be to ensure that there is fair and consistent eligibility for services across the country and that everyone who may need care and support can access the advice and support they require to arrange services - whether this is home care or help to find a care home.”*

With the older population becoming an increasing priority area for the NHS, there is evidence to suggest that joint working with the advice sector on informing the population on the types of care suited to their demographic could see beneficial results. *“Proper information, advice and advocacy is needed to fulfil the new emphasis on individual choice and control, the expectation of ordinary people taking greater responsibility for their interactions with public services.”*

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<sup>19</sup> [www.mind.org.uk](http://www.mind.org.uk)

<sup>20</sup> *The benefits of welfare rights advice: a review of the literature* (2006) National Association of Welfare Rights Advisers.

<sup>21</sup> *One Voice: Shaping our ageing society*, Andrew Harrop and Kate Jopling, Age Concern 2009

The 2008 report by Neil Bateman<sup>22</sup> *Just What the Doctor Ordered* includes the results of a survey carried out during 2007 and 2008, and provides information about welfare rights provision based on 2006 figures. For example 889 General Practices had some form of linked welfare benefits advice provision of which 523 were linked to Citizens Advice. This amounted to 10.5% of the 8,433 general practices in England at the time (despite the fact that there may be more that did not respond to the survey). It also showed that the distribution of services across England is variable and appears to be reducing; for example Citizens Advice reported a dramatic 33% decline in GP-linked services from 2005.

Advice services involved in this study felt that links with health care enabled them to provide a more rounded service to individuals while those with stable funding noted that links with health services had contributed to the stability. Those who worked in health services felt that links with advice services added value and could also reduce demand for health services.

This document also highlights the ways in which strong links with health professionals are crucial. Projects which had done well had invested substantial time in building relationships, to the extent of investing time and effort in informal contact at social events. From this, services felt better able to build an understanding of health professionals' advice service needs and to clarify how an advice service can help.

Finally the report compared and contrasted the impacts the project had on both patients and advice services. From a health perspective, medical staff saw relief in patients from a lot of financial anxiety and that it increases their quality of life while from an advice service perspective it raised awareness of the welfare rights service in general.

The 2008 Bateman report *Just What the Doctor Ordered* also includes examples of good practice relating to joint working, one of which has been paraphrased below:

**London Borough of Southwark Benefits and Health Project**

A local authority welfare rights service which includes a team of eight welfare rights advisers whose full-time work is dedicated to advising and helping patients of 39 GP practices across the borough with their benefits issues. All practices (except one with very unsuitable premises) have advice sessions. Fifteen have weekly sessions and 24 others fortnightly sessions, for up to five patients and with cases then being taken on for ongoing casework, including benefit

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<sup>22</sup> Just what the doctor ordered: welfare benefits advice and healthcare, Age Concern 2008

appeals.

In 2006, the service helped 2,004 people to gain an extra £1.7m in benefits. While 21% of service users are aged over 60, a significant proportion is people in their late fifties whose health is failing, often after a lifetime in low paid or insecure work. The team is part of Southwark's Health and Social Care Directorate - a joint service which includes both the local authority's social care and the local Primary Care Trust's health care services. The welfare rights service's manager is a council employee and his manager is employed by the PCT. The aim is to integrate health and social care services across the borough.

The service has stable, ongoing funding from the local authority and PCT.

**Interesting features**

We found that this health-based welfare rights service was highly valued by patients, social care and health professionals and GPs. GPs use the service as an active way to market their practices to prospective patients, to help with appointment keeping and to target benefits advice where this will particularly impact on people's health. The service has placed a high priority on being flexible while also always consistently delivering a service through each practice's nominated adviser. Great care is taken to build and sustain trust and to maintain an informal rapport with practice staff.

The close organisational integration of health and social care services in Southwark has greatly helped the service to have financial stability, become a mainstream service for GPs' practices and to resolve problems quickly. It has also made the service more secure financially compared to other areas of advice provision.

## 5 COMMISSIONING PLANS

After a general overview the report focuses on a number of local Primary Care Trusts (PCTs). These reviews are designed to be primarily illustrative and to inform those in the majority of parts of the country not covered as much as the minority which are. The opportunity is taken to highlight particular locations and key developments where these are specific to areas. In the interests of reasonable brevity, points and themes which recur are not raised each time they occur and readers are thus encouraged to read the points raised under all PCTs even if the one of most interest to them is one of those more extensively detailed.

Levels of detail vary as do the levels of detail in the PCT's plans. Some parts of plans are very specific, some very much at the stage of seeking solutions. The important thing is that these are evolving 5 year plans and while it can never be too early to become involved in the process, it is rarely too late either.

Some of the initiatives may seem to have no relevance to the provision at all but we have listed all the initiative headings in case readers with local or specific knowledge see needs and opportunities which we have not.

To an outsider a great deal of the terminology used in the reports is confusing and appears interchangeable. No attempt has been made to standardize this as this report will be a more practical tool if it retains each PCT's terminology. Note too that some of these are headed in the style *Anytown PCT* where this how they are styled on the plan - all will now have changed to the form *NHS Anytown* but this is only used where it appears on the original documents.

### 5.1 REVIEW OF A SAMPLE OF LONDON PCTS

#### 5.1.1 NHS SUTTON AND MERTON <sup>23</sup>

Principles of their funding are that it is to be:

- evidence based and
- take account of views of partners

They support "Healthcare for London" in its aim to *localise where possible, celebrate where necessary* and that prevention is better than cure.

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<sup>23</sup> Sutton and Merton Primary Care Trust Strategic Plan 27 November 2008

Their vision of *Better Healthcare Closer to Home* will involve building a network of four Local Care Centres, doubling current capacity for the intermediate and post acute care. Their eight priorities are:

- a. Stroke - speed of CT scans, and rehabilitation.
- b. Diabetes - prevalence, mortality and controlled blood pressure
- c. End-of-life care - palliative care and choice of place of death
- d. Mental health - access, patient experience, and appropriate care setting
- e. Cancer - screening
- f. Health Improvement with regard to smoking - quit rates and prevalence
- g. Coronary heart disease - controlled blood pressure and cholesterol
- h. Older people's health - focusing on falls

Their map of "provider landscape" does not include advice providers or specifically refer to an advice in the descriptions of the roles of the providers in place. The plan does include a concise and clear summary of demographic and other issues which could be valuable to service planners in other areas, including advice provision.

Croydon PCT host the specialist commissioning consortium which will co-ordinate purchase of services for Sutton and Merton. Croydon is also included in this survey and some further detail of this is included under 4.4 below.

Specifically relating to the third sector, the plan states:

*The PCT commissions from a number of local voluntary and not-for-profit organisations. The PCT is a partner in both the Sutton and Merton COMPACTs and adheres to COMPACT guidelines and protocols when commissioning from the third sector. In addition to being providers of services, local voluntary sector groups and organisations also play a key role in engaging public and patients in the on-going development of health care services.*

Development of new providers is an area they wish to look at and this offers scope for consortia to be developed. Such consortia need not be purely advice based but could be advice elements in the joint bids with care providers - such are referral mechanisms with long term domiciliary care providers.

Rather than provide a detailed commentary on the funding proposals in priority areas, the table summarizing them is reproduced below.

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| Priority Health Need/Delivery Programme (£000's) | 2008/09      | 2009/10      | 2010/11      | 2011/12       | 2012/13      |
|--|--------------|--------------|--------------|---------------|--------------|
| Stroke (AHP and ESD team)                        | 130          | 535          | 860          | 860           | 860          |
| Diabetes (patient education)                     | 0            | 25           | 50           | 50            | 50           |
| End of Life Care                                 | 450          | 450          | 450          | 450           | 450          |
| Cancer *   | 0            | 0            | 0            | 0             | 0            |
| Health Improvement                               | 500          | 680          | 860          | 860           | 860          |
| CHD (vascular prevention)                        | 270          | 740          | 640          | 740           | 840          |
| Mental Health                                    | 970          | 975          | 1,095        | 1,095         | 1,095        |
| Older People's Health                            | 953          | 1,910        | 2,210        | 2,210         | 2,210        |
| <b>SUB-TOTAL</b>                                 | <b>3,273</b> | <b>5,315</b> | <b>6,165</b> | <b>6,265</b>  | <b>6,365</b> |
| Better Healthcare Closer to Home                 | 700          | 1320         | 1,753        | 4,900         | 2,505        |
| <b>TOTAL</b>                                     | <b>3,973</b> | <b>6,635</b> | <b>7,918</b> | <b>11,165</b> | <b>8,870</b> |

The plan includes specific targets in the priority areas to be achieved by 2013. While many of these are, naturally, clinical (treatment times, etc.), it would be well worth local advisors studying the full list to consider the role they could play in supporting the achievement of these. The list below is simply indicative of some of the areas which stand out.

- **Stroke**
- *Have established long-term support services to prevent deterioration and readmission of stroke patients.* Advice services which can ease anxieties caused by housing, income or debt problems can be invaluable here if an appropriate relationship with the providers of long term care are developed.
- **Diabetes**
- Although not relating directly to the targets set, adequate income to follow a healthy diet and action to deal with other stressful issues will support both the prevention and successful treatment.
- **End-of-life care**
- *Improved carer/patient experience.* Issues around benefits both during the life and in dealing with the bureaucracy needed after death are stressful both to patients and cares and can be greatly eased by the available of good basic advice at the right time. Advice about wills is also invaluable.
- **Mental health**
- *Have shown incremental use of community-based services, early intervention and crisis resolution home treatment services, with related reduction in mental health bed usage.* Again advice which takes care of practical problems causing stress is valuable here.
- *Improve access to services which offer early diagnosis of dementia and increased support to patients and carers within an appropriate community setting.* Benefit and sometimes debt advice to cares can be very important in developing this

- **Cancer**
- *Have ensured >70% of cancer patients found their experience with the service excellent or good.* Direct routing to good advice on the practicalities of benefits and debt particularly for those unable to work is invaluable.
- **Health Improvement**
- *Meet targets for smoking quitters as agreed with NHS London, ideally improving by 5% per annum.* Again relief of stress can have a positive impact on smoker's behaviour.
- **Coronary heart disease**
- *Increase the percentage of CHD patients with controlled blood pressure (BP) from national average to top quartile*
- *Increase the percentage of hypertensive patients with controlled BP from national average to top quartile.* For both good advice on life's practicalities can be a great help and early delivery by direct referral removes much of the stress of finding and accessing that advice.
- **Older people**
- Targets are around falling and there is perhaps little that advice contributes directly other than specific advice about aids and adaptations and sources of funding.
- **On Better Healthcare Closer to Home, the PCT aims to have:**
- This aims to transfer 10% of inpatient care to home or community care settings and see and the Nelson Local Care Centre, Wilson Local Care Centre and Wilson Local Care Centre ready to open their doors to service to patients. These clearly offer venues from which services can be provided but advisors need to be involved at as early a stage as possible to secure accommodation as well as funding to develop services.

Points for advisors

- A significant shift from hospitals to GP's surgeries and the development of Local Care Centres provide opportunities to develop services specifically linked to a preventative agenda, particularly the early provision of debt advice and income maximization.
- There is a need to be clear about which areas geographically and medically are being jointly commissioned and who leads the commissioning process. Joint working with advice providers in across the whole (geographic) area under joint commissioning could be key both to effective service delivery and developing proposals and tenders attractive to commissioners.
- Advice providers should look beyond their traditional range of relationships and look to building their work into the development of new service providers.

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- Where new primary care facilities are being developed from which it is hoped to deliver advice, advisors need to engage as early as possible to ensure that there is space and other necessary facilities for them to operate effectively. Building links with the centre administrators as soon as these are appointed would be good practice.
- Advisors need to develop links with agencies in other PCT areas/Boroughs involved in Collaborative Commissioning - see notes under Croydon (4.4 below).

**5.1.2 NHS ISLINGTON<sup>24</sup>**

Islington's strategy relates very closely to the Sustainable Communities Strategy (SCS) for the Borough and the vision focuses on reducing poverty, improving access and raising aspirations.

The Strategic objectives are:

- 1 Improve the health of local people especially targeting those with the worst health experience;*
- 2 Improve the quality of the patient experience and health outcomes;*
- 3 Ensure people and services work together to design and deliver the best care pathways;*
- 4 Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best;*
- 5 Achieve financial balance and free up resources to deliver the key objectives;*

The key health outcomes are those which will:

- *Reduce our inequalities gap; improving life expectancy and reducing premature death from cardiovascular disease and cancer by identifying people at risk and early intervention*
- *Deliver healthy lifestyle plans for smoking; healthy eating and physical activity; better mental health through focusing*
- *Improve the quality of the patient experience through listening to our population and acting on these findings, addressing practitioner performance and commissioning for quality*
- *Reduce the number of people with mental health problems through earlier identification and intervention in primary care and redesign of care pathways*
- *Provide more care in primary care settings, designed around agreed care pathways, with earlier intervention and integrated working especially for people with long term conditions*

Emphasis is placed on this complementing a North London wide sector approach. And the role of the Local Area Agreement (LAA) in promoting non smoking (Smoke-Free Islington), physical activity (Pro-Active) and healthy food and mental health preventative strategies is highlighted.

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<sup>24</sup> Commissioning Strategy Plan – 2007/08 – 2011/12

Again the analysis of the context is valuable but in the interests of reasonable brevity is not reproduced here.

One of the Healthy Outcomes selected is improving the quality of the patient experience and improving customer care. Seamlessly available advice on the non medical consequences or indeed causes of the need for consultation could and should form part of this.

The presence of HMP Holloway and HMP Pentonville in the borough is highlighted. In addition to the direct health needs there are issues about the welfare of prisoners' dependants and work with the welfare officers in the Prisons as well as health services can bring dividends.

Analysing the "provider landscape", again no specific mention is made of advice but it is acknowledged that this landscape has remained stable for many years and needs to change radically over the duration of the plan to meet the strategic objectives.

Community based services are provided primarily in co-operation with the Local Authority and these entered a Section 31<sup>25</sup> (now Section 75) partnership in 2002 to provide for pooled funds and single management of services. A single assessment process has been developed for LA and PCT provided services. Such processes provide an opportunity for benefit take up screening and access to other advice.

Analysing its internal strengths and gaps, the Trust identifies the Patient Experience as a gap and there is double role for advisors here in that their primary function, the giving of advice, could and should form a significant part of that experience for many patients and they can be an invaluable part of the feedback on the Patient Experience.

Another highlighted gap is in pursuit of value for money with providers of commissioned services and the development of Service Level Agreements.

The plan identifies five goals and details the expenditure to be targeted at each in a very specific manner. The financial targeting is lengthy and is not reproduced here but the goals and the key initiatives within them are as follows.

***Goal 1: Improve the health of local people especially targeting those with the worst health experience.***

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<sup>25</sup> S.31 Health Act 1999 / S.75 National Health Service Act 2006

There could be role here for advice in supporting cessation services by assisting patients to deal with stress inducing life situations. This could be particularly perhaps be effective for pre-operation cessation services.

The healthy sustainable food initiative is supported by securing adequate income for residents.

Information, Advice and guidance is specifically referred to in the contraception strand as well as convenience and accessibility. Some advice providers can have an important role here in providing confidential non health related environments which may make it easier for some to obtain advice.

Identifying people at risk and intervening earlier. Many advice providers have detailed knowledge of deprived and potentially at risk communities which can contribute to the service targeting process.

Socioeconomic deprivation and neighbourhoods, including housing issues, are identified as causative in the Borough's high level of Mental Health Needs. Redesign of support and care pathways and support in employment, education and training are identified actions.

Under securing involvement and engagement of all service providers a cultural shift in care pathways towards those promoting healthy living is sought. This is at a business planning stage and seeks to work with partner organizations.

***Goal 2: Improve the quality of the patient experience and health outcomes.***

The first initiative here is about performance monitoring and while advisors have a role in relating the patient experience, little funding will be available for this.

***Goal 3: Ensure people and services work together to design and deliver the best care pathways.***

Redesigning Mental Health Care pathways is the first initiative. Reduction in social exclusion is a specific aim in which advice services can play a considerable role.

End of life care is the second initiative and the role of good advice to patients and dependants has already been highlighted. This could be delivered directly or by training other professionals to deliver basic advice.

The third is stroke care and advice input here would probably take the form of part of a broader package of work with care providers. The same observations would apply to the fourth initiative under this heading, cancer and the fifth, renal services.

***Goal 4: Improve and expand services delivered closer to home and commission acute and specialist hospitals to provide only those services that they do best.***

This is a key area. The Trust wishes to develop fewer larger practices delivering a greater range of services and to work with local commissioning groups to specify these, again improving the patient experience as an outcome.

The second initiative here is the reduction of outpatient attendance and beyond the provision of safety information and information on the most appropriate way to contact the health service, there is perhaps little role for advice work here. However borough / PCTs drawing up welcome packs to arrivals in boroughs with a high population churn would undoubtedly welcome advisor's input.

The third initiative concerns urgent care and there is little to add to the above.

***Goal 5: Achieve financial balance and free up resources to deliver the key objectives through our financial strategy.***

Reducing emergency admissions is the first initiative. Other than as information providers, it is hard to see an advice role.

The Trust is anxious to tackle Health Inequalities and to identify and target disadvantaged communities including BME communities. It is also anxious to engage partners and service providers in the Borough. Their aims in this regard are very similar to those of many advice providers. There is a clear role here for advisors in service design as well as in service delivery.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated).

- In addition to studying the demographic and related needs of the areas, agencies should be aware of unusual and separate communities, in this case, prisons which may have particular unmet needs and may need different forms of service delivery. Major hospitals which provide regional or national treatment centres create needs for patients' dependents whether visiting or being forced to adjust to changed circumstances at a distance.
- Agencies need to be familiar with the Community Care management structures. Where LAs and PCTs have pooled funds and created a single management and assessment structure the scope should be increased for having some level of financial assessment/benefit check included as part of the framework for keeping people out of hospital, residential or

nursing care.

- Trusts identifying a gap in their ability to address the Patient Experience issues provide an opportunity for agencies to deliver part of that experience in seamlessly delivered and smoothly referred services and also to deliver feedback to the Trust on patients' views.
- Agencies wishing to contribute to the health agenda must be prepared for the value for money objectives which go with it and expect to so sign (and demonstrate delivery on) Service Level Agreements. For many agencies this will be a normal part of their funding regime, for some it will not.
- Advice services should look for opportunities to contribute to service design in order to assist PCTs in targeting their most health disadvantaged residents.
- This is a time of very significant change and the opportunity provided by the will for radical change in services provided and the “provider landscape” should not be missed. It is important to ensure that options for incorporating advice into the agenda for improving health are heard as early as possible in the planning stage. Agencies should seek to be involved in local commissioning consultation at the earliest stage.
- Commissioning Strategy Plans are viewed as works in progress as is appropriate for a five year plan. It is never too late to introduce something into the planning process.

### 5.1.3 WALTHAM FOREST PCT <sup>26</sup>

The specific targets for the plan are:

- *20% more people will be cared for at home*
- *Every year 4000 people with long term conditions will have personal support*
- *2400 long term condition admissions will be avoided*
- *4600 admissions avoided through reducing disease and improving primary care*
- *Primary Care access will be 12/7 <sup>27</sup>*
- *There will be 7000 more primary care appointments*
- *There will be 700 more smoker quitting*
- *More than 7000 people will have help to manage obesity*
- *More than 3000 people will have help to reduce alcohol consumption*
- *8859 diagnostics tests will take place in the community*

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<sup>26</sup> Waltham Forest Waltham PCT, PCT Commissioning Strategy Plan 2007 – 2012

<sup>27</sup> (i.e. 8 a.m. to 8 p.m. daily, though this seems to mean Monday to Friday with Saturday a.m. for PCRC's)

- *More than 41000 outpatients consultants will take place in the community*

There are four key initiative areas. Again for each of these detailed spending programmes are included but they are not included here due to their total length.

### **Initiative One: Improving Health Through Specialist Local Intervention**

The areas picked for attention are:

- Reducing the Impact of Diabetes
- Smoking Cessation
- Obesity
- Alcohol
- Sexual Health

Beyond the general observations made under other PCTs above on the relationship of advice, stress and health, there is little specific here for advisors save the desire to find new providers of services for Sexually Transmitted Infections. Links with these services may enable advice to be delivered to some disadvantaged groups.

### **Initiative Two: Improving Local Access to Out of Hospital Care**

The key aim here is to provide service to people while they are in their normal place of residence rather than in hospital. It is notes that community infrastructure is underdeveloped in Waltham Forest.

Long Term Conditions - a provider of services for people with long term care needs has been commissioned on a three year contract. The Expert Patient Programme, previously stalled for lack of resources is to be re-launched and the voluntary sector has been commissioned to lead on this.

The aims of Expert Patient Programmes are:

*To try to alleviate some of the pressure on public health services, the future of the NHS should not be that of a passive patient. If we can encourage people to take responsibility for their own health needs and provide them with the skills and knowledge to take control of their conditions(s), this would allow resources to be better targeted.*<sup>28</sup>

### **Intermediate Care and Community Services**

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<sup>28</sup> Simon Knighton, Chief Executive, Expert Patient Programme Community Interest Company (EPP CIC) <http://www.expertpatients.co.uk/public/default.aspx>

The aim is to move all care beyond acute care into people's homes, community facilities or intermediate care (residential) facilities. This will include services such as

- Chemotherapy
- I V Treatments
- Tracheostomy
- Ventilator support
- End of life care

A new Intermediate and Community Care team will be set up as a joint health and social care service with a single access point and a common assessment system. These should be integral with at least one Primary Care Resource Centre (PCRC) in each locality with a main base at Whipps Cross University Hospital Trust (WXUHT).

Specific reference is made to those living in poor housing and BME communities.

The role of advice as part of supporting the work of these teams is potentially enormous, particularly where people are making a transition from work to a lengthy period of illness or disability which will limit their capacity to earn and require re-assessment of their financial and in some cases housing options. The intended earlier discharge from hospital will intensify this need.

#### **Initiative Three: Improve Access to Primary Care**

The plan sees the natural communities as Waltham Forest, Chingford, Leyton/Leytonstone & Walthamstow. The aim is for GP practices (or exceptionally group of practices) serving 12,000 - 20, 000 residents, primarily in existing buildings but with some new development. A range of services are envisaged including Long Term Care Support and "Community Services including Social Services". By 2015, it is envisaged that there will be 15 Primary Resource Centres. Good links to high quality relevant advice could significantly improve the patient experience in both areas. While the note on this is brief, it is clearly where much of the future opportunities will lie.

#### **Initiative Four: Improving the use of Mental Health Resources in Community Settings**

There is a focus here on a holistic approach with early diagnosis and integration with care for physical conditions, including action on obesity, smoking, etc. The clear intention is to develop relationships with non Mental Health professionals - the example given being the Police. Advice services have a role in dealing with crises as well as ongoing needs. The most obvious example being eviction or threatened eviction and links to a source of emergency housing advice could be particularly valuable.

It is worth noting that there is no intended capital spending on this initiative.

**Providers**

Broadly providers are seen as being the same with the notable exception of the new Waltham Forest Intermediate and Community Care Service and changes foreseen in the number of GP surgeries.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.

- Primarily the observation here would be that early involvement in the detailed plans for the PCRCs and the single access point for the Mental Health service could offer enormous scope for advice services to be integrated into these services and indeed included in the planned accommodation in appropriate cases.

**5.1.4 CROYDON PCT<sup>29</sup>**

Croydon PCT is part of a Local Strategic Partnership working on a 20 to 30 year strategy for the Borough. The PCT's vision is:

- *Communities and individuals can make informed choices about their health and health care*
- *Whereby they can maximise their health and well being*
- *They are supported by high quality services which are responsive to the needs of individuals and which do not unnecessarily disrupt their daily lives*
- *Where inequalities in health and health services are tackled*

Many of the sought outcomes are specific and medical but improvement of patient experience scores and tackling health inequalities are included.

Croydon PCT is part of a number of South West London Collaborative Commissioning Initiatives, for example in renal care.

Seven Goals have been identified, each supported by a number of initiatives.

**Goal One: Improving Health and Reducing Inequalities**

There are three initiatives here:

- Children and young people. This includes sexual health, an area in which some advice agencies have considerable experience. This is the target of the largest amount of funding under this goal.

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<sup>29</sup> Croydon Primary Care Trust's Commissioning Strategy Plan 2008/9 - 20012/13

- Smoking
- “Healthy Weight, Healthy Lives”

### **Goal Two: Long Term Conditions: Prevention Treatment and Care**

Initiatives here are:

- A Whole System Approach (Long Term Conditions, Disease Focus, End of Life) Long term conditions, Disease focus (Diabetes, Chronic Obstructive Pulmonary Disease, Vascular) End of life care and Renal (which is a collaborative commissioning initiative). This is underlain by a concept of “virtual community wards”. A need for emphasis on end of life care is perceived here and comments about the importance of advice to both patient and dependant made above apply equally here.
- Cancers - here the commissioning of advocacy and patient support services is specifically specified. This too is a collaborative commissioning initiative.

### **Goal Three: Care Closer to Home**

Initiatives here are:

- Planned Care - there is an intention to redesign diagnostic, primary and community services and to scope the impact on the patient experience. This seems to be at an early stage. It is worth noting here that paediatrics is another collaborative commissioning initiative.
- Urgent care - little here is specifically relevant to advice provision but advice to patients who may have faced a life changing event or their dependants of timely advice on changed circumstances.
- GP Led Health Centre and Primary Care Networks - it is proposed to develop six clusters each with a hub. The PCT intends to work with a great range of partners to develop these services and consultation is ongoing about their precise shape.

### **Goal Four: Maternity: Quality, Access, Choice**

The two specific initiatives here are:

- Promoting Birth as a normal event - including promotion of choice / home births. This may require a response in terms of how advice can be delivered and by whom to new mothers who would formerly have been inpatients. Benefit advice, particularly to BME households and non English speakers where even the almost universally claimed Child Benefit can be missed in addition to the raft of income related support aimed at meeting the Government’s aim of eradicating child poverty.

- Provision of high quality, safe and accessible maternity services that are both women focused and family centred - it should be noted that neonatal intensive care is another collaborative initiative.

**Goal Five: Learning Disability: Social Care Change Programme**

- Social Care Change Programme - “This initiative has been created to manage the transfer of current resources invested in Surrey and Borders Partnership NHS Trust to independent not for profit, voluntary and private sector providers for the provision of residential care and group home living.” Each home is being managed as a separate project and each individual will have a care plan. The transitions for the individuals concerned will need to be managed for the financial well being of the both the individuals and the new service providers and benefit advice should form part of this plan there is a clear role here for provision of advice to new service providers and to representatives of patients.

**Goal Six: Mental Health and Well-being**

The two initiatives here are:

- Delivery and implementation of Croydon Mental Health Promotion Strategy and
- Improving mental health services - early intervention and social inclusion are included in this initiative - again this is a collaborative initiative.

**Goal Seven: The Patient Experience**

The single initiative here is entitled “Patient Centred Improvement”. Plans are not specific and the funding is limited. Advice agencies have a role in the feedback and perhaps of its monitoring. Availability of the right advice at the right time while perhaps delivered under other initiatives can have a beneficial impact on the patient experience - developing seamless, holistic and inclusive services.

**Impact on Providers**

“The Commissioning Strategy Plan will enable a significant shift in where people receive their health care. There will be a shift from the traditional development of service delivery in hospital settings and more emphasis on health care being geographically closer to home where possible and centralised where necessary based on quality, safety and value for money.” For both GP’s and Community and Intermediate Care, this will mean an increase in numbers of people accessing services - and a corresponding reduction in the footfall at hospitals.

Pre-tender discussions were underway at the time of publication of the CSP with a number of

potential suppliers.

### **Managing the Provider Market**

A set of principles is included in the CSP including the PCT's recognition of its leadership role in the development of the local provider market prioritising increasing diversity of service provision to better ensure local access to a sustainable and expanding range of services appropriate to meet the needs of the local population.

Assessments will be based on

- Access
- Choice
- Patient Experience
- Governance/Compliance - patient safety
- Value for Money
- Equalities and Diversity

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Co-operation between agencies in the South West London Collaborative Commissioning Initiative will enhance the ability to deliver advice support in this framework. The five PCTs are Wandsworth, Croydon, Sutton and Merton, Kingston and Richmond and Twickenham.
- Contact with potential service providers should be made at the earliest possible stage to see if delivery of relevant advice can be included in tenders.

### **5.1.5 LAMBETH PCT<sup>30</sup>**

Lambeth's plan is a huge document (237 pages) containing a wealth of detail and explanation. 6 PCTs in South East London work jointly, particularly with regards to the Cardiac and Stroke Network, Cancer Network, Trauma, Maternity services. The initiatives in the Collaborative Commissioning Initiatives are compatible and consistent with individual South East London. The six PCTs are Lambeth, Southwark, Greenwich, Bexley, Bromley and Lewisham.

In analysing the "provider landscape", the CSP specifies the current voluntary sector commissioned services. It allocates approximately £9 million a year to 90 providers in the following fields and in the following proportions.

- Sexual health - 30%

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<sup>30</sup> NHS Lambeth 5 year Commissioning Strategy Plan: 2008/9 update.

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- Substance misuse - 25%
- People with physical and sensory disabilities - 18%
- Mental health - 11%
- Older people services - 11%
- Other - e.g. homelessness, primary care counselling, learning disabilities - 5%

The Voluntary Sector as seen as key partners but the development of “greater specificity” of outcomes in contracts is seen as a priority.

There are 8 initiatives at the heart of the plan. The most relevant parts of these detailed initiatives are under the heading Commissioning Intentions, these and relevant parts of the implementation proposals are summarised below.

#### **Initiative One: Staying Healthy**

Commissioning Intentions here are in the areas of:

- Information to support healthy lifestyles
- Reduction in vascular risk
- Reducing obesity
- Reducing Smoking
- Reducing Alcohol abuse
- Reducing substance abuse
- Mental health
- Work with partners in the health and well being framework
- Investment in Health promotion.

The referral pathway and early interventions sought for could and should include pathway to solving underlying problems in which advice has a clear role. The implementation strategy specifically mentions voluntary sector providers and includes telephone support services. A review of current providers is planned.

#### **Initiative Two: Mental Health**

Commissioning Intentions are:

- Mental Health Promotion and Prevention
- Developing Primary Care - this includes training and development for staff - which could include elements such as debt awareness. It also includes the appointment of a manager to oversee primary care development. This person should be a key contact.
- Common mental illnesses - a service review.

- Serious Mental Illness - a new expanded user, cares and community involvement pilot and befriending services are proposed.
- Social Inclusion - in addition to the services above, improved responses to the needs of BME communities and better pathways to employment are sought.

#### **Initiative Three: Birth Children and Young People**

- Promotion and development, including core competency training for staff. Training could include benefit awareness and referrals.
- Implementing Healthcare for London<sup>31</sup> recommendations - including childbirth choices and homebirths, issues around which are discussed above.
- Implementing the Child and Mental Health Strategy - including access and referral issues
- Improving services to children with disabilities. Access to advice on and the ability to challenge benefit decisions must form a significant part of this. The claim process for DLA in particular is difficult both in length, complexity and the challenges of putting on paper distressing symptoms. Poorly completed claims lead to poor decisions - and those to unnecessarily poor families. Dedicated welfare rights work shared by social and health care services can be very important.
- Quality of outcomes
- Responsiveness - includes a needs assessment for all looked after children - which should include benefit entitlement screening.

#### **Initiative Four: Long Term Conditions**

Commissioning Intentions cover

- Hypertension Management
- Further implementation of managed care model - including further development of community based services.
- Quality and outcomes
- Work with sector colleagues to implement Healthcare for London
- Personalised care plans
- Equalities Impact Assessment

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<sup>31</sup> See <http://www.healthcareforlondon.nhs.uk/what-we-re-doing/>

All the financial, housing, etc. issues facing people whose circumstances may have changed suddenly but for the long term following a trauma or diagnosis can be addressed through the developing community based services.

#### **Initiative Five: Sexual Health**

- Health promotion including information and advice
- Reduce Teenage pregnancy rates
- Redesign of care pathways - this involves more services going to primary care centres and community pharmacies
- A new Community Sexual Health Centre in Streatham Hill and development of those in Camberwell and Vauxhall
- Community engagement in service redesign

Advice services, particularly those working with disadvantaged groups of young people can have an important role in enabling people to access these services and thus improve both prevention and treatment.

#### **Initiative Six: End of Life Care**

Commissioning Intentions are:

- Improve quality
- Improve choices - this includes improved discharge planning. Housing, debt and benefit issues can all be key to a successful, and indeed safe, discharge.
- Improve access - very much in line with the theme of all three plans, a move to home and community based services is planned. More and better bereavement services are specifically included - these should involve advice and support on dealing with the practicalities of bereavement and changed financial circumstances.
- Redesign of end of life care pathways - it should be noted that some of these services are funded as well as provided by charities.

#### **Initiative Seven: Planned Care**

Commissioning intentions are:

- Cancer - reducing mortality and improving quality. This again involves more community based services
- Access, choice and personalisation - this covers information for patients and referrers. There is a role here for clear explanation and for some patients perhaps need for advocacy to ensure they derive the benefits available from choices.

- Redesign of care pathways - again with a move to community based services

#### **Initiative Eight: Unplanned (Unscheduled) Care**

Commissioning intentions are:

- Integrated delivery across Lambeth and Southwark including a wider range of services available and a move to community settings. This will include walk in centres. Although not specified walk in centres are a potential venue for services and if they achieve their intention may attract many disadvantaged people who do not use services and who otherwise would present at A&E.
- Improved quality
- Improved awareness - of services such at walk-in and out of hours services.

Market management here will be in the form of a refreshed joint strategy with Southwark PCT

The PCT has identified gaps in its skills and resources in the following areas

- Community, patient and public involvement
- Information and intelligence for planning
- Communication
- Market management and procurement
- Fit for purpose workforce - training in core skills.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Where structures are changing and new development post are proposed, such as the proposed Primary Care Development Officer, contact should be made at the earliest possible stage with a view to incorporating services, training and referral pathways into the new service framework.
- The possibility of specialist welfare rights work dedicated to her disabled children and their parents or carers working with health and social care professionals should be explored.

#### 5.1.6 HILLINGDON PCT<sup>32</sup>

The CSP aims “puts people at the heart of commissioning: patients and clinicians to have more say on how services are to be delivered”<sup>33</sup>. Prevention and long term needs and joint working with partner organizations to improve access are planned.

The separation of the PCT Provider Services as an autonomous provider and establishing a single acute sector commissioning partnership in North West London are highlighted as evidence of their determination to improve commissioning.

They see the financial environment as tough and getting tougher.

Hillingdon PCT has identified six priority areas:

**Priority Area 1: tackling health inequalities by strengthening primary and community services in the South of the borough;** this envisages taking the “polyclinic” to its logical extreme and having education, housing and voluntary sector services located together with traditional health services. Although not specified, advice must have a role or indeed roles in such centres. Much here is at an early stage, proposals are:

- Primary and Community Care - scoping the meaning of “well-being”, engagement and stakeholder consultation are included
- Mental Health - increasing community base and decommissioning current day care
- Unscheduled Care - GP led health centre in Hayes, design and commission single access point, develop model to co-locate children’s and community midwifery service.
- Children’s Centre - the plan is to develop 19 Children’s Centres (i.e. an additional 7) and see as last point above about midwifery services.
- Planned Care - design and commission single point of access
- Long Term Conditions - diabetes strategy
- Palliative and end of life care - improve access to screening

**Priority Area 2: Improved, early access for women to community based maternity services**

The key point here for advisors is the planned move to more local settings and move to moiré choice of location including home births which have been discussed above.

**Priority Area 3: Improve the emotional and behavioural health of children, in particular that of children in need.** This includes decreasing teenage conceptions and improving

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<sup>32</sup> Hillingdon PCT Strategic Plan 2008 - 13.

<sup>33</sup> Hillingdon PCT Commissioning Strategy Plan 2008/13 (Refresh 1) Executive Summary

educational attainment. It aims to intervene early in mental health issues and prevent mental health problems in later life. Developing sexual health services in the south of the borough is part of the strategy. Good links with the young people's advisory services would seem essential in designing and delivering this service.

**Priority Area 4: Develop and implement obesity care pathways, for children and adults**

There is specific concern for children on the borough and this initiative links to the children's and long term care agendas outlined under priority one above.

**Priority Area 5: Assess and reduce cardiovascular risk - including diabetes**

There is particular concern here over some parts of the BME community and agencies within those communities could clearly have a role in projects to tackle behaviours, secure early diagnosis, etc..

**Priority Area 6: Improve inclusion for people with mental health problems, to employment, and access to other preventative services**

Focus is to be on people in employment and in contact with Mental health services and thus with work local businesses. Obesity and cardiovascular problems also to be part of the mental health focus. Moving care into the community is again part of the plan.

**Market and Commissioning**

The Trust has a historic deficit with which it must deal. There is a North West London Collaborative Commissioning Group comprising Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster. No growth is expected in Hospital spending in order to fund the community based initiatives. Partnership opportunities are seen with other PCTs, with the Borough, with schools and with others. "Lean" services, value for money and the development of Service Level Agreements are also part of the envisaged process.

Working with new providers from without the Borough is specifically discussed and this may raise issues as well as opportunities for some agencies.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- This is a prime example of where many of where many quite high level decisions have yet to be made and the concept of the polyclinic seems to be intended to be exploited to the full.
- A Trust's historic financial position may need to be understood as will affect, if nothing else, the pace at which initiatives can be developed.
- Agencies would not necessarily only be able to develop services with their own local PCT and may have opportunities in neighbouring or other areas. The impact of bidding to deliver services in areas traditionally served by peer agencies would have to be considered.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

#### **5.1.7 HAMMERSMITH AND FULHAM PCT34**

##### **Vision**

*Hammersmith and Fulham Primary Care Trust will improve the health of the local population.*

*We want to:*

- *Enable and support health, independence and well-being*
- *Give people more control of their own health and healthcare*
- *Offer timely and convenient access to quality, cost effective care*
- *Proactively tackle health inequalities*

*At the end of five years we want to be able to show a significant and tangible improvement in services for the most deprived areas and communities.*

##### **Not for profit sector**

Mapping its providers, the PCT conclude that the “voluntary sector is relatively under developed as a service provider” and that “more can be done to stimulate voluntary sector provision of core services that will tackle health inequalities in the borough”. The intention and the opportunity could not be more clearly stated.

This PCT reports being in strong financial position

No less than 27 initiatives and sub-initiatives are planned

##### **Group 1 collaborative initiatives**

##### **Initiative 1 - Unscheduled care**

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<sup>34</sup> Hammersmith and Fulham Commissioning Strategy Plan June 2007.

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The intention through the North West London Collaborative Commissioning group is to offer a near immediate Primary Care response - including top people who present at A&E.

**Initiative 1a Urgent Care Centre**

- Primary care “front ends” to be developed on the two A&E sites - these represent North and South of the Borough.
- Develop short notice hubs - short notice walk in services
- Three new premises White City Polyclinic, Charing Cross Polyclinic to include a newly commissioned GP practice) and redevelopment of the nursing facility at Wandsworth Bridge Road to deliver primary and community services.
- Out of hours services
- Commissioning/re-commissioning of community services to provide “hospital at home” style services and reduce hospital admissions.

The intention is to invest savings from A&E admissions in these services.

**Initiative 1b - Unscheduled care, Single access telephone line**

The aim is to commission a single telephone line to provide advice, care, appointments and referral pathways. This will have 24/7 call handling. The intention will be that the provider invests the capital costs and this is to be reflected in the tender price.

**Initiative 2 - Long term conditions**

The aim is to have collaborative commissioning for many of the services. The sub initiatives are briefly outlined below

**Initiative 2a - Long term conditions** bronchitis and emphysema, smoking and improved end of life care are the issues here.

**Initiative 2b - Long term conditions - Back pain, musculoskeletal and arthritis** in addition to the more clinical intervention, it is intended to commission psychosocial support - there is a role here for advice which may help to lower life stresses. Weight and diet issues are linked to this.

**Initiative 2c - Long term conditions - Heart failure**

**Initiative 2d - Long term conditions - Dermatology**

**Initiative 2e- Long Term Conditions- Diabetes**

There is nothing which specifically related to advice in these but all relate to healthy lifestyle and stress management and the role advice in controlling many of the more objective causes of anxiety have been referred to under other PCTs above.

#### **Initiative 3 - Standardising clinical practice**

This, also a collaborative venture is as the title implies heavily related to clinical interventions, priorities and outcomes.

#### **Initiative 4 - Primary Care**

Again this is a collaborative initiative aiming for common standards and the use of a common balanced scorecard across the collaborative area. Intentions include:

- 8:00 a.m. to 6:30 p.m. access
- Planning to be done in units of approximately 50,000 population to enable full ranges of services to be developed.
- Work with the Borough to include Children's centres and extended schools
- No services delivered from sub-standard premises by 2012

The changes offer the opportunity to include advice in the full range of services offered by the future centres.

#### **Initiative 5 - Acute episodes and trauma**

This revolves around the most effective response to acute incidents and involves in specialising in a limited number of centres. There is little new here but for advisors but they need to keep abreast of the changing patterns and locations of care in developing their own service plans.

#### **Initiative 6 - Paediatrics**

Concerns her are clinical but it the location of these services will be linked to A&E and other specialist services.

#### **Initiative 7 - Maternity (Obstetrics)**

Collaborative commissioning focuses on availability, quality and choice services were being reviewed. This is linked to smoking and also to the improved and earlier access to termination services. Some specialist and community advice agencies will have a role to play, particularly in the latter as they may trusted and be approached rather than GP's.

#### **Group 2 - local initiatives**

**Initiative 8 - Improve Child and youth health**

A whole range of initiatives on health education, immunisation, and mental health are envisaged. There is little specific to advice agencies not already covered above.

**Initiative 9 - Staying healthy**

This includes development of self management for many conditions. Support and development of a self management approach to may related problems such as debt could be built in

**Initiative 10 - Screening services**

There is a role for advice in referring people from disadvantaged communities for screening and in dealing with some of the consequences of the outcomes of screening but this too is predominantly a clinical issue

**Initiative 11 - TB services**

As 10 above

**Initiative 12 - Smoking Initiation and Prevalence**

As 10 above

**Initiative 13 - Improve Sexual Health**

Increase in community availability of services and early treatment and improved access to pregnancy termination are included. Centres advising young people and BME groups in particular have a role in the effectiveness of these services and shared locations could greatly enhance that role

**Initiative 14 - 18 weeks**

This refers to NHS treatment time targets

**Initiative 15 - Mental health**

Re-development of day centres and targeting unemployment of mentally ill

**Initiative 16 - NHS continuing care**

This is an area recognised as in need of improved and new models of care are proposed. There is clearly a role for advice in addressing people's changing, often deteriorating circumstances and the housing, debt and benefit issues which arise and which can challenge the effectiveness of continuing care in the community.

#### **Initiative 17 - Offender Healthcare**

As with many boroughs, Hammersmith and Fulham plays host to a major prison and issues have been discussed under Islington above. Particularly discussed here is the issue of disruptive offenders. It is a reasonable assumption that addressing the problems of prisoners' families outside will assist in some cases and good referral links with agencies in other areas could be very valuable.

#### **Initiative 18 - Prevention of Alcohol Related Harm**

It is intended to address this at Charing Cross Hospital (which has a very high alcohol related A&E load), in primary care settings (possibly with 3 or 4 beds at a polyclinic and in criminal justice settings. The polyclinic and criminal justice setting would seem to offer options to address drinkers' housing, debt, etc. problems which they are sober.

#### **Initiative 19 - Developing Quality Management Framework for Commissioning**

Much of this concerns gathering and distributing information, in both of which there is a role for advice services as a secondary function where they are already involved in provision of services.

#### **Initiative 20 - Community based alternatives to hospital**

The impact of earlier discharge and different forms of care on benefits will always need to be assessed and benefit screening at discharge or entering any form of residential or domiciliary care can make that solution more sustainable. Much the same could be said of debt or housing advice but for a more limited part of the population.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

##### 5.1.8 **BARNET PCT**<sup>35</sup>

There are eight Strategic Initiatives:

#### **Initiative One: Improving Access and Choice in Primary Care**

- Open seven Primary Care Centres (polyclinics or hubs) and at least 16 GP practices in premises as functional as purpose built premises. A "hub and spoke" model.

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<sup>35</sup> [Delivering Better Health in Barnet, Barnet Primary Care Trust Commissioning Strategic Plan 2008-2013](#)

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- Redevelop Finchley Memorial Hospital as one of the Centres
- Procure a GP led Health Centre in the South to be open 8 a.m. to 8 p.m. seven days a week
- Extend Hours and services

Although advice is not specified, other services such as dentistry are seen as being available. The plan envisages what it sees as community services being delivered by its own provider arm. Much of this is still in early stages of development and the opportunity for involvement at the planning stage is there.

#### **Initiative Two: Providing Care Closer to Home**

This sets out a range of specific clinical services to be moved to community locations and there does not seem to be a role for advice in this.

#### **Initiative Three: Targeting Improvements in Health Equality and Lifestyle choices**

- “Finding the 5,000” an initiative to reduce morbidity from cardiovascular disease
- Reducing obesity in adults and children
- Reducing smoking
- Improving sexual health
- Increasing childhood immunisation (MMR)
- Increasing rates of breast screening

Social marketing is seen as the “key enabler” in this initiative. Advice agencies have some role here in disseminating information and in assisting to target communities, particularly in the sexual health area where they can provide non NHS venues where this is appropriate.

#### **Initiative Four: Improving Maternity and Children’s Services**

This includes early identification of health and social care issues, though no specific mention is made of housing or income related problems. Advice both to pregnant women and new mothers could be important. Research into the patient outcomes will be undertaken with University College London.

The second part of this initiative covers support for disabled children and will be delivered in partnership with the Borough’s Children’s Services.

#### **Initiative Five: Improving Mental Well-Being**

The service is highly regarded and a local provider rated excellent by the Health Care Commission. A priority is people with mild mental illness and early intervention. Tackling inequality and social exclusion is a stated aim.

There are three main components to the initiative

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- Improving access to psychological therapies
- Improving dementia care
- Improving and expanding care for people with personality disorders

**Initiative Six: Reducing Chronic Obstructive Pulmonary Disease Related Hospital Admissions**

This includes more home care and better follow-up for patients receiving home oxygen.

**Initiative Seven: Implementing National Cardio Vascular Disease Risk Assessment and Management Programme**

This is a clinically specific initiative looking at CVD and Stroke.

**Initiative Eight: Supporting patients to live independently and building resilience - improving end of life care**

The analysis of provider is medically based and does not consider voluntary sector providers.

Services in Barnet are part of a Local Area Agreement and of a Barnet, Enfield and Haringey Clinical Strategy and are part of the North London Collaborative Commissioning Plan. The analysis of the provider landscape takes no specific account of the community and voluntary sector as providers of services.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Some plans appear to reflect a level of satisfaction with current services and to offer limited opportunities or perceived need for advice outside of medical advice or counseling. Based on the plan it would appear that a case may need to be made for the inclusion of advice. The opportunity would appear to be there in Barnet as the Primary Care Centres are developed.

**5.1.9 CITY AND HACKNEY PCT<sup>36</sup>**

The Trust has a well developed relationship with the voluntary and community sector as a provider of services - mainly in Community and Intermediate Care, Mental Health, Drug and Alcohol and HIV services. It sees itself as having firewall between its commissioning and provider functions and it has a form of internal contract. The Trust had year end surplus in 07/08 but is unsure of future financial provision.

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<sup>36</sup> City and Hackney PCT 2008/09 - 2012/13 commissioning Strategy Plan

It intends to open four Primary Care Resource Centres on the polyclinic model supporting a network of GP's. The list of services to be provided specifies the provision of benefit advice and access to employment advisors. This is perhaps the clearest specification of the need for and intended location of benefit advice encountered in this research.

There are eight initiatives proposed in the plan and these are summarized below and should be read in the context of the preceding paragraph.

**Initiative one: Ensure 100% access to high quality primary care services, with sufficient capacity for genuine choice**

This includes the four new Primary Care Resource Centres - first south east Hackney, secondly South West Hackney and City at St. Leonard's, Shoreditch, thirdly a joint development with the London Borough of Hackney in North East Hackney and finally in another joint development, North West Hackney replacing the John Scott Health Centre. A new facility is planned for Dalston again as a joint venture with the Borough - this will be part of the regeneration around the new tube station. Centres will be open 8 a.m. to 8 p.m. A significant proportion of long term care will move from Secondary setting to these Primary care settings. No mention is made in the plan but these new centres would seem to offer excellent locations for advice provision.

**Initiative two: Tackle the emergency led health economy**

Particular concern is expressed about alcohol related admission to hospital. A new Urgent Care Centre is planned associated with the St Leonard's development in addition to more walk in access linked to GPs. An increase in end of life care at home is also planned including commissioning support for carers. Several forms of advice but particularly welfare rights advice could have an important role in supporting carers and keeping people in their homes.

**Initiative three: Improving health outcomes in cardiovascular disease**

A broad ranging initiative covering free fruit to nurseries and refurbishment of sports facilities and including screening at risk parts of the population. There seems little specific link to the need for advice provision.

**Initiative four: Prevention and treatment of Cancer**

Tackling smoking is the number one target along with cancer screening. Other than disseminating information, there is little specific role for advice.

**Initiative five: Children's Health & Wellbeing: Improving life chances of children**

The target is primarily about reducing inequalities and includes immunization, tackling obesity, teenage pregnancy, infant mortality and mental health. Success of targeted initiatives with African and African-Caribbean women is highlighted. The under use of Child and Adolescent Mental Health Services (CAMHS) by BME communities is noted. There would seem to be significant opportunities for agencies strongly based in minority communities to contribute to packages aimed at increasing income to improve nutrition and to provide non-NHS locations for some services where members of some communities would not want to attend NHS clinics or premises.

**Initiative six: Mental Health**

The work of the Mental Health Partnership is seen as heavily augmented by services provided by the voluntary and community sector targeted at particular groups. Drug users in effective treatment is a key target. No specific mention of advice is made but it must be seen as part of a pathway to a more settled lifestyle in setting up accommodation and employment opportunities and tackling benefit and debt problems.

**Initiative seven: Communicable and Sexually Transmitted Diseases**

Other than providing information and possibly not NHS premises for some services, there seems little specific role for advice in this

**Initiative eight: Patient, user and carer experience**

This includes work to promote social inclusion and particular projects targeted at isolated over 50's. There would seem to be a dual role for advice services here - as service deliverers promoting social inclusion and as providers of high quality volunteer placements both to tackle individuals' isolation and as a possible pathway into employment.

**Collaborative Commissioning**

City and Hackney PCT is part of the North East London Collaborative Commissioning Initiative. This comprises City and Hackney PCT and Barking and Dagenham PCT, Havering PCT, Newham PCT, Redbridge PCT, Tower Hamlets PCT and Waltham Forest PCT. The initiatives cover stroke, end of life care, and redesign of the acute provider landscape, TB and primary care.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- The role of advice services in the local economy and labour market should not be

forgotten. Particularly the ability to provide high quality volunteer placements and training could for part of any package aimed at tackling isolation whether as part of a return to work initiative or a long term volunteering one. The two are not exclusive.

#### **5.1.10 HARINGEY PCT<sup>37</sup>**

##### **Collaborative Commissioning**

Haringey is part of the North Central London Collaborative Commissioning Initiative along with Barnet, Camden, Enfield, and Islington PCTs. Collaborative priorities are currently Cancer, Urgent Care (Stroke), Renal, Trauma, Maternity and TB. It is also part of the Barnet, Enfield and Haringey Clinical Strategy.

##### **Provider Landscape and Finance**

A range of voluntary and not for profit sector providers are commissioned but advice is not specifically mentioned. A need to strengthen the market is seen. The Trust ended 2007/08 with a surplus.

Haringey see the merits of crossing what they see as artificial boundaries in the commissioning process - be this pan-London initiatives, sub-regional initiatives or sector initiatives. There is no reason why the same approach cannot be take to advice provision as to, say, breast screening. It should not be taken as read that the only possible provider is a local one.

Five Goals are set out with a range of initiatives to support each and these are summarised below.

##### **Goal One: Healthy Communities**

- Engaging with new arrivals to improve registration with GPs - advisors in contact with Haringey's myriad small communities may be able to support this initiative.
- Community health trainers programme
- Social marketing - focussed on breast and cervical screening, smoking cessation, Chlamydia, antenatal booking, diabetes early warning signs and childhood obesity. The programme ultimately aims to improve uptake of services.
- Well-Being Network - to support and train people delivering health improvement work on a voluntary basis and will be linked in to the health trainer work programme. While this envisages recruitment form the voluntary and community sector, the role for advice seems

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<sup>37</sup> NHS Haringey Strategic Plan 2008-13 (Final version 4)

to be limited though enabling people to afford a healthy diet should play a part.

**Goal Two: Healthy Starts For all Children and Young People**

- Improving access to Maternity Services
- Integrating Health into Children's Centres - this would seem to offer opportunities to deliver advice to parents at critical times, particularly in the context of initiative below.
- Implementing "Aiming High for Disabled Children". This agenda for timely integrated services, part of the government's Every Child Matters programme. This includes improving the management of the transition from children's to adult services, a time when correct benefit advice is critical.
- Improving mental health - see separate initiative

**Goal Three: Good Mental Health and Wellbeing for All**

- Children and Young people's mental health is a priority including developing the Children and Adolescent Mental Health Service.
- Improved access to Psychological Therapies
- Adopt a Choice and Partnership approach
- Local Borough Joint Commissioning
- Investment in supporting services - health advocacy and prevention of the loss of employment are the examples given and these themselves may interest some agencies but are cited as examples, not the whole range of supporting services and there may be opportunities to broaden the advice input, particularly in areas which reduce stress such as debt.

**Goal Four: Preventing and Managing Long Term Conditions in Adults**

- A coordinated approach to changing health behaviours particularly with target groups - including smoking, alcohol, and weight management
- Implementing integrated model for long term conditions management through the networked primary care model - e.g. diabetes. Walk in services will be re-tendered for on February 2010.
- Commissioning effective, community based rehabilitation and intermediate care services.
- Substantially improving end of life care. This includes bereavement support and training for staff. There is clearly a role for information and advice on the practical as well as the emotional consequences of a death on benefits, housing, debts, etc.

**Goal Five: World Class Primary Care**

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This will be via the development of “locality healthcare communities” (networked polyclinics), which will offer:

- 12 hours 7 days per week extended hours access to primary care (planned/appointments and walk-in) at Neighbourhood Health Centres
- A greater range of services - diagnostics, long term conditions, intermediate care

Consultation is still taking place on these services.

Two of the perceived advantages of the approach are seen as being:

- *Greater range of more integrated services available*
- *Opportunity for Neighbourhood Health Centres to become community resources.*

Both of which would be supported by the integration of advice services into the new centres.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- There is a need, perhaps particularly in London, to be aware of what is being commissioned on a regional, sub regional or clinical sector basis and to be aware of pan London approaches and the attempts to bring the economies of scale to the commissioning process. This means that the assumption that only local agencies can supply services is a false one and advice agencies should look to setting up consortia to bid supply specific support across a number of areas - or be prepared to find themselves in competition with each other.

## **5.2 REVIEW OF A SAMPLE OF PCTS OUTSIDE LONDON**

### **5.2.1 BRIGHTON AND HOVE CITY PCT<sup>38</sup>**

The Trust sets out five commissioning goals and a range of initiatives under each. These are listed in full below but no comment is added where there seems little role for advice.

#### **Goal One: Adding to Life**

- Smoking - drop in clinics are envisaged along with usual range of publicity, etc.
- Screening - breast and bowel cancer screening - little role for advisors in this.
- Coronary Heart Disease - aimed at identifying people at risk and targeting them.

#### **Goal Two: Maximising Life Choices of Children and Families**

- Teenage Pregnancy - the aim is prevention with “assertive outreach” including schools.

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<sup>38</sup> Improving Health and Developing World Class Healthcare in Brighton and Hove Strategic Commissioning Plan March 2009

Wider availability of contraception is planned together with a Healthy Living Centre and drop ins at GP's. Agencies specialising in advice to young people can have a clear role in these initiatives.

- Children and Adolescent Mental Health (CAMHS) - an increase in treatment at home and in local management of cases rather than management by specialists is envisaged.
- Long Acting Reversible Contraception (LARC) this will provide outreach in areas of high teenage conception - which tend to be areas of high health inequality. Agencies serving those areas may have a role in how this develops.
- Childhood obesity - advice work focussed on families and family incomes can play a significant role here as part of a package of support for new mothers along with more health specific initiatives such as breast feeding.

#### **Goal Three: Developing a Healthy Young City**

- Suicide - crisis resolution is highlighted here - advice has a very strong role here in resolving objective and material causal and aggravating factors. Promotion to vulnerable groups and service delivery at home are other parts of the initiative.
- Alcohol - incentives are to be provided to GPs for successful interventions. If advice can be shown to improve success of these interventions, there is an incentive for GPs to develop a relationship with advice services - or groups of GPs to fund a dedicated advisor. A health advisor is to be appointed to lead work with vulnerable communities, including the LGBT communities.
- Chlamydia Screening - other than awareness and taking part in campaigns, there is little role for advice here
- Psychological Therapy - improving access to low and high level interventions is the key. In appropriate cases advice may be part of such interventions.
- Sexual Health - as with Chlamydia screening above.

#### **Goal Four: Promoting Independence**

- Admission Prevention - much of this is about rapid "roving GP" assessment and clinical measures. Other than a referral scheme there is little direct role for advice here.
- New Short Term Care Pathways - this will see community beds and earlier discharge from acute hospitals. Patients will have longer periods unable to work and not in hospital and may have benefit issues as a result of that.
- Long Term Conditions - this is focused around a number of conditions and the theme of keeping people in the community. Specific initiatives such as an independent living centre

and extra care housing services both offer opportunities and create need for advice, not least in the planning stages.

- End of Life Care - little to add to the above.

#### **Goal Five: Commissioning Nationally Recognised Good Practice**

- Urgent Care
- Referral Management
- Elective Pathways
- Access & Choice
- MRSA Reduction
- Access to Primary Care
- Quality of Primary Care

These are taken together. The aim is to integrate walk-in provided by BSUH and South East Health Care Ltd. with GPs at an Urgent Care Centre at the Royal Sussex County Hospital. A GP led referral service (BICS) is to be set up and 8 a.m. to 8 p.m. seven day primary care access is planned. The focus of urgent care on one walk-in centre provides an opportunity.

#### **Provider Management**

There is little specific here but the move to locally based services and to community provision is expected to see new provider join and increased competition. Partnerships with bidding providers to deliver integrated advice, guidance and support services are clearly an option.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Crisis intervention is specifically mentioned here - the role of advisors in dealing with life crises which can trigger or aggravate mental health crises should not be underestimated.
- New initiatives can benefit from an analysis of the benefit consequences of the service models proposed at a planning stage and advisors generally best positioned to deliver this. Quite small changes in service design and description can affect the income of users / residents and need to be considered in work with financially vulnerable people.

#### **5.2.2 BRISTOL PCT<sup>39</sup>**

NHS Bristol has two types of goals:

- *Health outcome goals which are central to improving health for the people of Bristol and in particular those who are most disadvantaged*

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<sup>39</sup> Medium Term Strategic Plan 2008/09 - 2012/13, Bristol PCT

- *Goals associated with commissioning a comprehensive range of high quality services for the people of Bristol.*

The strategy for achieving Health Outcomes is set out under ten headings.

**One: Reducing health inequalities between different parts of Bristol:**

Voluntary and Community Sector agencies are identified both as delivery partners and stakeholders in this - examples given include cooking classes and food co-ops. Where existing agencies are involved, they may already have links with advisors which can be developed.

**Two: Increasing Life Expectancy at Birth:**

This identifies the correlation between socio-economic factors, particularly income, and life expectancy. The role of advisors in increasing actual income or effective income (by for example reducing debt payments or having debts written off) is clear and needs no further comment. This however is not picked up and the Voluntary and Community Sector is not seen as a stakeholder, the initiative focusing on clinical risk assessment, primary prevention (of smoking, obesity, etc.) and tackling infant mortality.

**Three: Reducing the under 18 conception rate:**

This is being led by the City Council's Children and Young Peoples Service and aims to adopt national best practice. Faith groups and education establishments are among those identified as stakeholders, advice agencies are identified but clearly there is a role for those who successfully target disadvantaged young people. There is a Children and Young People's Executive, chaired by the PCT Chief Executive.

**Four: Reduce Smoking Rates:**

Community settings are sought for support services.

**Five: Reduce Cancer Mortality in under 75's:**

The voluntary sector are identified as a stakeholder here and cultural issues in some communities are identified as a problem. There is no specific advice role here which is not covered elsewhere.

**Six: Reduce Cardiovascular Disease mortality and**

**Seven: Improved Stroke Management:**

Primarily a clinical agenda, longer term issues are covered under other headings.

**Eight: Reduce Childhood Obesity:**

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A wide range of stakeholders including employers and food retailers are identified.

**Nine: Reduce Harm caused by alcohol misuse:**

There is nothing specific here but the role of advice in relieving stress makes it a useful service to include, at least by referral in centres aiming to deal with alcohol abusers.

**Ten: Improve End of Life Care:**

The agenda is to allow people, where appropriate to determine how and where they die. Voluntary sector as well as clinicians are identified as stakeholders. There are many advice related issues benefits for the patient and for dependants, housing issues, debts, wills etc. which can demonstrably improve the end of life and bereavement care.

**Commissioning:**

As implied by the goals above, commissioning is separated from the health initiatives. A significant amount of work is expected to be commissioned on a Bristol, North Somerset and South Gloucestershire wide basis. Major initiatives include a midwife led birth centre at Cossham Hospital and joint Health and Social Care commissioning for children with complex needs.

**Market Development and Providers:**

Bristol leads the joint initiative with North Somerset and South Gloucestershire and the essential values of the commissioning are set out and include:

- *Effective incentives for providers to deliver the right care in the right place at the right time*
- *Services which promote independence and intervene early to avoid crises*
- *A system which fulfils an important regional role by providing appropriate support to other local health systems across a wider area*
- *Effective interfaces between different parts of the system (e.g. primary/secondary/mental health care) in order to optimise patient experience and health outcomes*
- *Choice for patients about the model of service which they receive and where they receive it*
- *Effective engagement of local people in developing and changing local health services to achieve improved outcomes and patient experience*
- *Excellence and innovation in research, development and education through effective partnering with Universities*
- *Plurality of provision, in order to stimulate quality, innovation and improved performance*

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

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**Our Patients, Their Clients:**

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- The role identified for Voluntary and Community Sector agencies may need to be challenged if opportunities are not to be missed - even in Trusts such as Bristol who are clearly aware of and value that role.

**5.2.3 HEART OF BIRMINGHAM TEACHING PCT<sup>40</sup>**

Heart of Birmingham Teaching PCT's vision is to "Close the health gap in a generation through partnerships and transformation of healthcare".

**Provider Landscape**

The PCT has 62 contracts with the voluntary sector valued at £11.4 million so is clearly not averse to contracting with the sector. It regards its current financial position as strong. Major providers are analysed in terms of this performance - this does not include the voluntary sector providers.

Five strategic goals are set and initiatives are defined under each. They are as follows.

**Strategic Goal 1: Excellent care Every Time...**

- **Primary Care Transformation Complete Care Franchise - of Primary Care -**  
By autumn 2010, new franchise organizations should be in place each serving 10,000 to 15,000 people to deliver integrated primary care and some diagnostic and community services. These will be in new and modernised Primary Care Health Centres. The scope for incorporating some advice into a primary care setting is greatly enhanced by larger centres serving sizeable populations.
- **Increased information and advice to patients / publishing performance information, based on agreed quality indicators and the utilisation of patient feedback.**  
This actually focuses on gathering feedback and making it available to the PCT as commissioner, providers and the public to inform choice of providers.
- **Supporting the implementation of Brighter Futures - increasing access to and the impact on Child and Adolescent Mental Health Services**  
This acknowledges that some BME families find the voluntary sector more acceptable than traditional mental health services. Two community workers, employed by Barnardos, have been funded. The opportunity to link advice which helps prevent mental health crises is clearly there.

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<sup>40</sup> Strategic Plan, Heart of Birmingham Teaching PCT

**Strategic Goal Two: Excellent Care Every Time**

- **Development of community alternatives to hospital beds including intermediate care, effective case management and end of life services**

Local access to services and an increase in treatment at home or in “near home” conditions is planned. Redesign of care currently using 200 acute beds is planned in partnership with the local authority. The need for discharge planning and strategies to prevent re-admission is highlighted. While the financial and housing components of those are not specifically recognised, the need is there.

- **Redesign of sexual health services to meet the needs of young people**

Around half the infections are in ten inner city wards. The intention is to develop expertise and capacity in primary care settings to allow specialists to concentrate on vulnerable groups and complex cases.

**Strategic Goal Three - Shaping Your Own Health**

- **Implementation of (‘Level 0’) Well-being/ Self Care strategy jointly with the Local Authority, including investment in smoking cessation and obesity services**

Focus here is on Health Trainers and Chronic Disease Educators. The need to increase demand, access and referral in BME communities is recognised and there could be a role for some agencies in this.

- **Promoting health literacy access and self care through the health exchange, training and recruitment of local people, access to health language training**

This promotes Health Exchange outlets in Voluntary and Community Sector premises giving both 1:1 and group assistance. It highlights both the lack of spoken English and the lack of understanding of health terms. It looks at developing community well-being services with partners and developing standards for community engagement as part of new level 1 Primary Care Centres. While this may not be an opportunity for traditional advice, clearly many agencies delivering advice also have community connections and suitable premises for the delivery of these services.

- **Public and Patient Engagement in Decision Making**

Making patient networks more skilled and effective community representatives and widening the brief of the networks to both centrally and locally commissioned services is envisaged.

**Strategic Goal Four: Adding Years to Life**

- **Improving chronic cardio vascular disease management through mass screening, treatment and prevention**

Beyond publicity there seems little role for advice in this primarily clinical initiative.

- **New models of maternity care with systematic risk assessment and pregnancy outreach family support.**

This acknowledges the failure of traditional models to address social and economic factors in infant death and still birth and that previous remodelling of services has been, at best, partially successful. This specifically refers to benefits as a key part of the package of care and threatens disinvestment from current providers if no change is seen.

There is clearly a role for dedicated advice whether in clinics, by telephone support and referral, training or all of the above. Advice on debt and housing could be just as critical in improving the socio-economic conditions a child is born into.

- **Delivering a new model of alcohol treatment based on prevention**

There is a multi agency Birmingham alcohol strategy and work with other PCTs, the police and local authority is envisaged.

**Strategic Goal Five: A Voice, A Choice, Health for All...**

- **Incapacity Benefit - pathways back to work for those with mental illness**

Signposting patients to existing benefit and debt advice services is specifically highlighted. The issue must then be about including these services in the capacity building as it is highly unlikely that they will have the capacity to deal with an initiative of this scale - targeted at 1400 people.

- **Fulfilling Lives - Learning Disabilities Continuing Care**

Commissioning responsibility is transferring to the local authority. A new pooled budget under S.75<sup>41</sup> is being set up. Advocacy is a role which is required which may be of interest to some agencies providing advice.

- **Remodelling Offender Care**

A competitive tendering process is underway to provide care to prisoners and this includes commissioning from the third sector. As discussed earlier, there are a number of social welfare issues for dependants outside prison which can affect prisoners' mental health and

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<sup>41</sup> s.75 National Health Service Act, 2006

behaviour. Some of these may have to be addressed some distance from the prison and referral arrangements with peer agencies may be needed.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Very specifically, a challenge is presented to providers of maternity services to address benefit issues. We would see a role for other social welfare advice in the same package.
- Where existing services are highlighted to be part of an initiative, capacity needs to be considered - in increasing capacity, the opportunity should be taken to look at dedicated or specialist advice posts.

#### **5.2.4 COVENTRY TEACHING PCT<sup>42</sup>**

The following are the PCT's core values:

- *A focus on proactive prevention and wellbeing as well as clinical service delivery.*
- *Patients have the right to receive fair and timely access to a choice of services which are safe, clinically effective and patient-centred.*
- *Services should be local, joined up and easy for people to use, requiring them to 'tell their story' only once to an integrated team of professionals.*
- *Our resources should be used effectively and efficiently by investing in services that deliver best value for money within the resources available.*
- *Building and maintaining mature partnerships with partner organisations, clinicians and local people to create ownership of the city's mission, align priorities, improve service design and deliver faster transformation of health and health services.*

#### **Provider Landscape and Market.**

The Coventry and Warwickshire Partnership Trust provides mental health, learning disability, substance abuse. Other than the usual providers such as hospitals, GP's and Dentists, the Coventry teaching PCT spends some £13.5 million spent on housing support, employment, advocacy, counselling and psychological therapies with private and voluntary sector providers.

The Trust sees its financial position as being "substantially improved" fro previous years.

It sets four goals and groups its initiatives under these.

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<sup>42</sup> Coventry PCT Strategic Plan 2009/10 - 2013/14

**Goal One: Improving Health and Reducing Health Inequalities:**

- **Transformational Initiative - Reducing smoking:** this revolves primarily round increasing the size of the smoking cessation service.
- **Sexual Health Services:** at the time of writing the Trust were benchmarking their HIV services and anticipating an increase being needed in this service. Increases in nurses, health care assistants and pharmacists are anticipated.
- **Reducing Infant Mortality:** education and particularly breastfeeding are the focus here.

**Goal Two: More Integrated Care Closer to Home**

- **Transformational Initiative: Community Rehabilitation Strategy:** to be developed with partners and provide 28 rehabilitation beds in the community.
- **End of life strategy:** this anticipates a further 19 community beds.

**Goal Three: Faster More Responsive Services**

- **Transformational Initiative: Enhanced Community Provision:** less hospital admissions - this included community care for, amongst others, more musculo skeletal pain sufferers and people with mental health issues.
- No detailed improvement initiatives are identified here

**Goal Four: Patient Centred Quality Service**

- **Transformational Initiative: Improved Quality of Care:** This recognises that current primary care varies widely in quality and looks to robust performance management.
- **Robust performance management framework for community Services.**
- **Promotion of Patient Choice**

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- This is one of the harder plans in which to identify opportunities for advice but this does not mean they are not there, merely that the transformations are drawn in a rather broader brush. There is no substitute here for exploring the detail locally with the PCT.

**5.2.5 DERBY CITY PCT<sup>43</sup>**

**Provider Landscape and Finance**

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<sup>43</sup> Derby City PCT 5 -Year Strategic Plan Version 2.0 29th October 2008

Derby PCT contracts with some 40 voluntary sector agencies and delivers other services via the city council's services. It regards itself as having a strong record of market management and is seeking to further develop those skills. It sees a need to fundamentally reform primary and community services. It considers that it has not maximized the opportunity for commissioning services from the third sector. While this observation is doubtless aimed primarily at care and therapy services, there is no reason why it should not encompass advice where this is appropriate. The Trust is in a healthy financial position.

There are 14 high priority strategic initiatives grouped under 5 themes.

**Theme One: Primary and Community Care:**

- **Develop integrated Primary Care suitable for the 21<sup>st</sup> Century.** This envisages a “trailblazing and radical” model based on an in depth health needs analysis and subject to independent academic evaluation. This is seen as having a wider range of better integrated multi-disciplinary services and as having strengthened input from third sector, mental health and social care partners. The focus is to be on prevention. The way seems open for appropriate advice services to be integrated into this model.

**Theme Two: Staying Healthy**

- **15,000 fewer smokers by 2013** - a community development approach is envisaged which could involve some community based advice services.
- **Comprehensive programme to reduce Cardio-vascular Disease Risk** - there is little role for advice in the specific initiative
- **Reverse the tide of obesity** again a community based approach will be taken but there seems little specific contribution for most advice services
- **Reduce Alcohol consumption and related harm** - little in the approach seems to include advice but social welfare advice clearly can assist with the causes of drinking for some.
- **Implement staying healthy initiatives for specific populations** - minority communities and new mothers are highlighted and agencies working with them may have a role.
- **Reduce cancer mortality by better symptom recognition and earlier diagnosis** - other than in advising people to seek screening, there is nothing specific to advice here.

**Theme Three: Long Term Conditions**

- **Implement an integrated model of care for long term conditions**
- **Implement disease specific care for specific conditions** - these two are not yet very specific and are largely clinically based, there is clearly a role for advice in developing long term care for patients who would otherwise be in hospital in terms of finance and

housing.

- **Develop an integrated approach to Mental Health combining Health and Social Care models** - this model is to be developed and clearly envisages support in a broad range of fields including employment. There is no doubt that effective social welfare advice and advocacy should play a part in the development of this model.
- **Improve quality of specialist palliative care** - the initiative is aimed at extending these services to non-cancer patients and again does not contain specific detail relevant to advice but the general conclusions drawn from other PCTs are equally relevant here.

#### **Theme Four: Vulnerable Adults**

- **Improve independence, well-being and quality of life** - social care and third sector partners are specifically identified here and advice and advocacy services must have a role in this.

#### **Theme Five: Urgent Care**

- **Take forward Next Stage Review** - the aim is to increase access to GP's, nurses, and pharmacies and to reduce hospital admissions. What role there may be for advice in this will be determined by the type of centres emerging from the review. Agencies may wish to have their voices heard in the review.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- While there is little not discussed elsewhere above here, this is PCT which clearly values and expects the input of the third sector and there are large areas of work and large areas of coming investment into where advice service would fit well into integrated service models in a variety of ways.

#### **5.2.6 LEEDS PCT<sup>44</sup>**

The Trust has set out ten objectives which contain detailed targets which are summarized below.

**Objective One: We will improve your health and well-being and protect the health of the population** - "supporting people to live free of, discrimination, disease and poverty" is a theme highlighted. This is an objective shared by most advice services and while the individual

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<sup>44</sup> NHS Leeds Strategy 2008-2013

initiatives are specific and clinically based there is undoubtedly a role for advice in pursuing the overall objective. Commissioning with partners including the City Council is envisaged and includes work with the voluntary sector. Initiatives are as below the first three are joint initiatives in the Local Area Agreement:

- Increase numbers of people with anxiety and depression offered psychological therapies
- Reduce smoking
- Reduce cardio vascular disease
- Reduce child obesity
- Reduce alcohol; related hospital admissions
- Increase breast feeding
- Increase vaccination against cervical cancer

**Objective Two: Work with other s to reduce Inequalities in Health**

There is a nine year gap in life expectancy between areas of Leeds. The first and last of the initiatives are Local Area Agreement joint initiatives.

- Narrowing the health gap
- Improve access for vulnerable groups
- Reduce infant mortality
- Better sexual health and reduced teenage conception

Joint working with voluntary, community, faith and social care sectors is envisaged and importantly there is a realization that what works in one neighbourhood may not work in another. This specifically recognizes the role of benefits, fuel poverty and access to employment. Community workers for BME communities and public health coordinators have been appointed and practice based commissioning of other services is envisaged. Access to advice has a key role in tackling some of the specified issues and should form a significant part of meeting this objective.

**Objective Three: We will treat you with respect and ensure you receive safe, effective and well coordinated care in modern facilities**

- Targets here include tackling MRSA, reducing delays in hospital discharge and improving job and patient satisfaction. There is nothing specific to advice work here.

**Objective Four: We will provide care where and when you need it, promoting your health and wellbeing and avoiding unnecessary admission to hospital.**

- Community services to reduce hospital admissions for people with long term care needs
- Reduced waiting times

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- All GP's lists open for new patients and 50% open evenings or weekends
- Quicker follow up on urgent cancer referrals.

The PCT is anxious to avoid adverse impacts on carers when reorganising services and has pan Leeds Carers' Strategy. Benefits for carers are not mentioned but must be part of a strategy involving more people being cared for in the community.

#### **Objective Five: We will help you make choices and feel in control of your healthcare.**

This agenda is about more than choice, it covers access for hard to reach and vulnerable groups, using gypsies and travelers as an example. It includes work with the City Council to provide new mental health support services. It also covers information points, languages and formats. Again more care in the community and people choosing to die at home requires advice support and there is also a role for advice agencies in being information points, translators and in explaining choices to hard to reach communities where they may have a level of trust.

- More women to see a midwife or other health care professional for health and social care assessment.
- More parents of disabled children feeling supported
- Patients to have a choice of 3 GP practices and the gender of their GP
- More long term care patients in control of their own conditions
- Support for patients wishing to die at home

#### **Objective Six: We will work alongside our partners to deliver our vision**

Partners envisaged are the range of statutory, voluntary and faith organisations. The PCT looks to work with partners in neighbourhood networks targeting the most deprived areas of the City. Specific reference is made to fuel savers. Co-ordination of services is the aim and the example given is of health visitors being the door to other services. Initiatives are:

- Demonstrating meeting Local Area Agreement targets by work through such bodies as the Healthy Leeds Joint Strategic Commissioning Board, Children's' Trust and Safer Leeds.
- Increasing the role of joint commissioning and joint budgets
- Evidence of effective lobbying and influencing.

#### **Objective Seven: We will commission high quality care from a range of providers**

Voluntary, community and faith sector suppliers are envisaged. Specific initiatives are:

- Reducing the proportion of the budget spent on acute hospital care
- More patients needs met by new community care pathways and practice based commissioning
- Strong, responsive community services

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- Development of performance indicators
- 5% or more of commissioned services to be market tested.

**Objective Eight: We will ensure effective and sustainable use of resources**

This is broad ranging initiative covering issues from patient satisfaction to controlling energy bills. The most significant part for advisors is the intention to commission providers on a “cost per case” basis. The extent to which this could or should apply to linked advice provision is something that would need to be discussed.

**Objective Nine: We will support develop and value our staff**

There may be roles for advice agencies in training but other wise this is an inward looking objective.

**Objective Ten: We will be recognized as an organization of improvement and learning**

This covers such issues as increasing GP teaching posts and links with universities - again there may be training roles - for which there are precedents though little is published on them.<sup>45</sup>

This plan focuses heavily on the importance of partnership sand the Local Area Agreement and would seem to offer easier access to many of the opportunities created by the plan for advice to contribute to its effective delivery than

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Identifying the key contacts - community workers, public health coordinators and the practice base commissioning consortia is critical to obtaining rapid access to the agenda.
- Information on services and explanation of choices is a potential role for advisors, particularly those advising hard to reach communities where they may be trusted.
- The level of commissioning needs to be understood - highlighted in Leeds by clear proposals for local, practice based commissioning
- Agencies must be ready to be monitored and should prepare criteria against which they think their performance should be measured.
- Commissioning of providers on a cost per case basis could be extended to referral fro advice - the appropriateness of this needs to be considered.

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<sup>45</sup> this is based on direct experience, one of the authors ran basic benefit and debt awareness sessions as part of GP training in Manchester

### 5.2.7 LIVERPOOL PCT<sup>46</sup>

Eight Priorities are set divided between delivering health and delivering services. Each has a range of initiatives.

#### **Delivering Health**

##### **Priority One: Delivering the things that make a difference**

- Cut deaths from a range of causes such as cardiovascular disease, accidents and cancer
- Improving young peoples' health through Healthy Young Liverpool
- Everyone to know more about looking after themselves and their families
- Everyone to know where to go for help with health problems
- Everyone to have a dentist within 15 minutes public transport ride
- Reduces hospital admissions

The overview of these initiatives covers leveling health inequalities and specifically refers to maximizing income, tackling fuel poverty and pathways to work. Although no reference is made to advice, the role is clear.

##### **Priority Two: A better understanding of self care and how health services can support it**

- This revolves round a huge social marketing campaign. The Social Inclusion Team may provide a link to supporting this priority but it is, understandably, less specifically relevant to advice services.

#### **Delivering Services**

This requires robust contracting to deliver health and wellbeing.

##### **Priority Three: Gold standard primary care and community services**

- This will see £100m investment in new premises and staff to raise the availability and standard of primary care. This will mean new venues from which services can be delivered.

##### **Priority Four: Gold standard hospitals**

- This primarily will not be of concern to advisors except that monitoring where specialist services are delivered from is important in targeting some advice interventions.

##### **Priority Five: End of life services**

- As with other trusts the focus will be on care at home where that is what the patient desires. The implications for advice to patients and cares during the illness and consequent

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<sup>46</sup> A New Health Service For Liverpool, Strategic Plan 2008-2011 – discussion document.

bereavement cover care, benefits, debts, housing and wills.

**Priority Six: Personalised care**

- Collecting data on patient experience is key part of this and advice services with links to health provision can contribute to the collection of this data.

**Priority Seven: An end to waiting**

- There are no obvious advice interventions here.

**Priority Eight: Joined up services**

- That patients do not like to be passed from one provider to another is the underpinning principle. A Joint Strategic Needs Assessment prepared with the City Council and work on joint commissioning initiatives and joint performance indicators is ongoing. Such joint initiatives should make it easier to focus the intervention of advice, particularly in a City with such high levels of deprivation. It should be possible to pick up on the specific objectives under priority one such as income maximization in the joint commissioning arrangements.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- The breadth and scale of jointly commissioned services provide much better opportunities to introduce activities such as benefit screening on a viable scale.

**5.2.8 MANCHESTER PCT<sup>47</sup>**

This is the Trust's first strategic plan and is aimed at addressing "the most fundamental of inequalities" by improving health in the City. It identifies ten priorities and strategic initiatives to support each.

**Strategic Initiatives One and Two: Life expectancy and Health Inequalities**

These are combined and six work programmes are identified:

- Implementing best practice guidelines for reducing smoking in pregnancy and increasing breastfeeding;
- Tobacco Free Communities programme;
- Cardiovascular disease risk assessment and management;
- Improved prevention and early diagnosis of cancer;

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<sup>47</sup> Improving Health in Manchester: Commissioning Strategic Plan 2009 - 2014

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- Healthy living networks; and
- Health trainers.

A broad range of local partnerships such as Valuing Older People are expected to contribute to this as is direct commissioning of “providers of lifestyle advice”. Whether advice agencies would see themselves in that category is a moot point. Very significant investment is planned in this programme and some elements of this already have links to advice services and these should be developed. While it may be hard to see specific opportunities, this is in fact the heading under which most investment is likely.

#### **Strategic Initiative 3 - Reduce the number of teenage conceptions**

- Clinical outreach in those wards with highest rates of conception among under-18s;
- A prevention team to work on a targeted basis with young women who may become pregnant at an early age; and
- Teenage Pregnancy Programme.

There is nothing specific for advice services here but services working with young people undoubtedly would have some role to play in targeting the services.

#### **Strategic Initiative 4 - Reduce the number of alcohol related hospital admissions**

The aim is to ensure that problem drinkers have access to early intervention at key points of access to healthcare and that heavy/dependent drinkers attending the three A&E centres will be provided with timely support to prevent readmission. GP's and hospital will have targets for brief interventions and reduced hospital admissions. The latter have to fund most of this initiative and while there are undoubted advantages in effective referral to advice, it is unlikely that such services will be significantly directly funded by this initiative.

#### **Strategic Initiative 5 - Reduce the number of children who are overweight**

- Breastfeeding Peer Support Service
- Family centred lifestyle support for the under 5s, including the training of Early Years workers to work with families in supporting healthy lifestyles for the whole family; and
- Community Food Workforce expansion to address exercise/activity on referral, increased capacity in leisure services provision and an Early Years prevention programme around healthy weight which links with the Child Health Promotion Plan.

This will primarily involve work with early years services and little advice component can be seen in this specific initiative.

#### **Strategic Initiative 6 - Make sure health services are safe**

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- Build capability to deal with adverse clinical events;
- Implement best practice trigger tool analysis;
- Prevent 'Never Events';
- Resource patient safety; and
- Expand and reconfigure the community infection control team.

This is a clinical initiative and no role for advice services can be seen in this.

**Strategic Initiative 7 - Improve the quality and availability of primary care services**

- Additional GP practices;
- A GP-led walk-in health centre;
- Additional dental services;
- Extended GP opening hours;
- Reducing primary care demand (by increasing the role of pharmacists for instance) and streamlining patient access; and
- Developing the Manchester Standard as a new quality mark for primary care services.

This is another area of major investment and while no specific advice related issues, the changes to the landscape of primary care may change the venues from which advice can be offered.

**Strategic Initiative 8 - Make sure patients with a long term condition have a personalised care plan**

- Implementation of personal care plans for patients with chronic obstructive pulmonary disease;
- Implementation of personal care plans for diabetes patients from black and minority ethnic communities; and
- Personalised budgets for self care long term conditions.

It needs to be understood that this is an initiative which intends to save rather than invest funds, the saving coming from a reduction in unplanned hospital admissions. Nevertheless successful long term care in the community requires benefit issues, housing issues etc. to be addressed. Personalised budgets present interesting issues as discussed under Leeds PCT above.

**Strategic Initiative 9 - Improve access to planned care**

- New Clinical Assessment Treatment and Support Services (CATS) as part of a Greater Manchester wide initiative
- Working with existing providers to review and redefine existing second tier services;

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- Ensuring capacity gaps are identified annually and that alternative providers are commissioned to meet the shortfall;
- Working to enable GPs to access diagnostics directly to support patient management within primary care;
- Working with practice based commissioners on new initiatives for better access; and
- Working with secondary care to determine the best use of resources.

Much of this is about waiting lists and it is difficult to see how advice plays a role in this.

#### **Strategic Initiative 10 - Improve access to urgent care**

- System reform of urgent care;
- Managing urgent care demand; and
- Increasing the capacity and effectiveness of community services.

It is similarly hard to see a role for advice in this.

#### **Strategic Initiative 11 - Mental health**

This is across cutting initiative involving all the above except numbers three and five. Support to vulnerable residents and the Crisis Resolution Home Treatment service will require adequate debt, benefit and housing advice and possibly advice on other issues by referral to services able to effectively deal with people facing mental illness crises.

There are already three Practice Based Commissioning Hubs for North South and Central Manchester and one (South) has proposed a social enterprise model for its approach to commissioning care.

#### **Market Management and Providers**

The presence of local providers in the voluntary sector with strong community roots is an identified strength in the provider network. They are also sensitive to the lack of ability of small, local voluntary and community sector providers to respond to market management initiatives and this is identified as a weakness. Finance is seen as sufficient to develop the initiatives in the plan.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Again the issue of personalised treatment budgets emerges. The relationship between this and advice provision needs consideration.

### 5.2.9 NOTTINGHAM CITY PCT<sup>48</sup>

“An End to Health Inequality” is the proclaimed aim of the strategy.

The PCT see eleven core competences needed to take them from “good to great”. These are summarised below.

1. Recognition as local leaders of the NHS - ensuring they are the first port of call for political and community leaders on health issues.
2. Working collaboratively with partners - including the Joint Statement of Needs Assessment with the City Council.
3. Build meaningful public engagement
4. Lead meaningful engagement with clinicians
5. Prioritise knowledge and robust regular assessment of services
6. Prioritise investment to tackle inequality
7. Manage the market - to ensure a range of responsive providers and choice for patients
8. Continuous improvement and quality outcomes
9. Secure procurement skills to commission the providers
10. Managing the system values and relationships
11. Excellent Financial management - the Trusts financial position appears healthy

To these they have added tackling priorities across the East Midlands through NHS East Midlands set up by their last strategy.

Three priority areas are identified:

**Priority One: Improve health and wellbeing:**

Promotion of health not treatment - among targets are cardio-vascular disease, accidents and cancer. Community Health Trainers are one of the initiatives under this heading.

**Priority Two: Better Access to Quality Care:**

This includes:

- Designing and commissioning services to meet local needs
- NHS treatment centre to speed up diagnostic services
- Targeting services on areas of need
- Partnership with social care providers and the voluntary sector to develop a more coordinated approach.

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<sup>48</sup> Nottingham City PCT, Health Investment Strategy 2008 - 2013 (two parts)

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**Priority Three: Care Closer to Home:**

- Community nurses, case management by community matrons and practice based commissioning are included
- One stop centres are open at Clifton Cornerstone, Mary Potter Centre (Hyson Green) and Budwell is next in line.

The Trust will develop a balanced scorecard to ensure it all happens.

This is not one of the easiest plans to see the specific opportunities to integrate advice into the agenda. This does not mean they are any less present and indeed the Trust's priorities in tackling health inequality and references to the voluntary sector and joint working are throughout the plan suggest that the opportunity is there.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- Meeting the commissioners and looking at the type of services provided in the new centres already open would seem to be the key to development here, rather than relying on the plan.

**5.2.10 NHS SHEFFIELD<sup>49</sup>**

In its very detailed plan, NHS Sheffield's stated aims are:

*Working with local NHS organisations and their staff, the City Council, partners in the voluntary, community, faith and independent sectors, and above all the people of Sheffield, we are trying to achieve two things:*

*Saving lives by reducing the gap in good health and life expectancy between the healthiest and least healthy*

*and*

*Organising health services to ensure they remain affordable for the City so that everyone gets the highest quality and most personalised service possible.*

**Provider Landscape and Financial Position**

The Trust spends £4 million with 66 voluntary sector providers (ignoring jointly commissioned services) and sees changes in the provider landscape as it moves to more community and home delivered services. It sees itself as having cleared substantial debts and now to be in a healthier financial position.

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<sup>49</sup> Achieving Balanced Health, NHS Sheffield

The Trust's two strategic goals are as set out above. These are supported by nine local priorities and twenty local initiatives as summarised below.

These are very comprehensively set out in appendix 2 of the plan which in some ways makes them easier to summarise briefly from an advice perspective. The brevity of the summary is almost inverse to the comprehensiveness of the health information and detail of the plan.

The Trust's two strategic goals are as set out above. These are supported by nine local priorities and twenty local initiatives as below:

**Local Priorities**

**Priority One: Heart disease:**

Investment here is seen as being primarily in GP and pharmacy led services such as screening 40-74 year olds and would seem to have little need for advice input.

**Priority Two: Chronic respiratory disease:**

The biggest new need here is seen as Tuberculosis screening; however initiatives do include improving end of life care and as discussed above this has a significant need for good advice if patients are to be kept at home.

**Priority Three: Stroke:**

Major investments here are expected to be in primary care to prevent stroke and comprehensive long term support. Previous observations on long term support apply equally here.

**Priority Four: Tobacco Control and Smoking:**

Smoking cessation support is available on 153 sites and there is a drive to work with partners to deliver the service from more non-NHS sites. Beyond the role of reducing stress and the possibility of using premises for specific cessation services and taking part in campaigns, there is little specific for advice work here.

**Priority Five: Diabetes:**

This is a clinical agenda about improving take up of screening and reducing HBA1c glucose levels.

**Priority Six: Drugs and Alcohol:**

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A support service for families and carers is provided and the plan discusses “industrialization” of brief interventions. The provision of advice is not mentioned but as discussed elsewhere, screening for and tackling financial, accommodation and other problems could form a valuable part of such interventions and of longer term support.

**Priority Seven: Children and young people (including obesity)**

Services are jointly commissioned with the City Council and priorities are:

- Child and Adolescent Mental Health
- Teenage Pregnancy
- Obesity
- Substance misuse
- Looked After Children
- Adopted Children
- Children with Learning Difficulties and Disabilities

Community services and behaviour support is included and, while there is no specific mention of advice provision, there is a need for income maximisation, particularly for families of disabled children and those with learning difficulties.

**Priority Eight: Reducing inequalities in life expectancy**

Much of this work is already done through voluntary sector partners and some is targeted at minority populations. Of particular interest is a target of building community infrastructure in areas where there is none.

**Priority Nine: Mental Health**

The role of the third sector is seen largely as providing specific services and alternative pathways to care. Advice is not specified but the need to view patients’ lives “in the round” is recognised and there clearly is a role for focused advice interventions here. Access to employment is highlighted as an issue.

There are some twenty Local Initiatives

**Priority Ten: Maternity Services**

Breastfeeding, smoking, drug and alcohol abuse are focuses of this and are largely covered in the nine priorities above.

**Priority Eleven: End of Life**

There is a focus on choice and quality and delivering high quality services in co-ordination with social care providers. A specific role for advice is again not recognised but access to advice around accommodation, income, debts and wills are all important in the overall package of care is nonetheless inherent.

**Priority Twelve: Planned Care**

This is a very clinically focused initiative.

**Priority Thirteen: Specialised Services**

This looks at low volume high intensity services which are commissioned generally on a national or regional basis Yorkshire and Humberside Specialised Commissioning Group and North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium (NORCOM) commission. There may be a role for advice here but it will, in volume at least, be a small one.

**Priority Fourteen: Cancer**

This covers screening and prevention and is particularly linked to tobacco initiatives and there is nothing additional for advice services here.

**Priority Fifteen: Unscheduled Care**

By the time this is published, the Equitable Access Centre should be open. It is acknowledged that people from the south east of the City have further to travel to access services. Again no specific role for advice is envisaged but it can have a valuable role in providing one stop access to services people need.

**Priority Sixteen: Long Term Conditions - Personalisation**

This aims through co-ordinated health care and social care to maintain people living independently as long as possible. Self directed support and the use of direct payments of social care funding are included. This will be a developing area and while no mention is made of advice, advice and advocacy will be needed on the choice of services as well as drawing down financial and other support necessary to pursue an independent existence.

**Priority Seventeen: Long Term Conditions - Neurological**

Again no mention is made of advice as part of the package of support but patients with neurological injuries and illnesses may well need specialist advice particularly in the area of disability benefits where issues over “good days and bad days” may impact on entitlement to

benefits needed to maintain an independent life. This fits well with the stated aims of autonomy and self management. A need to formalise *ad hoc* use of voluntary agencies is identified.

**Priority Eighteen: Learning Disabilities**

Services are commissioned in partnership with the City Council. Employment options and the particularly the transition from children's to adults' services are targeted areas where advice input would be beneficial.

**Priority Nineteen: Primary Medical Care**

Capacity of existing providers is expected to expand to match increase in service delivery from primary care venues. A new GP led health centre should be open by the time this report is published. Open hours are to extend to the national standard (8 a.m. to 6:30 p.m.) and beyond where appropriate. Recruitment of workers with language skills to reduce the reliance on interpreters is proposed. There is nothing specific here but the changing primary care environment must give opportunities for enhanced services.

**Priority Twenty: Dental Care Services**

This concerns access and waiting times and there is no real scope for advice

**Priority Twenty-one: Optometry Services**

Developing and delivering an ophthalmology strategy has little relevance to advice work provided in this as in dentistry, awareness of NHS benefits is included - there could be a training need.

**Priority Twenty two: Community Pharmacy**

All neighbourhoods are served and the priority is increasing range and quality of services available. Training in prescription charges pre-payment, exemption and refunds together with referral information would seem to be the needs here.

**Priority Twenty three: Medicines Management**

There is no obvious role for advice agencies other than as disseminators of information here.

**Priority Twenty four: Carers**

NHS Sheffield and the City council jointly commission the Carers' Centre and Young Carers' Project. And commission services from a number of voluntary organisations. There is a specific

target of improving the social inclusion of carers and advice should have a key role in this. Carers are encouraged to self identify and refer. Benefit screening and referral for other advice where needed could be done at this stage.

**Priority Twenty five: Intermediate Care**

Short term rehabilitation and pathways to discharge of patients may need housing and benefit advice and the design of packages of care can be optimised to maximise income.

**Priority Twenty six: Enablement**

Much of the investment will go into assistive technology for people with disabilities. As ever, maintaining people in the community is enhanced by increasing income and screening for take up of disability benefits would be valuable.

**Priority Twenty seven: Older People's Services**

There is nothing specific to advice here that is not already covered under other headings.

**Priority Twenty eight: Continuing Health Care**

While there are interesting ideas here including developing a legal alternative to Direct Payments for NHS funded patients to ensure continuity of care, there is little to add to the comments under earlier initiatives from an advice standpoint. There will be considerable development of supply here and integration of basic advice and ongoing training in partnership with providers is potentially invaluable.

**Priority Twenty nine: Sexual Health (including teenage pregnancies)**

There is no clear role for advisors here except where they have contact with target groups and can assist in delivery of messages and services such as discrete testing away from NHS premises.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- The PCT's concern to develop community infrastructure where little or none currently exists is of particular interest and is something which agencies which do or could supply advice to such communities should engage with.
- Training as well as service delivery opportunities should be looked at - for instance with reception staff in new surgeries, dentists, pharmacists or opticians on NHS benefits and how to help patients complete the relevant paperwork.

- Identification of points where advice input will be most effective is important. The encouragement of carers to identify themselves and self refer is a good example. A benefit check together with screening for other advice needs at the point of referral could enormously improve the lot of carers and patient alike while delivering work in a manageable flow.
- There is a role for advisors in the design of packages of care to ensure that income from sources other than NHS or local Social Care Services is maximized. This can improve quality of life and save money from local budgets.

#### **5.2.11 STOKE ON TRENT PCT<sup>50</sup>**

The PCT acknowledges that despite overall improving health, inequality is growing. The plan maps income, health, employment and multiple deprivation - all showing similar patterns and tackling inequality is key focus of the plan. The financial position is reported as healthy with a surplus in 2007/08 available for investment.

##### **Provider Landscape**

The PCT sees itself as having some difficulty recruiting providers as it is remote from other cities and the surrounding countryside has different needs. Much commissioning is jointly carried out with Stoke City Council and a Local Strategic Partnership and Local Area Agreement are in place alongside the North Staffordshire Regeneration Partnership. A growing role is seen for voluntary and community sector services and the need for capacity building in the sector is recognized. This however does not relate specifically to advice. A new Neighbourhood Hub is planned for Cobridge in 2010 and new Primary Care Centres for Meir and Tunstall together with new GP practices from Middleport and Meir.

There are three Strategic Goals, each supported by a range of initiatives. These are summarized below:

#### **Strategic Goal 1: Health Inequality**

##### **Initiative A: Tobacco Control**

Targeted at increasing smoking cessation services and a specific initiative “Quit for a New Life” aimed at pregnant smokers. Voluntary and community sector agencies are seen as key partners but there is no specific role for advice.

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<sup>50</sup> Towards a Healthier Future, World Class Commissioning Strategic Plan 2008 to 2013, NHS Stoke on Trent Primary Care Trust

**Initiative B: Social Marketing Approach to Breast Feeding**

There is little role for advice agencies here other than in providing information

**Initiative C: Reduce Alcohol Related Hospital Admissions**

Both the prevention and Treatment and Children and Young People's strands of this initiative include advice, information and support and look to providers having appropriate packages to deliver.

**Initiative D: Reduce Child Obesity**

There is probably little role for advice here beyond distribution of information.

**Initiative E: Contribute to reduction in Teenage Pregnancy Rates**

Agencies well used by young people and particularly young people from minority communities may provide discrete non NHS premises from which advice and contraception can be provided which could be valuable.

**Initiative F: Lifestyle Support Programme**

This is aimed at issues such as diabetes and coronary heart disease. Partners are seen as including Voluntary Action Stoke and other voluntary and community sector providers but the role of advice is not specified and may be relatively small.

**Initiative G: Improving activity and reducing obesity in adults**

There is probably little role for advice here beyond distribution of information.

**Strategic Goal Two: Put our Patients and Public First**

**Initiative H: Increase Self Management of Long Term Conditions**

Commissioning courses for patients and developing the Expert Patient Programme are the main methods here and while no role is seen for advice agencies, there should be some benefit advice input into such courses.

**Initiative I: Improve Public and Patient Engagement and Experience**

Agencies have a potential role both in disseminating information and in gathering views from their clients on health provision. This would be particularly the case for agencies working with hard to reach communities.

**Strategic Goal Three: Modernise Healthcare**

**Initiative J: Improve Quality and Access in General Practice**

The new centres have been covered above. Noteworthy here is the intention to set up a Primary Care Development Unit with Keele and North Staffordshire Universities. This would seem to offer an opportunity to contribute to the design of services and to research into the effectiveness of advice in medical settings.

**Initiative K: Heart Failure Pathway Redesign**

This will involve more community based services but it is hard to see a specific role for advice beyond that in reducing anxiety by providing routes to deal with day to day problems.

**Initiative L: Cancer Reform**

This will lead to many patients in long term care at home and perhaps dying at home and issues around accommodation, benefits, debts, wills, etc. will arise.

**Initiative M: Deliver more services in Community Locations**

This involves a redesign of outpatient services and is a major source of investment in which the voluntary sector are seen as partners. The delivery of services as envisaged from modern purpose built centres offers an opportunity to provide advice services where people are attending for treatment or medical advice.

**Initiative N: Reducing Healthcare Related Infection**

Distributing Information is the only advice role in this.

**Points for Advisors** (NB those already raised in the summaries of other PCTs above are not repeated.)

- The importance of relationships between strategic bodies such as regeneration partnerships is emphasized here.
- Opportunities to contribute to research to identify the impact of advice in medical and care settings should be sought and the Primary Care Development Unit proposed would seem an excellent opportunity to do that.

**5.3 SPEARHEAD PCTS**

The Spearhead Group of local authorities and primary care trusts following the 2006 PCT

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reconfiguration<sup>51</sup>.

**Local Authority**

Barking and Dagenham  
Barnsley  
Barrow-in-Furness }  
Carlisle }  
{ Birmingham East & North PCT  
Birmingham  
{ South Birmingham PCT  
Blackburn with Darwen  
Blackpool  
Blyth Valley }  
Wansbeck }  
Bolsover  
Bolton  
Bradford  
Burnley }  
Pendle }  
Rossendale }  
Hyndburn }  
Bury  
Chester-le-Street }  
Derwentside }  
Easington }  
Sedgefield }  
Wear Valley }  
Corby  
Coventry  
Doncaster  
Gateshead  
Greenwich  
Hackney  
Hammersmith and Fulham  
Haringey  
Hartlepool  
Islington  
Kingston upon Hull, City of  
Knowsley  
Lambeth  
Leicester  
Lewisham  
Lincoln  
Liverpool  
Manchester  
Middlesborough  
Newcastle upon Tyne  
Newham  
North East Lincolnshire  
North Tyneside  
Nottingham

**Primary Care Trust**

Barking & Dagenham PCT  
Barnsley PCT  
Cumbria PCT  
  
{ **Heart of Birmingham PCT**  
  
Blackburn with Darwen PCT  
Blackpool PCT  
Northumberland Care Trust  
  
Derbyshire County PCT  
Bolton PCT  
Bradford PCT  
  
East Lancashire PCT  
  
Bury PCT  
  
County Durham PCT  
  
Northamptonshire County PCT  
**Coventry PCT**  
Doncaster PCT  
Gateshead PCT  
Greenwich PCT  
**City and Hackney PCT**  
**Hammersmith & Fulham PCT**  
Haringey PCT  
Hartlepool PCT  
**Islington PCT**  
Hull Teaching PCT  
Knowsley PCT  
**Lambeth PCT**  
Leicester City PCT  
Lewisham PCT  
Lincolnshire PCT  
**Liverpool PCT**  
**Manchester PCT**  
Middlesborough PCT  
Newcastle PCT  
Newham PCT  
North East Lincolnshire PCT  
North Tyneside PCT  
**Nottingham PCT**

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<sup>51</sup> Letter from the Minister of State to trust and local authority chairs and chief executives 14 September 2006 (gateway ref 7085)

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|                       |                               |
|-----------------------|-------------------------------|
| Nuneaton and Bedworth | Warwickshire PCT              |
| Oldham                | Oldham PCT                    |
| Preston               | Central Lancashire PCT        |
| Redcar and Cleveland  | Redcar & Cleveland PCT        |
| Rochdale              | Rochdale PCT                  |
| Rotherham             | Rotherham PCT                 |
| Salford               | Salford PCT                   |
| Sandwell              | Sandwell PCT                  |
| South Tyneside        | South Tyneside PCT            |
| Southwark             | Southwark PCT                 |
| St Helens }           | Halton & St Helens PCT        |
| Halton }              |                               |
| Stockton-on-Tees      | Stockton-on-Tees Teaching PCT |
| Stoke-on-Trent        | <b>Stoke on Trent PCT</b>     |
| Sunderland            | Sunderland PCT                |
| Tameside              | Tameside & Glossop PCT        |
| Tamworth              | Staffordshire County PCT      |
| Tower Hamlets         | Tower Hamlets PCT             |
| Wakefield             | Wakefield PCT                 |
| Walsall               | Walsall PCT                   |
| Warrington            | Warrington PCT                |
| Wigan                 | Ashton, Leigh and Wigan PCT   |
| Wirral                | Wirral PCT                    |
| Wolverhampton         | Wolverhampton PCT             |

Highlighting indicates inclusion in this report.

#### 5.4 REFERENCES AND FURTHER READING

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