



RCN Policy Unit

Policy Briefing 03/2006

Introduction

The headings below loosely reflect the structure of Prof Corrigan's report, which is divided into three chapters. In the first chapter, Corrigan argues that primary care should be organised more effectively to meet patient demands. Second chapter focuses on how PCTs might fail in a system of patient choice. The second chapter outlines how the Government should deal with PCT failures in a patient choice system and, finally, the third chapter focuses on providing patients with information to help them make informed choices regarding Primary Care.

Report summary

Capacity and quality: Paul makes a compelling point that Primary care choice is dependent on increasing capacity and accepts that this has not been addressed in the past. But instead of arguing simply for more resources and in essence providing more of the same (or as he puts it leaving it to PCTs), he suggests that the solution lies in 'differentiation'. In other words, whilst two separate parts of the country may have the same general primary care needs; do both sets of needs need to be met in the same way? He suggests that 2 things need to happen at once – increased financial investment *which should lead to* "differentiated" primary care services to meet different needs. As long as the service meets both local (i.e. strategically planned but patient led) and national (i.e. qualitative, quantitative and financial) standards, why should all services look the same?

This process shouldn't be top down only as this would inevitably lead to more of the same, so the top down distribution of resources and provision needs to be supplemented by empowered patient choice.

Voice: Prof Corrigan simply states that the problem with implementing choice in Primary care is that there is little or no experience of effective

service entry to markets. Patients should be able to petition the PCT to call for new services – perhaps a critical mass of qu

He does state however that patient choice in isolation will not determine what is best for collective interests hence the need for more effective legislation, regulation and inspection in primary care.

Information for choice: this is a key part of the publication and provides a useful description of some of the current challenges as well as best practice in existence. He points out as we did that information is classically asymmetrical and that every effort must be made to develop a range of solutions to this problem. In summary he states information may take the following forms

Convenience of access: where and when services are available and to whom.

Services on offer: descriptive information on the nature of services available from each provider

Quality, safety and reassurance: Here he suggests that patients would need to have data on the quality outputs or outcomes of the service on offer. He goes on to suggest that the lack of transparency surrounding primary care regulation and inspection and the fact that the Healthcare Commission cannot inspect GP practices is an “odd exception” and should change.

Communication and dissemination - In terms of providing technical information to the public he proposes the use of initiatives like the NHS Expert patients program, trained, non-medical leaders as educators or patient reviews of services (he uses ‘Amazon.co.uk’ as an example of how consumers can review the products on sale...). This has echoes of the patient stories initiative that proved to be such an influential part of the leadership program.

Information will be provided by Primary care organisations, partnerships between public and private interests, consumer groups and entrepreneurs who have identified a need for information. This process should be managed by Govt however to ensure that the data collected is accurate and appropriately published. He places this responsibility with the DH and the Healthcare Commission but I suspect another agency could be developed specifically to run this process.

In conclusion to this part he also identifies, as have we, that in order to address the inequity of information in this complex area, additional support will be needed. Here he resurrects the idea of Patient Choice Advisers, again refers to the use of expert patients or local councillors, and latterly mentions that NHS / PCT staff might have a role to play (!).

Conclusion

The main conclusions of the report are:

- A new PC framework needs to be developed to avoid hospital admission and deal with long term conditions
- More effective health improvement strategies
- Closer relationship between primary care and social care
- Providing more 'secondary care' in the primary care setting
- PC to play a stronger role in diminishing health inequalities

In essence this is all dependent on effective voice in choice – genuine consumer power to move between providers; a clear, transparent, failure regime which keeps a watching eye on quality, effectiveness, and distribution of services; and finally a wide range of mechanisms to distribute qualitative, quantitative and experiential evidence and information on the range of services provided.