

# **Press Release: 'Equity and Excellence: Liberating the NHS' White Paper Consultation Response**



The Queen's  
*Nursing Institute*

**11 October 2010**

The Queen's Nursing Institute is the national charity concerned with the quality of nursing care patients receive in their own homes. We aim to improve care by funding nurse-led improvement projects, and inspiring nurses through the example of our Queen's Nurses. We also aim to influence policies that impact on the quality of care patients receive. The groups involved in preparing this response were our Community Nurse Forum, our Queen's Nurse community, and QNI professional staff.

## **Overall summary**

There were aspects of the proposals in 'Liberating the NHS' that appealed to and were welcomed by the community nurses who responded to the consultation. The most popular proposal by far was for joint working by health and local authorities, to give patients a better experience of 'joined up' care, and more personalised services. There was a more cautious welcome for issues such as abolishing targets, where they took pressure off parts of the service; although respondents were worried about losing the benefits to patients that had resulted from a focus on issues such as reducing waiting times.

The introduction of GP commissioning aroused serious concern, because of the GPs' vested interests, the exclusion of other professionals who could have contributed usefully, and the complexity of the task which might create inequalities for the more excluded or complex patient groups.

The development of competition amongst providers – although understood in principle to be about making everyone strive to be the best - was widely condemned as likely to lead to cost-cutting, reductions in quality and greater inequities in service provision.

The HealthWatch proposal was generally considered a duplication of existing bodies' work, and likely only to hear from the 'usual suspects', leaving other groups marginalised and unheard.

The QNI is already receiving regular reports from community nurses about reductions in staff numbers, down-grading of posts, ending of innovative projects and a rush to retirement amongst colleagues who are eligible. Morale is undoubtedly very low, and practitioners are very concerned about their ability to sustain high quality services

and care.

We believe that the delivery of the vision in the White Paper, of a service that is equitable, of high quality, integrated, inclusive and patient-centred, is entirely dependent on the skills, knowledge and engagement of community nurses, midwives, health visitors and AHPs, in addition to GPs. There is no alternative workforce to deliver services, even under competition. So it is essential that the workforce issues are addressed early on – including the falling numbers of community specialists, highly diluted skill mix, rapidly-increasing use of health care assistants to do nursing tasks, and exclusion of all but GPs from input into planning, commissioning and designing services.

Community staff don't want to be 'liberated'; they just want to be included in the future of their services. They need to know that their skills, knowledge, experience and expertise are valued, if they are to be persuaded to stay and deliver the health services of the future.

More detailed commentary on the proposals of 'Liberating the NHS' is below.

### **Abolition of targets to free up NHS staff**

Summary: there was a mixed response to the abolition of targets. While some saw it as a reduction in paperwork and a chance to focus on individual patients, others feared a return to previous high waiting times and lower quality care.

Around one third of respondents (32%) reacted positively to the proposal to abolish targets. They felt that patients would have more choice and information to make decisions, and more freedom of choice. For practitioners:

'the abolition of through-put targets and the amount of time spent justifying over or under target activity would 'remove a potential stressor, and enable staff to concentrate on delivering quality care effectively and efficiently';

'such an approach would enable practitioners to respond to and also be proactive in assessing in meeting the needs of their local populations'.

There were also suggestions that this would reduce paperwork and give more time with patients/clients, allowing staff to concentrate on the issues that matter to their individual patients, and on providing fundamental care 'which appears to have been lost in the target agenda.'

'The pressure will have been taken off some departments such as A&E in particular.'

However, nearly half of respondents (48%) had concerns about abolishing targets. This was summarised by the person who wrote: 'It won't [free up NHS staff].

Abolishing targets is only the first step to recovery. In the last ten years, the basic philosophy of care has been systematically undermined, reinvented and devalued

in pursuit of targets. What needs to happen now is a refocus on the needs of the patient, not a politically charged response to a person in need of care.'

Other comments included:

'With targets at least everyone was having the same standard of care for their conditions regardless of where they were.'

'Some targets weren't met but at least ensured that money was ringfenced which did ensure care was focused for clients e.g. GUM 48 hour access, teenage pregnancy and 4 hour A&E waits.'

'Unless you can change the attitude of staff and make them care about the individuals they look after, I'm not sure it will make a difference. At least with targets there is something to aim at that will benefit the patient, based on facts and research, even if the practitioner didn't care for the person as an individual.'

'The corporate memory is short when considering how bad things were before targets. Without a management imperative through measured targets, we run the risk of slipping back to clinicians being blamed for poor patient management quality when a completely full hospital is the cause. I don't ever again want to suffer the demoralising experience, the utter frustration and helplessness of being in charge of an A&E department with 6 ambulances outside waiting to deliver patients and not be able to accept them because every patient trolley is occupied by ill patients waiting for beds in the hospital to become available.'

There was also considerable cynicism that simply removing current targets would make a difference at all:

'In reality targets will still exist as will be set locally.'

'These targets will be replaced under another name and not free up clinical time at all.'

## **Outcomes framework for increased transparency**

Summary: this received an even more equivocal response, reflecting the novelty and unknown nature of the proposed NHS outcomes framework.

Nearly half of those who responded (48%) felt that the proposals were vague, unfocused, or subjective, and therefore hard to judge. However, nearly one third of respondents (32%) saw positive elements to the proposals, commenting that the five outcome domains cover 'basic rights' and the 'unquestionable expectation of every patient.' There was particular approval for the focus on the patients' experience of care, and patient-reported outcome measures.

Concerns expressed included how data would be collected and presented to the public; what measures would be used for some of the indicators; and whether this is

a 'medical model' causing a focus on treatment to the detriment of preventive work. One person commented: 'This is just another form of auditing and box ticking ... yes, outcomes need to be measured, however I don't see why we need to improve transparency ... don't the countless audits and surveys already provide enough transparency as it is?'

## **GP consortia and the role of the NHS Commissioning Board**

Summary: respondents were almost unanimous that a wide range of professionals should be involved in new commissioning bodies, both because they know communities well, and hold a lot of pertinent information; and to bring objectivity to counter GPs' vested interests. They saw a number of reasons why practitioners might want to sit on consortia boards, including altruism, and the chance to change services for the better, get their voices heard, influence the agenda and make sure decisions are appropriate. The most challenging role of the commissioning board was seen as developing GP consortia and holding them to account.

All community specialisms were mentioned as potential members of commissioning boards. However, one respondent questioned 'whether GPs have the necessary skills to undertake this role', while suggesting that health visiting, midwifery, primary mental health services, parents, social workers and learning disability should be represented on commissioning boards, as they 'have an understanding and local knowledge of health care needs.' There was one comment about the title of the consortia: 'the very language used seems to exclude other health care professionals... GP consortia, why not Primary Care consortia?'

One respondent questioned whether clinicians should be involved in commissioning at all, saying: 'Should any health care professionals sit on them as commissioning is about what is wanted not what can be provided?'

The incentives for health professionals to sit on commissioning boards were largely altruistic, and included a strong desire to be able to influence decisions 'so that services are provided to meet people's health and social care needs ... additionally to ensure that social exclusion agenda is addressed'. Two respondents mentioned payment as 'the best incentive', with all board members paid the same amount. There was some doubt that the involvement of non-GPs could be achieved however:

'This sounds like PCGs again. Nurses and AHPs should be engaged with the process, but the culture is of being a passenger while the GPs drive change.'

'We are seeing Consortia 'Boards' appointing themselves ... and they consist of all GPs!'

'The argument (which has been made to me by GPs) that nurses will be involved "when we think it's necessary" is not really sufficient. Without 'nursing knowledge' and input GP commissioners will not know what they don't know. Nurses who have been involved in delivering clinical services will have a very good knowledge of what works effectively.'

Concerns about the objectivity of GPs as commissioners were summed up by the participant who wrote:

'The situation remains that GPs (and nurse partners!) are on the whole self-employed small businesses. If GP consortia are made up with a majority of GPs then we will have organisations with financial vested interests in the allocation of resources and the development of services. It is therefore crucial that the Government makes it mandatory for nurses (who are on the whole employed) to be on the boards of commissioning groups. It is crucial that there are other clinicians who do not have a financial vested interest able to challenge clinical decisions in a way that managers are unable to.'

52% of respondents saw 'developing GP consortia and holding them to account' as the most challenging role for the new NHS commissioning board. 18% thought patient and public involvement would be the most challenging, while 12% highlighted the difficulty of funding the proposals, 12% the role of national commissioning, and 6% the management of 500+ GP commissioning bodies.

Comments included:

'Too many important aims for one body to achieve.'

'What levers will the board have in relation to consortia? What if consortia fail?'  
'Think the brief is far too big and will not be equitable for all.'

'This requires a monumental change in the NHS and I feel there will not be the resources or the know how to complete these roles adequately.'

### **The impact of competition**

Summary: the great majority of responses on competition were negative or equivocal, with respondents finding it difficult to see how this would increase quality or give better value for money.

Amongst the 24% of comments that were positive about the continued development of competition amongst providers in health care, the strongest support came from a nurse who had been involved in the development of a mutual organisation that involved residents as members, and had achieved change 'where large hierarchical organisations were unable to bend to provide services in ways that made sense locally.' Others felt that quality could be enhanced by competition providing 'quality of care is measured by reasoned criteria in addition to financial criteria'; and that it would encourage all services to strive to provide high standard care, and highlight areas that are not delivering the same standard of care. One said: 'Hopefully it will have the effect of making each surgery strive to deliver the best care for their clients and make others want to achieve the same levels enabling each surgery to retain their clients.'

The 76% of responders who objected to competition felt that it would lead to cost-cutting, diluting skill mix, and less access to care for the most vulnerable. There were suggestions that 'the cheapest will always be chosen', 'inappropriate promises will be made that cannot be delivered', and that quality could be reduced 'depending whether the service providers are driven by care or profit'. One said: 'I have seen how the private sector works and I would not say that their care is any better than the NHS!' There were also concerns that providers would waste money on marketing and responding to tenders, taking funds away from front line services.

One summarised the issue by pointing out that 'competition in the NHS is manufactured not real and as such unlikely to help.'

With regard to how competition might affect the continuity of care that service users receive, one summed it up as 'devastating to nurses, business as usual to GPs'. Others commented that people want the services they have to be good, not to have to make choices about what will be best. There was concern that competition could lead to fragmentation of services, and make some conditions more 'lucrative' than others, so that some services suffer. The issues of contract length, change of providers and hand-over between providers were highlighted as important to preserve continuity.

## **HealthWatch**

Summary: there was a lukewarm response to this, with the majority of respondents pointing out that many existing bodies have the role of involving patients; and that they often fail to hear from the most vulnerable people, and are filled with the 'usual suspects'. They do not see that HealthWatch will be any different.

Comments included:

'These bodies tend to attract people with one issue to promote and don't see or want to see the bigger picture.'

'Every effort should be made to reach those patients who are unable to join these groups. Their input, in my experience, is often the most pertinent.'

'Why not realign existing services rather than create a new organisation?'

'I am always worried about this as it is patients collectively that matter more than individually in terms of making decisions about health spending but they may be subjected to the wants of those who speak loudest.'

## **Health and social care joint working/shared budgets**

Summary: the great majority of people were supportive of this idea, though many wondered how it could be made to work; and several pointed out that this replicates the situation of 30 years ago.

Overall, 87% were supportive of joint working, with only a few negative or concerned comments. These were about the culture change necessary to make joint working happen; the paperwork it might generate; and the 'battle lines' that are currently drawn up, and the time and money expended, to agree joint working initiatives at present.

In support, respondents anticipated that it would smooth the patient's journey, with community matrons cited as an example of how boundaries can be crossed; and that it would allow patients more personalised care. One called it 'the most positive recommendation' of the White Paper.

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