Royal College of Nursing

RCN Policy Unit

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NHS reforms - Que Sera?

Whatever will be, will be?

An RCN Policy Unit Discussion Paper

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On September 19th 2006, at a workshop organised by the policy think-tank Institute for Public Policy Research (IPPR), Secretary of State for Health Patricia Hewitt was asked "What will the NHS look like in 10 years time?" She said that she could not determine how the service would look because it would be shaped by 3 factors;

1. The choices of patients
2. The decisions of commissioners
3. The innovations of practitioners

The Secretary of State emphasised that the government remain committed to NHS Principles[1] and that by applying those principles, SHAs will assure the integrity and patient-centred nature of future NHS services.

However what was less clear was the role of Government in managing the market in healthcare to guarantee that NHS principles are protected. For example, how do we ensure healthcare organisations work together collaboratively to improve the health of the local population when at the same time being in competition for patients, or that the closure of services does not disproportionately restrict access to health services by elderly or lower income patients?

This discussion document is part of the RCNs ongoing work to explore what the end game of NHS reform might look like in order to inform our current work on policy development, implementation and influencing. This paper specifically examines more closely the 3 factors that the Secretary of State said will dictate the nature and structures of our future NHS.

The Choices of Patients

Whilst the concept of choice has been central to the government's programme of reform for the NHS, the implementation of choice has so far been limited to "Choose and Book" which is built upon a form of macro-level commissioning of services by PCTs to promote and develop local healthcare markets.

[1] Department of Health, *NHS Plan*, London (2000)

As a system of choice, "Choose and Book" is focussed upon acute sector services and requires patients to make choices between NHS Trusts, NHS Foundation Trusts and Independent Sector Treatment Centres as the venue for their elective surgery. More recently the Dept of Health has consulted widely on extending choice, particularly into areas such as maternity care, community care and mental health[2].

Looking to the future, if that same system of choice is adopted in community-based services, then the Department of Health's policy of increasing the "plurality" of providers could mean that patients would be choosing between providers from a range of sectors. The sectors involved would probably be;

- **mainstream NHS**; in the form of clinical services from a PCT,
- **NHS Community Foundation Trusts**; still at the planning stage but an increasingly viable alternative to existing provider organisations,
- **Private sector**; in the form of clinic based or primary care-based services and an aspect of business which some companies, e.g. United Health Europe,
- **3rd sector organisations**; either a charitable or social enterprise organisation, both of which are being promoted by government policy as viable alternatives to state sector provision of public services.

In her speech at the IPPR workshop, Patricia Hewitt went on to say that it was not sufficient in a patient-led NHS to only have choice in terms of service providers. Patients, she said, should have an increasing opportunity to choose between clinicians and practitioners. Increased individual choice of practitioners by patients will lead to commissioning at a micro level.

It would appear, within a market driven model that this can only be achieved by firstly encouraging the development of credible, qualified and indemnified practitioners from a variety of fields. The concept would clearly present increased opportunity to nurses and an increasing threat to traditional practitioners where they have a monopoly on practice; usually doctors.

Secondly, in order to express their preferences through choice, patients would need to hold the purse strings and be able to 'buy in' the services that they require. In social care this achieved through the payment of benefits as "Direct Payments" which enables people to buy their own

[2] Department of Health, *Update and Commissioning Framework: Extending Choice*, London (2006)

services and packages of care. They are generally helped in this process by the services of a service broker or "Care Manager" who assists with the commissioning of individual packages of care. The equivalent in healthcare services would be a form of "Individual Health Budget" which was based upon the cost of care for an individual, usually someone with a long term condition. That person would then be able to purchase their own package of care, thereby commissioning services for themselves or with the assistance of a care manager. Community Matrons already offer care management services as do some nurses in mental health and learning disability services.

This raises some key questions about the nature of the NHS in the coming years

- **Can the current patient choice policy enable sustainable growth in the health economy of local communities if the preferences of the individual appear to take priority over the needs of the community?**

- **If services are to shift from the acute to community-based provision, what should be the investment priorities for workforce development?**

- **What new forms of accountability should accompany patients and the public if they are to be co-producers of their own health through initiatives such as choice?**

The Decisions of Commissioners

In August 2006 the Department of Health issued new guidance on a "Commissioning Framework"[3], following in the wake of the establishment on new-look SHAs and merged PCTs.

The clear message from that guidance and the policy development that followed the publication of "Creating a Patient-Led NHS"[4] in March 2005 is that PCTs will have a decreasing role in the provision of services and an increasing role in the commissioning of services.

The Government have made no secret of the fact that they consider commissioning to be the least efficient part of NHS service management and the reform of SHAs and PCTs is principally focussed upon remedying that deficiency. The introduction and development of Practice-Based Commissioning has also increased the scope of and range of "commissioners" in the NHS and nurses, GPs and other healthcare professionals are now central to the creation of a market economy in the

[3] Department of Health, *Commissioning Framework*, London (2006)
[4] Department of Health, *Creating a Patient-Led NHS*, London (2005)

NHS through their commissioning decisions on behalf of individuals and groups of patients.

But to what degree will the decisions of commissioners shape future services? If the service is to be truly patient-centred then commissioners at GP and PCT level would surely be doing nothing more than reflecting the wishes and choices of their patients, much as Patricia Hewitt described. However, with practitioners increasingly adopting brokerage and case management roles and making decisions in the best interests of patients when directing them towards service options, especially at primary care level; and especially in the role as GPs.

What the White Paper, (Our Health, Our Care, Our Say) sought to emphasise is that the decisions of practitioners have got to be based upon inclusive and equitable relationships with patients and must reflect the views and preferences of their patients. The same must therefore be true for the decisions being made by commissioners at the collective, or macro level in PCTs.

Are these, then, the only factors that will shape the decisions of commissioners? How can it be so in a tax-funded, free at the point of delivery service in which there are finite resources? There has to be some control over the number and cost of services on offer, just as there has to be some control over the demands made upon the service.

Waiting lists have been one of the main activity control factors in the NHS historically but increasingly the recommendations of bodies such as NICE have also acted as control mechanism on the range of services available to patients through our tax-funded NHS system.

However, with the advent of deficits and financial recovery plans there has been an increasing emphasis in the reorganised PCTs and SHAs to develop more robust methods of a system known as “demand management”. This has been accompanied by an increasing tendency for government health policy to emphasise the “responsibilities” as well as the “rights” of patients and to try to ensure that every patient makes a personal contribution to achieving a more cost effective and efficient use of resources.

Demand management requires commissioners, healthcare providers and clinicians exercising greater control over the flow of patients into high cost treatments and interventions and trying to develop alternative, less costly procedures. What we have so far witnessed, therefore, from PCTs has been a demand management system which builds in “thresholds” of entitlement, many based around the health behaviours of individual patients. Excess Body Mass Index; Smoking; failure to comply with treatment regimes, all have been introduced in some services as thresholds of entitlement to services, as well as specific clinical indicators

such as the degree of sight loss one must endure before being entitled to a cataract operation. If the patient exceeds those thresholds they will not get a service. We have also seen the introduction of “referral panels” whereby GPs and other healthcare professionals must not send patients directly to consultants for treatment but must send them to a form of clearing house where the referral for treatment is reviewed so that alternative means of treatment can be considered for patients many of whom are being referred for surgery as a first course of intervention. This system has proved to be unpopular with clinicians who are concerned that their clinical judgements are being called into question by managers whose primary concerns are about the cost of interventions, not the efficacy of treatment and the benefit to the patient.

This raises another set of issues for nurses and the public they serve

- **How can the tension between the decisions of commissioners and the choices of patients be reconciled in a resource limited NHS?**

- **To what degree should affordability and personal behaviours dictate the range and complexity of services available to patients on the NHS?**

- **What role can nursing play in an era of personalised care, individual choices and systems of demand management which are located outside of the patient practitioner relationship?**

The Innovations of Practitioners

Let us be clear here – we are not talking here about the decisions of managers; or the reports of accountants; nor the processes of administrators. The Secretary of State focussed down on clinical practice and the innovations of practitioners as the third crucial element in determining how health services will develop over the next ten years.

By virtue of this statement nurses should feel reassured that practitioners will be at the forefront of patient-led practice in an increasingly community-based service. We should be challenged yet comforted by the prospect of specialist nurses leading the way in developing new methods of research-based practice and treatment in partnership with their professional colleagues and the patients that they serve.

More enterprising nursing practice and nurse-led entrepreneurial services is a model of delivery that should be consistent with moving to increasing community-based provision. But in this light-touch regulation, market-driven economy of care with business-orientated management systems,

many nurses would relish the challenge but some might be daunted by the change in culture and practice this would entail.

Nurses are concerned that in reality the development of a market driven economy of care is *not* strategically driven and that the playing field of partnership working and entrepreneurial practice is far from level. As the NHS struggles to come to terms with recovery from financial deficits, nurses describe a service where short term financial decisions take precedence over sustainable planning which will have long term consequences for services and for patients. Indeed nurses express concern that the consequences of this new market driven NHS will be fewer, not more, opportunities for nurses to innovate in the interest of better services for their patients.

Two particular requirements would need to be met in order to promote innovation in nursing as part of a market-led, patient-focussed economy of care. These requirements are:

- Continued investment in and development of high quality nursing practice by clinically based nursing leaders; and

- Opportunity to further develop evidence-based practice skills whilst also providing time and support to acquire the business acumen that goes with becoming increasing entrepreneurial and enterprising.

The response of NHS organisations to financial deficits and the urgency of financial recovery (i.e. cutting training budgets and removing staff capacity and cover for study leave) suggests that staff development, education and training has slipped on the list of organisational priorities. The result is that professional development may be seen as a luxury, rather than an essential investment, in a system with an overall financial deficit.

"Turnaround Teams" have produced financial recovery plans that consistently seek to drive down nursing labour costs by making redundant the posts of nurses at the higher bands, 7 and 8, of Agenda for Change. At a stroke, they can wipe out a generation of Nurse Specialists in NHS Trusts where there are few if any alternatives to medical practitioners fulfilling those same roles. As a result services are being lost and nurses are losing the very role models and practice leadership that they need to promote clinical innovation and instead, downgrading produces a cohort of nurses who lack the clinical status to be able to challenge and develop services for the benefit of patients care. The emerging picture appears to be inconsistent with the policy of promoting practitioner innovation.

Funding for nurses and other health practitioners to pursue academic studies is crucial to the development of innovative practice and to creating

a culture of practitioner innovation within the NHS. That funding is paid to SHAs, NHS Trusts and PCTs in the form of two funds MPET and SiFT.

From MPET and SiFT these organisations identify monies for investment in courses and training for practitioners, usually in Universities and Institutes of Higher Education. At the same time, contracts are established between NHS organisations and the universities for the pre-registration education of nurses who will be the future backbone of the NHS workforce.

As a result of their requirement to meet the financial targets set by turnaround teams and "fitness for purpose" reviews, NHS Trusts and PCTs have drastically reduced their investment in the very courses that would drive forward innovation in practice. A recent report by the Deans of Faculty[5] stated that, at post-registration level community nursing courses have been most dramatically affected with up to 30% of places reduced and entire contracts cancelled at a time when the future direction of health policy seems to indicate the need for the complete opposite. At pre-registration level, 10-15% of pre-registration courses have been cancelled raising fears of a workforce supply and skills-mix crisis by 2011 which would make all concerns about innovative practice irrelevant.

So, we need to answer the following questions to provide for a future nursing workforce fit to survive and thrive in a competitive market driven NHS;

- **What provisions need to be in place to promote practice innovation by nurses and other health care practitioners?**

- **If such systems presently exist, are we learning from best practice and sharing learning to ensure an even and planned development of the nursing workforce in this respect?**

- **Do existing systems of workforce planning and contracting for practitioner education ensure that the expressed choices of patients and the decisions of commissioners are captured and prioritised - if not, how can this be achieved?**

[5] Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, *Crisis in nursing, midwifery and allied health professions education in England*, London (2006)

Summary

The overall effect of the three determinants of how future services will develop, patient choice; commissioner decisions; and practitioner innovations, equate to the three drivers in an NHS of increasingly complex market forces. If it is truly the case that market forces will determine how, where, when and why services are provided, the question of who is held to account for the NHS and how this can be achieved?

This in turn leaves three further questions to consider;

- **If the these three factors alone will determine the future shape of NHS services, which, if any would be the predominant factor in deciding how the service will look in 10 years time, and why?**

- **If market forces make it so difficult to determine how the NHS will look in 10 years time, is there a more relevant way of managing the NHS than the current system with a Government Minister at the helm?**

- **… and finally, what is the most appropriate position for the RCN to adopt in response to this situation?**

The Policy Unit would welcome your thoughts on any of the questions that have been raised or observations more generally on the direction of health policy reform and what you see as the critical issues for nurses and the patients you care for. We aim to produce a further paper latter in the year based on the responses we receive. Your comments should be e mailed to colin.beacock@rcn.org.uk.