

RCN Policy Unit

Policy Briefing 16/2007

Our NHS, Our Future – A World Class NHS

December 2007

Introduction

'Our NHS, our future' is the name given to a wide-ranging review to develop what is in effect the next NHS Plan for the next 10 years of the NHS. Whilst there is still an obvious public and patient focus to the consultation there is also a welcome effort to address the views and perspectives of the NHS workforce on what needs to change and what needs to remain.

In particular the terms of reference¹ for the review are

- Ensure that clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery
- Improve patient care, and ensure patients are treated with dignity in safe, clean environments
- Deliver more accessible and more convenient care integrated across primary and secondary providers, reflecting best value for money
- For the 60th anniversary of the NHS, establish a vision for the next decade of the health service with an emphasis on patient control, choice and local accountability. Part of this will also involve looking at whether or not the NHS needs a constitution or written framework of some kind to enshrine NHS 'values'.

How is it being run?

Nationally, there have been a series of stakeholder events dealing with bigger national issues such as quality, leadership and so on. The local element is designed to be more clinically led and is being run primarily by SHA leads. It will develop the consultation process through the following 8 clinical pathways

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|--------------------|-------------------------|
| 1. Birth | 5. Children |
| 2. Staying healthy | 6. Long term conditions |
| 3. Acute episodes | 7. Planned care |
| 4. Mental health | 8. End of life care |

¹ Adapted from DH terms of ref. www.ournhs.nhs.uk

Local groups consisting of a range of practitioners, patients and members of the public will be set up in SHA area to look at each pathway. The role is to identify best practice in each area and 'champion' care pathway models.

During September, 9 national discussion forums involving patients, members of the public and staff focused on the priorities for the review. The interim report in October captures progress to date and makes observations on issues that have arisen.

The pathway groups will continue work at SHA level through October and November and in December there will be further stakeholder discussion groups which will feed into draft vision statements to be published in January 2008 for consultation. These vision statements should capture the SHA's view for local service delivery for the coming years. Where necessary, there will need to be a further period of consultation from January 2008 onwards where there are any reconfigurations. All SHA level final vision statements and the final *national* report will be published in June 2008.

The interim report which was launched in October 2007, highlights four themes or concepts which characterise the vision for NHS care - respondents have told the review that NHS care should be

- **Fair** - specifically that care is equally available to all, taking full account of personal circumstances and diversity
- **personalised** to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- **effective** - in that it is focused on delivering quality outcomes for patients that are among the best in the world
- as **safe** as it possibly can be, giving patients and the public the confidence they need in the care they receive

The four above headings will be used to review the content and key issues within the interim report which can be found on the 'Our NHS, our future' website². Each section will also contain a number of questions for you to consider which you may wish to use as framework for your own contributions.

² www.ournhs.nhs.uk

Executive Summary

In summary the RCN considers the following to be key issues arising from the interim report.

- In developing a fair NHS, clarifying what is meant by fair (for e.g. to whom will it be fair and when) will be vitally important
- We welcome the commitment to expand primary care services, but it is disappointing to see a recommendation for these health centres to be GP led. There are a number of primary care practitioners who are just as able to lead these centres – it is about having the right practitioner with the right skills
- The RCN has undertaken much work around dignity in care. We believe that health care professionals come to work with the belief and desire that they will provide dignified and respectful care to their patients and clients. Our recent work has identified the following key areas as influential in the delivery of dignity at work.
 - Appropriate Staffing Levels
 - Leadership, Teamwork and Communication
 - The Physical Environment of Care
- Workforce planning is a key concern for the RCN, particularly given the recent crisis in newly qualified nurses finding posts. What workforce planning challenges (and opportunities) are emerging from the review and how will these be tackled? Particularly around creating a workforce fit for the future – how will MNC be reflected in this review?
- In terms of tackling HCAs in a sustainable and effective way, better staff training; more routine but effective cleaning of equipment and clinical areas; and reductions in the level of overall patient movements are efficacious in reducing HCAs. We would urge the review to consider how professional skill and expertise can be brought to bear on understanding safety issues, particularly around HCAs. As has been shown time and time again, key professionals need to be facilitated to raise concerns and suggest adjustments at the sharp end of care.
- We welcome the reference in the report that guidance from the DH will be issued to ensure resources are made available to open new facilities alongside old ones closing. We look forward to receiving more details about this.

A fair NHS

There is no doubt that health inequality remains a significant challenge for the Govt and for the NHS. This section of the interim report highlights widely available statistics on differences between life expectancy rates in different parts of the country.

Clarifying what is meant by fair (for e.g. to whom will it be fair and when) will be vitally important. As with words like 'choice' and 'free', these words can conjure up images of an endless flow of services and resources which are simply not achievable within a cash-limited NHS.

We hope that the consultation events in this review and the final report in June 2008 will be explicit in what is being offered and what is not being offered to a public who continue to expect continuing improvement from the NHS. Set against a particularly challenging CSR allocation, this will be a significant challenge for NHS staff.

In terms of fair access to services, it is clear that under provision of GP services is an issue however it is not clear from the evidence that there is a direct link between health inequality and GP provision alone. Reducing health inequalities and expanding access is a significant challenge for health *and* social care services and the report rightly highlights the necessity of a range of agencies working together to tackle inequalities in health.

Incentivising health services to enter a particular part of the community is as much about encouraging sharing of budgets (a facility already possible under the Health Act), encouraging innovation in practice, and investing in new models of service as it is about relying on the private and independent sector to enter the market.

Issues for care pathway groups to consider:

1. What is the evidence base for the most effective solutions to tackling health inequalities?
2. Are there other models of collaboration or interagency partnership that they can learn from in the area or nearby?
3. Has the care pathway groups made direct contact with other agencies as part of this process? It would seem to make sense to be discussing the issues with social care, charities, and voluntary groups as well as with the private and independent sectors.
4. To what extent have they attempted to directly address the people in these hard to reach groups before beginning to plan a response

to their needs? Are they all agreed on what the needs are before planning solutions?

A Personalised NHS

The interim report again highlights the need to improve access to services and the fact that many people who took part in the consultation exercises want to be able to make routine contact with their GP at the week end or in the evening.

The report suggests investing resources to enable PCTs to develop 150 GP lead health centres in easily accessible locations offering a range of services to all member of the local population (whether or not they chose to be registered with the centres).

Whilst we welcome the commitment to expand primary care services, it is disappointing to see a recommendation for these health centres to be GP led. There are a number of primary care practitioners who are just as able to lead these centres and we will be looking to the DH to ensure that it is the right practitioner with the right skills who are commissioned to lead these new services.

The commitment to extend practice opening hours will be welcomed by many members of the public but there are a range of practical questions around practice staff employment, some of which were changed when out of hours services were contracted out a few years ago.

The RCN considers that any proposals to change practice opening hours should be developed in partnership with staff to ensure new ways of working are adopted, work for patients and staff and represent value for money. The staff delivering services are not only best placed to know what will work, if they are included in decision making, change is easier to implement.

Dignity and focus on the patient as a person

The interim report highlights the need to improve the dignity and respect with which patients are treated. The report identifies the following areas which patients have recognised as areas of concern:

- Feeling neglected or ignored while receiving care
- Being treated more as an object than a person
- Feeling their privacy was not respected during intimate care
- Needing to eat with fingers rather than being helped with a knife and a fork

- Generally being rushed and not being listened to
- Beds not being cleaned
- Not being helped to wash
- Mixed sex wards

The RCN considers that it is essential to address these and ensure that all patients have a dignified experience of care. Whilst the RCN believe that all members of the nursing family have a key role to play we also recognise that Chief Executives, Executive Directors, and other members of the multi-disciplinary team, including facilities staff, administrative staff and allied health professionals, have an essential role to play in the provision of dignified care. It is only through a multi-disciplinary approach that this will be achieved

The RCN has undertaken much work in this fundamental area of care. We believe that health care professionals come to work with the belief and desire that they will provide dignified and respectful care to their patients and clients. Our recent work has identified the following key areas which influence if dignified care can be provided.

- Appropriate Staffing Levels
- Leadership, Teamwork and Communication
- The Physical Environment of Care

The RCN already has a wealth of information, guidance and best practice on this topic at www.rcn.org.uk. During the next year we will be developing further learning and development resources to support all members of the nursing team to deliver dignified care. We would encourage you to make best use of this information and send relevant parts to members of the care pathway teams or to the review team via the Our NHS website.

Issues for care pathway groups to consider

1. What workforce challenges and opportunities exist around extending practice opening hours?
2. To what extent is choice of GP available for those in rural areas or whose mobility is severely restricted?
3. How will nursing staffs' views about the best practice be taken into account? How can GPs be encouraged to ensure their views are included in developing new ways of working?

4. How can other health care practitioners be prepared, supported and encouraged to lead services in areas with the greatest need?
5. What lessons can be learn from PMS schemes and other joint ventures which may provide alternative solutions for the local health economy?
6. How will the work of the Primary Care Review team be reflected locally? Will the SHA and PCTs be contributing directly and how will front line staff be able to share their views on the issues at hand?

An Effective NHS

The report rightly highlights the progress made in addressing major conditions like cancer and coronary disease. The investment provided to the NHS coupled with new national service frameworks has provided a welcome strategic focus for providers of these services.

It is clear that more needs to be done to improve overall effectiveness of the NHS (such as survival rates and treatment rates) but the report doesn't discuss what participants in the review felt the blockages to further progress were.

The report highlights reluctance within the NHS to adopt new products and procedures calling for better demonstration of benefits including improved safety, effectiveness, personalisation, fairness and value. In addition to improved demonstration of benefit, a focus on the human or process elements of change and innovation may also be necessary. Innovation as well as requiring people to start doing things, frequently requires people to stop doing things this is often one of the greatest challenges.

This section of the report also emphasises the centrality of preventative care and the link between prevention and long term conditions. Whilst this focus has been on the agenda for some years, to really make it happen requires a change in relationship between professional care and service providers and those using the services. Many health and social care professionals and organisations are in early stages of making this shift.

There is a proposal to establish a new Health Innovation Council (HIC) to overcome some of the challenges to innovation. It is suggested that NICE, The National Institute for Health Research and the NHS Institute for Innovation and Improvement are all members of the HIC. It is questionable that the establishment of another national body will enhance the work of these existing entities and overcome the challenges to innovation. Improved ways of sharing, communicating, complementing and integrating work between the existing national organisations and local health and

social care organisations may be have more benefit that creating another central body.

Again the RCN has a wealth of information, guidance and support around implementing evidence based practice, creating cultures that support innovation and working with change. These can be found through our website in the Professional Development section at www.rcn.org.uk. We would encourage you to make best use of this information and send relevant parts to members of the care pathway teams or to the review team via the Our NHS website.

Issues for care pathway groups to consider

1. Workforce planning is a key concern for the RCN, particularly given the recent crisis in newly qualified nurses finding posts. What workforce planning challenges (and opportunities) are emerging from the review and how will these be tackled?
2. What steps have been taken to model the workforce requirements for the emerging new model NHS? For example, how many advanced practitioners, support workers, therapists?
3. What training and development provision will there be for nurses and other healthcare workers to emerge from the next steps of the review. In particular, what plans will be made to review the new roles and ways of working that will emerge?
4. What training and development provision will there be for nurses and other healthcare workers in relation to implementing evidence based practice, service improvement methodologies, working with change.

A safe NHS

The review rightly focuses on the need to make urgent progress in improving patient safety in the NHS. Various studies have investigated the extent of adverse events which shows that this is a problem for health services around the world.

In Europe, the Hospitals for Europe's Working Party on Quality Care in Hospitals estimated in 2000 that every tenth patient in hospitals in Europe suffers from preventable harm and adverse effects related to his or her care.³ In the UK, the Department of Health estimated in 2000⁴ that adverse events occur in around 10% of hospital admissions, or about 850,000 adverse events a year.

³ WHO - Quality of Care: patient safety (2002)

⁴ DH (2000) An organisation with a memory.

It is important that the review team take careful note of current conceptual thinking on the safety of patients which places the prime responsibility for adverse events on deficiencies in system design, organisation and operation rather than on individual providers or individual products.

For those who work on systems, adverse events are primarily shaped and provoked by “upstream” systemic factors, which include the particular organisation’s strategy; its culture; its approach towards quality management and risk prevention; and its capacity for learning from failures. Counter measures based on changes in the system therefore tend to be more productive than those that target individual practices or products.

This is particularly true when considering the issue of HCAI in the NHS. There is a body of evidence which points not only to the impact of practitioner behaviours such as hand washing, hygiene and so on but which also highlights the effects of excessive patient movement, constantly high activity levels and the impact of a poorly designed clinical environment.

The National Audit Office noted the effect of increasing movement of patients on an increase incidence of HCAI⁵. There is also ample evidence which points to the effect of rising pressures on staff activity (intensification) and reduces the thoroughness of decontamination procedures⁶.

We would urge the review to consider how professional skill and expertise can be brought to bear on understanding safety issues. As has been shown time and time again, key professionals need to be facilitated to raise concerns and suggest adjustments at the sharp end of care.

The RCN has a wealth of information on standards of hygiene and infection control which you may want to download and use as a reference source.

Issues for the care pathway group to consider

1. In terms of tackling HCAs in a sustainable and effective way, it would seem that the evidence support better staff training; more routine but effective cleaning of equipment and clinical areas; and reductions in the level of overall patient movements as more efficacious in reducing HCAs. What practical steps will the SHA leads take to address capacity and throughput issues?

⁵ NAO (2004) Improving Patient Care by Reducing the Risk of HCAI: a progress report. NAO London

⁶ Gould D J (2005) ‘Infection Control: the environment and service organisation’ Nursing Std Oct 12 20:5. p57-64

2. How would providers in the new multi provider environment promote responsiveness in the *whole* system where competitive tensions may make adjustments to activity difficult?

A locally accountable NHS

The RCN remains committed to an NHS which is tax funded, universally provided, free at the point of need. Part of the attraction of a tax funded system is the additional accountability it lends to the overall management of the NHS and its resources.

The interim report offers some useful additional measures of accountability in respect of reconfigurations of NHS service and the extent to which the public can expect to be consulted.

We wholly support a more evidence based approach to reconfiguration and an assurance that decision making processes will be subject to greater public and clinical scrutiny. However, it is not just the decision making process that needs to be opened up.

The RCN have expressed concern in the past that some of the consultations have been presented to the public in an almost finished state, seeking only the public's approval rather than exploring what the public might actually want from their local services. We would advocate greater public and clinical involvement in identifying the problems and creating solutions – not just what feels like a distant scrutiny of a process owned by others.

True consultation offers the chance of varying or changing the proposals – but effective consultation begins with the question in hand rather than one particular perspective on what the answer might be. In this respect, all the members of the healthcare team have a valuable role in exploring different solutions to the problems and helping the public to make informed choices over future service configurations.

We also welcome the brief mention in the report that guidance from the DH will be issued that resources are made available to open new facilities alongside old ones closing.

Issues for the care pathway group to consider

1. We welcome the stated intention to overhaul the approach to workforce planning and the commissioning of education and training needs of NHS staff. How will that become a reality locally? What investment will be made in ICT to facilitate more effective planning?

2. Future health care will be defined more by care pathways across different settings and so any future education programs must develop with those different settings in mind and equip nurses to operate effectively and efficiently⁷. How far have education commissioners and providers been involved in this review?
3. Our greatest concern is that Modernising Nursing Careers is completely missing from the body of the report. MNC represents a fundamental opportunity to reshape the future of the nursing profession and create a system of education and development which develops staff to meet the needs of the patients and the public. What steps will be taken by the review process of the provisions of MNC as the consultation is launched later this year?

What is the RCN doing?

The RCN has responded nationally through attendance at discussion groups and through meetings with national leads including Lord Darzi.

At SHA level key RCN staff and board members have linked with SHA leads and have lobbied intensively for widespread engagement of key staff on each of the clinical pathway groups. In some cases, a number of the clinical pathway groups have significant RCN representation.

Following the release of the interim report in October, the RCN Health and Social Care Policy group will collate feedback from the groups and share next insights with members and staff.

How can you contribute?

Each SHA is required to set up the 8 care pathway groups as detailed above. The groups are tasked with identifying best practice so it is important that they are getting a full picture of the range of health services being provided in your area.

Here are a few ways you can contribute:

- Make contact directly with the care pathway group if you feel you are involved in a particularly innovative service in that area. Don't assume that they know everything about the local health economy – you might just be part of a service which is directly addressing some of the issues raised in the report.

⁷ See

http://www2.rcn.org.uk/resources/policy_unit/projects/future_nurse_future_workforce_project for a more detailed treatment of the RCN view on MNC

- Your RCN Regional office will be involved in this process of be connected to various people involved. If you have concerns or questions you can contact them for advice and support on 08457 772 6100
- Go to the 'Our NHS' website (www.ournhs.nhs.uk) and add your own comments via the web questionnaire and feedback forms.
- Let us know what the experience is like of engaging with the review of what you think the big issues are. E-mail us at policycontacts@rcn.org.uk to let us know