Liberating the NHS: what the white paper means to community nurses

Proposals to integrate community services with acute and mental health trusts can be beneficial if nurses take advantage of the potential opportunities

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Liberating the NHS (Department of Health, 2010a), published in July, continues the previous administration’s policy of moving community services away from the commissioning organisations in England. It also confirms the intention to create a diverse market of different providers, creating “the largest social enterprise sector in the world”.

The white paper removes the possibility of community services remaining with primary care trusts since they are to be abolished, so it is likely that even more community services than originally planned will merge with local hospital trusts or mental health trusts.

This article looks at the potential impact of these moves. It also considers how nurses who are moving and those who will have new community colleagues can ensure the best outcomes for patients from the changes.

The Department of Health’s Transforming Community Services programme was set up to deliver the NHS next stage review final report (Department of Health, 2008).

The TCS makes the case for radically changing the way in which services outside hospitals are organised and delivered, to meet the growing need for community based care.

It aims to make care everywhere as good as the best. Its transformational guides bring together the research evidence for good practice that will improve care in six areas:

- Health, wellbeing and inequalities;
- Children, young people and families;
- Acute care closer to home;
- Care of long term conditions;
- Rehabilitation and neurological services;
- End of life care.

The Queen’s Nursing Institute has produced matrices so community teams can check themselves against these guides, and identify areas that are priorities for change to improve services (QNI, 2010). The result should be better services, based on evidence, that achieve better outcomes for patients.

TCS also addresses the organisation of community services, with guidance on the options for provider services to be based in and commissioned from a wider range of organisations (Department of Health 2010b). These include social enterprises, independent companies, community NHS foundation trusts or other existing NHS organisations.

This is not a new idea: in 2005, the then chief executive of the NHS, Sir Nigel Crisp, wrote to all PCTs to tell them that they should focus on their role as commissioners of services, and divest themselves of their provider functions, that is, employing and deploying community nurses, health visitors and therapists (Department of Health, 2005). Nurses and other professionals who work in community services have therefore had five years of uncertainty about their future. This insecurity is now coming to an end with the proposed moves into other NHS or non NHS organisations.

The decision about who should provide community services, if not PCTs, is not driven solely by policy. Factors such as the economic squeeze and the need to find solutions in a reasonable timescale make mergers with existing NHS organisations more attractive than creating new bodies. Local plans suggest that there will be a small number of new foundation trusts, and some social enterprises or integrated community organisations.

MOVING COMMUNITY SERVICES

After nearly two decades away from acute sector and mental health organisations, during which community services have changed and developed, many nurses have reservations about reintegrating with them.

There are risks and benefits to merging community services into hospital or mental health trusts. In anticipation of these moves, the QNI asked members of the All Wales district nurse forum for their views on the issue, as community services in Wales had remained part of integrated hospital trusts. The forum members identified the following benefits to integrated services:

- It is an opportunity for community nurses to demonstrate high quality care in the key areas of their expertise;
- It improves working relationships between acute and primary care;
- Joint priorities can be set and shared;
- The transfer of care from acute to primary care can be smoother;
- It provides an opportunity to raise awareness of district nursing and what it can do for patients;
- All staff work to the same policies and procedures;
- Training is integrated and shared;
- The costs of specific treatments should not be an issue of dispute between hospital and community services.

Forum members felt that integration could lead to improved and coordinated patient pathways. For example, “a rapid discharge pathway for patients at the end of life, which has been developed with inpatient and community services, has greatly enhanced patient choice in last days of life”.

One note of caution was offered:
“Improvements happen] sometimes, not always. Hospitals don’t always see further than their own role… when planning a change in service, they often don’t consider the impact on other services.” This comment reflects the risks that the forum anticipated from integrated services, which were that:

- The priorities for an acute organisation might have a greater focus on acute areas and not across the whole of the patient pathway. The targets set by government will dictate the organisation’s priorities;
- The quality of community nursing could be difficult to maintain. A hospital based body may not support the staffing required to source community teams appropriately because of financial constraints;
- Resources are drawn into the acute area to meet targets; since none are set for community services, these services are often seen as an easy way to save on costs.

**MAKING THE BEST OF THE MOVE**

Nurses and their colleagues are not passive onlookers to these changes. There are many things they can do to mitigate risks and help protect the quality and integrity of their services as they settle in to new organisations.

The Welsh forum suggested using the move as an opportunity to raise awareness among the public, new colleagues and trust executives of the range, complexity and importance of modern community services.

Community nurses could invite acute colleagues and executives to visit their services in action, to see how community services prevent admissions, speed up discharges and contribute to care pathways. They could use audit to demonstrate the effectiveness of services, publicise innovative projects and celebrate achievements. Most importantly, nurses should try to “break down the artificial barriers between community and secondary care: ‘them and us’ will not promote motivation and commitment”.

**ISSUES FOR HOSPITAL NURSES**

Many hospital nurses’ experiences of community nursing will be confined to a brief placement during their preregistration education, and their own encounters with their practice nurse or health visitor. They may not know that community services have expanded significantly in the years since they split from hospitals (in England) and that, consequently, a much greater variety and complexity of nursing work is taking place outside hospitals (Box 1).

Hospital staff need to be familiar with local community nursing services so they can integrate them with acute care, to ensure a smooth transition for patients. For example, a nurse in an acute unit might need to ask:

- Who will be there to answer my patient’s questions after discharge?
- Are rehabilitation or support services available in the home?
- Who is going to check on the patient’s condition over the next 10 days?
- Is specialist advice available to this family?
- Who can they contact if they have an urgent query at night?

The answers to these questions will help hospital teams to develop a map of local services, including those of community nurses, wherever they are based.

**THE FUTURE OF HEALTHCARE**

Numerous factors are already affecting demand for and supply of healthcare outside hospitals in the UK that are entirely separate from government policy or ideology. These include demographic issues (see Box 2), technological advances, economic circumstances and changes in people’s expectations. All of these are driving the move towards more care in the home, both complex and acute care, and more routine care for long term conditions (QNI, 2009).

Wherever nurses work in future—whether in a mixed economy involving the NHS, the independent sector, cooperatives and charities—the trend towards integrated services that break down divisions between hospital and community is likely to continue. Patients will expect more flexible, convenient, tailored and technologically astute services than they have traditionally received. A health service with financial pressures will need to be much smarter and more efficient in its delivery of care.

It is essential that the transfer of community services to other organisations does not stall the development of services. The gains of recent years must not be swallowed up by acute sector priorities if we are to create and sustain a community based health service that can meet the massive needs of the future population.

**REFERENCES**


Box 1. DEVELOPMENTS IN COMMUNITY SERVICES

- Prescribing: district nurses and health visitors were the first nurse prescribers; community nurses with training recorded with Nursing and Midwifery Council can now prescribe from full British National Formulary.
- Acute care in the home: procedures including blood transfusions, cancer chemotherapy and ventilator support were carried out in patients’ homes in some areas.
- Autonomous roles: advanced nurse practitioners see undifferentiated patients, assess, diagnose and prescribe. Practice nurses are responsible for managing long term conditions. Nurses lead walk in centres, urgent care units and community based surgical units.
- Business opportunities: nurses are running general practices, social enterprises, charities, nursing homes and out of hours services, combining clinical and corporate roles.

Box 2. POPULATION CHANGES AFFECTING HEALTHCARE DEMAND

- One in four people aged over 75 and one in two aged over 85 need nursing at home (Audit Commission, 1999).
- Since 1983, the number of people aged over 65 has more than doubled from 600,000 to 1.3m (Office for National Statistics, 2009).
- By 2025, there will be 42% more people aged 65 or over than today (DH, 2010c).
- In England, 15.4m people live with a long term condition (DH, 2010c).
- The number of people with at least one long term condition will rise to 18 million by 2025 (DH, 2010c).


