NHS reforms: White Paper response from national diabetes nursing groups

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On 21 January 2011, the Department of Heath (DH) published the *Health and Social Care Bill* (DH, 2011), which takes forward the NHS reforms proposed in the White Paper *Equity and Excellence: Liberating the NHS*. These reforms will see the healthcare system in England undergo the biggest revolution since its inception, with NHS management costs to be reduced by over 45%, and 80% of the NHS budget given to GP practices. As nurses working in diabetes care, we welcome the principle of moving away from bureaucracy, but are concerned about how these radical plans will be implemented in practice and how this market-led approach will impact the quality of care. Based on a roundtable meeting of the authors, this article outlines our response to the public consultation on the White Paper prior to the publication of the bill, discussing key issues around service commissioning and the development of the NHS Outcome Framework.

Article points

1. The NHS reforms set out in the White Paper will see the healthcare system in England undergo the biggest revolution since its inception.
2. GP consortia will be given responsibility for 80% of the NHS budget and will commission the majority of NHS services.
3. Clarification is needed on the commissioning of specific services, such as diabetes care, and related outcome measures.
4. Nursing expertise must be recognised and utilised during the new commissioning process.

Key words

- GP commissioning
- NHS Outcome Framework
- NHS reforms
- White Paper

The NHS is facing the most radical reforms since its inception following the publication of the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health [DH], 2010a) on 12 July 2010. Under the Government's plans, NHS management costs will be reduced by more than 45% (DH, 2010a). In addition, all strategic health authorities (SHAs) and PCTs in England will be abolished in the next 4 years. In their place, hundreds of GP consortia will be created and given responsibility for 80% of the entire NHS budget (Roland, 2010).

The White Paper was accompanied by four supporting documents that formed a public consultation on specific aspects of the reforms:

- *Liberating the NHS: Commissioning for Patients* (DH, 2010b).
- *Liberating the NHS: Transparency in Outcomes – a Framework for the NHS* (DH, 2010c).

This article is based on a diabetes nurse working group discussion that took place in London on 30 September 2010. Novo Nordisk provided an educational grant to support the meeting and this article. Novo Nordisk have had no input into the content of the meeting or this publication.

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- *Liberating the NHS: Increasing Democratic Legitimacy in Health* (DH, 2010d).
- *Liberating the NHS: Regulating Healthcare Providers* (DH, 2010e).

We appreciated the opportunity to respond to the White Paper and organised a diabetes nurse working group discussion that took place in London on 30 September 2010. The aim of the meeting was to discuss key issues in the first two consultation documents, and to form a formal response on behalf of the following organisations:

- Training, Research and Education for Nurses in Diabetes-UK (TREND-UK).
- The National Diabetes Nurse Consultant Group.
- The Diabetes Inpatient Specialist Nurse Group.
- The Royal College of Nursing (RCN) Children and Young People's Diabetes Community.
- RCN Diabetes Nursing Forum.
- Diabetes Nurse Facilitators Group.
- The Primary Care Diabetes Society (nurse representatives).
- The Practice Nursing Forum.

We summarised comments from all meeting participants and submitted our full response to the DH on 11 October 2010. This article outlines the main outcomes from the meeting and discusses our concerns regarding the NHS reforms.

General comments

Implementation of the reforms

We warmly welcome and share the Government's commitment and its key principles, but are concerned by the lack of detail addressing how these principles will be implemented in practice and how they would interact with existing NHS initiatives. Clarification is also needed on the commissioning of specific services, such as diabetes care, and related outcome measures.

Multidisciplinary team working

High-quality patient care relies on successful partnership working from the whole multidisciplinary team. Although vast and diverse, the NHS is an organisation with a cohesive and unifying ethos. The reforms set out in the White Paper may fragment the present service into many different and competing services. We are concerned about how collaboration and sharing of knowledge will be supported in an increasingly competitive healthcare market. Clarification is needed on how care providers at different levels, from those working in the communities through to specialist centres, will be empowered to work in a coordinated way to provide truly integrated care.

Workforce competency

In order to achieve the Government's ambition to move care closer to home and to ensure continuous delivery of high-quality care in the community, it is vital that healthcare providers have the necessary skills and competencies. The White Paper has not addressed how to prepare staff for the dramatic changes and how to assess essential workforce competencies. We would like to see professional standards being developed to ensure proper investment in an appropriately skilled and sustainable workforce.

The role of nurses in the new NHS

Nurses have an invaluable insight into the practical issues of service delivery and their unique perspective of patient experience is vital to any reform of the NHS. Over the years, the role of the nurse has evolved to encompass greater responsibility in many areas, including making treatment decisions. Moreover, nurses have also taken a decisive role in hospital administration and hospital and community service redesign, and as such they can positively or negatively impact the way health care is provided. As a result, nursing expertise must be recognised and utilised during the new commissioning process. However, we are gravely concerned that the Government failed to explicitly mention within the White Paper the role of nurses, who make up some 70% of the NHS workforce (RCN, 2010). We are keen to see genuine involvement and input of nurses in the future NHS.

Financial concerns

The implementation cost of the reorganisation set out in the White Paper has been estimated at £2–3 billion (Walshe, 2010). At a time of

financial austerity, we are unconvinced that each GP consortium will have ring-fenced funding for necessary professional training for staff and various support materials for patients.

Our response

Below is an overview of our response to two of the four consultation documents that accompanied the White Paper: *Commissioning for Patients* and *Transparency in Outcomes – a Framework for the NHS*. We chose these two documents because they are most pertinent to nurses working in diabetes care.

Commissioning for patients

The consultation document *Commissioning for Patients* provides information on the Government's intended arrangements for GP commissioning and seeks views on a number of specific questions (DH, 2010b).

Commissioning responsibilities have for some years largely rested with PCTs and to some extent the primary care groups that preceded them. In a bid to "shift decision-making as close as possible to individual patients", the coalition Government has proposed to "devolve power and responsibility for commissioning services to local consortia of GP practices" (DH, 2010a). Under this plan, GP consortia will commission the great majority of NHS services, including out-of-hour emergency care, elective hospital care, rehabilitative care, most community health services, mental health services and learning disability services. To provide overall leadership on commissioning, the Government will create an NHS Commissioning Board, which will calculate practice-level budgets and allocate them directly to consortia. Consortia will be responsible for managing these budgets and the Board will in turn hold consortia to account for their performance.

We appreciate the principle of cutting bureaucracy and empowering healthcare providers who are working close to patients. However, we feel that it is essential for GPs to actively engage with specialists in order to successfully deliver the extra services proposed in the White Paper. During the roundtable meeting, we raised a number of general questions regarding GP commissioning, which are listed in *Table 1*. We also answered some of the questions brought up in the consultation document. Key points from our response can be found in *Table 2*.

Transparency in outcomes

The consultation document *Transparency in Outcomes – a Framework for the NHS* provides information on proposals for developing an NHS Outcome Framework and seeks views on some specific aspects (DH, 2010c). Here, we summarise our discussion during the meeting regarding proposals for the development of the framework. Readers should note that following the consultation period, the DH has recently published this document entitled *The NHS Outcomes Framework 2011/12* (DH, 2010f).

Table 1. Commissioning for patients (DH, 2010b): Our general questions.

- What leadership roles will nurses have in the new NHS?
- Will there be nurse representation on the NHS Commissioning Board?
- How will the NHS Commissioning Board ensure that members of GP consortia have the relevant skills and competencies to facilitate world-class commissioning?
- What measures will be taken to ensure that experience in diabetes, a condition that can have a negative impact on many other conditions, is adequately represented on the NHS Commissioning Board and in all GP consortia?
- Will existing healthcare contracts remain?
- How will the person with diabetes know which GP consortium to choose? Will there be a patient guide to diabetes services offered in each location and will this be available in different languages and formats (e.g. paper documents, web resources, local meetings, audio and visual methods of communications)?
- Will each GP consortium have a ring-fenced budget to offer the above patient guide in various forms?

Table 2. Commissioning for patients (DH, 2010b): Key points from our response to some of the consultation questions.	
Question	**Response**
• *In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?*	GP consortia need to establish robust links with existing national and regional networks offering care for people with diabetes and to ensure that the voice of multidisciplinary teams is heard. This is especially important when commissioning services for people at high risk of emergencies or complications, including: • Children and young people with diabetes. • Insulin pump users. • Renal replacement patients with diabetes. • People with diabetes who experience sleep apnoea.
• *How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?*	"Low volume" services are not defined in the consultation document. However, we would like to see less-commonly used diabetes services, such as those for people with diabetes and cystic fibrosis, commissioned regionally but delivered as close to home as possible.
• *Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?*	Some services, such as insulin pump services, could be commissioned by GP consortia. But what policies and measures will be put into place to ensure only staff with appropriate skills, experiences and competencies deliver this care?
• *How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?*	GP consortia should involve both local and national user groups, including charities such as Diabetes UK, to support decision-making pertaining to the quality of diabetes service provision.
• *What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?*	GP consortia need to make the following information available in the public arena: • Information on population demographics. • Priority care areas. • Actions linked to NICE standards and outcomes aligned with national standards. This work should include audit and benchmarking.
• *How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?*	We strongly recommend that NHS Diabetes becomes part of the Commissioning Board to ensure that effective relationships are built between GP consortia and people with diabetes. The Commissioning Board and GP consortia need to engage with, and be responsive to, recommendations from local, regional and national multidisciplinary organisations. There should be robust links between requirements for service provision and the skills of nursing staff and other healthcare professionals who deliver the services. These skills should be reflected in appropriate salaries in line with national guidance in order to avoid inequality.

As stated in the original White Paper consultation document, the NHS Outcome Framework is intended to "sharpen the accountabilities in the system for delivering better and more equitable outcomes" (DH, 2010c). The framework is made up of a set of national outcome goals that provide a means by which patients, the public and Parliament can hold the Secretary of State for Health to account for the overall performance of the NHS. The framework has been developed with the following key principles in mind:

- Accountability and transparency.
- Balance.
- Focus on what matters to patients and healthcare professionals.
- Promotion of excellence and equality.
- Focus on outcomes that the NHS can influence but working in partnership with other public services where required.
- That it would be internationally comparable.
- That it would evolve over time.

In terms of the structure of the NHS Outcome Framework, it was proposed that the framework should be developed around a set of five outcome domains (see *Table 3*) that attempt to capture what the NHS should be delivering for patients, and indeed the subsequently published document reflects this (DH, 2010f). Each of the domains is covered by one or more overarching outcome indicators, five to eight improvement areas and a suite of supporting quality standards, most of which are in development.

During our discussion, we agreed with the key principles and the structure of the framework. However, we felt that there was a lack of detail regarding outcome measures for specific services. Some of the indicators proposed may not be applicable to diabetes services and clarification would be needed when measuring the quality of diabetes care. Key points from our response to some of the consultation questions can be found in *Table 3*.

In the newly published *NHS Outcome Framework*, we are pleased to see that NICE quality standards for diabetes that are relevant to domain 1 and 2 are due for publication by June 2011 (DH, 2010f); however, the other domains do not appear to provide sufficient clarification for diabetes.

Conclusions

The principles driving the White Paper – removing unnecessary bureaucracy, empowering healthcare professionals working close to patients, focusing on clinical outcomes and providing greater transparency of data – are commendable and welcome. However, a lack of detail is notable throughout the proposals. In our view, the White Paper fails to provide sufficient evidence about why the Government believes this is the right action to take now.

We are concerned about how GP consortia will link with other organisations to ensure similar levels of engagement from all parties in the multidisciplinary team. We also feel that the nursing profession, which is vital to high-quality patient care, is inadequately represented in the current proposals for the commissioning and delivering of services. As nurses working in diabetes care, we would like some clarification on how the reforms will affect diabetes services and we look forward to making our best contribution to the new NHS. ■

DH (2010a) *Equity and Excellence: Liberating the NHS*. DH, London

DH (2010b) *Liberating the NHS: Commissioning for Patients*. DH, London

DH (2010c) *Liberating the NHS: Transparency in Outcomes – a Framework for the NHS*. DH, London

DH (2010d) *Liberating the NHS: Increasing Democratic Legitimacy in Health*. DH, London

DH (2010e) *Liberating the NHS: Regulating Healthcare Providers*. DH, London

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Table 3. Transparency in outcomes (DH, 2010c): Key points from our response to some of the consultation questions.

Question	Response
Principles	
• *Do you agree with the key principles that underpin the development of the NHS Outcomes Framework?*	Yes, we do. However, we feel that supporting information and evidence is needed regarding how "what matters to patients and healthcare professionals" (DH, 2010c) is going to be established.
• *How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?*	Network groups must be representative of the whole multidisciplinary team; for diabetes this means including consultant diabetologists, specialist nurses, practice nurses, allied healthcare professionals (e.g. dietitians, podiatrists) and social care representations. The implementation of the White Paper may potentially lead to fragmented, rather than integrated, care provision. For example, it may lead to DSNs working in isolation without peer support or clinical supervision. GP consortia need to be certain that where outcomes require integrated care services across the NHS, public health and social care services, there are systems in place to ensure adherence to jointly agreed and documented care pathways.
Five domains	
• *Do you agree with the five domains that are proposed as making up the NHS Outcomes Framework?*	We broadly agree with the five domains; however, there are notable omissions, these being: • Prevention of long-term conditions. • Promotion of self-management by people with diabetes. • Ways to improve quality of life for children and young people with diabetes, such as support from education providers and partnership working between school nurses and paediatricians.
Domain 1: Preventing people from dying prematurely.	
• *Do you think the proposed method* is an appropriate way to select improvement areas in this domain?* *(*Lower mortality rates from a particular condition in other countries vs the UK indicate that mortality rates in the UK could be improved. Following this logic the two causes with most scope for improvement [excluding those with known coding issues] are heart disease and stroke.)*	Although diabetes is highlighted as an area for improvement, we feel that the mortality rate from diabetes may have been underestimated. Indeed, studies have demonstrated that diabetes significantly increases the risk of ischaemic heart disease (Timmis, 2001) and stroke (Jeerakathil et al, 2007). As mentioned in this domain, different coding practices in different countries can skew the comparisons of mortality rates. We suspect this may have led to inaccurate counting of the number of diabetes-related deaths "amenable to healthcare" (DH, 2010c). This issue needs to be clarified.
• *The UK appears to perform badly on infant mortality and premature mortality from respiratory disease in children aged 0–14. Are either of the suggestions appropriate areas of focus for mortality in children? Should anything else be considered?*	Other areas worth considering include: • Diabetes ketoacidosis at diagnosis. • Infant deaths caused by congenital malformations in children of women with diabetes. • "Dead in bed" syndrome in young people with diabetes. (Continued on next page.)

Table 3. Transparency in outcomes (DH, 2010c): Key points from our response to some of the consultation questions (continued).

Question	Response
Domain 2: Enhancing the quality of life for people with long-term conditions.	
• *There are two existing surveys that collect information relevant to this domain: the Labour Force Survey (measuring the "percentage of people with long-term conditions where day-to-day activity is affected") and the GP patient survey (measuring the "percentage of people feeling supported to manage their condition"). Are either of these suggestions appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?*	The two overarching indicators highlighted do not adequately reflect the impact of living with diabetes on a daily basis. The indicators would benefit from an emphasis on specific requirements of carers, including parents. The GP survey should be amended to include the percentage of people with diabetes who feel adequately prepared to self-manage their condition. Other indicators that could be included are rates of diabetes amputation and rates of hypoglycaemia in people with diabetes.
• *As well as developing quality standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?*	Care for those with coexisting conditions (e.g. those with diabetes on renal replacement therapy and those with diabetes and cystic fibrosis) is often suboptimal, because these individuals usually fall between healthcare teams. It is vital that the care of these groups is coordinated or case-managed. For example, one of the quality standards could relate to quality of life of people with diabetes on renal replacement therapy.
Domain 3: Helping people to recover from episodes of ill health or following injury.	
• *The two proposed indicators are: 1) emergency hospital admissions for acute conditions usually managed in primary care and 2) emergency bed days associated with repeat acute admissions. Are these appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?*	This domain needs clarifying for diabetes. Prevention of certain diabetic emergencies, such as episodes of hypoglycaemia and diabetic ketoacidosis, often relies on a person with diabetes adhering to his or her self-care regimen outside the hospital environment. Having frequent admissions for these conditions is not an accurate reflection of inpatient management of the episode and therefore is not an appropriate outcome indicator. We strongly recommend that episodes of hypoglycaemia and diabetic ketoacidosis are excluded from this domain.
• *What might suitable outcome indicators be in areas selected for improvement?*	It has been estimated that 12–15% of inpatient beds are occupied by people with diabetes (Sims et al, 2010) and the hospital stay for a person with diabetes is likely to be up to twice the average (Diabetes UK, 2008). A good indicator to include would be inpatient length of stay for people with diabetes versus people without diabetes.
Domain 4: Ensuring people have a positive experience of care.	
• *Would there be benefit in developing dedicated patient experience quality standards for certain services or client groups? If yes, which areas should be created?*	Quality standards developed by NICE will improve patient experience and care delivery. As diabetes nurses, we look forward to being able to contribute to the development of these national quality standards during the consultation period.
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.	
• *Do you agree with the proposed improvement areas (safe treatment; safe discharge/transition; patient environment; safety culture; vulnerable groups) and the reasons for choosing these areas?*	This section focuses on hospital statistics only, but safety does not solely refer to inpatient care. We assume that there will be similar measures being developed for all environments. For children and young people with diabetes, this domain should also include safe practices in nurseries, schools and colleges.