CHAPTER 6

2000s: Transforming Community Services

Abstract The new millennium saw the publication of *The NHS Plan* in 2000, which bought a welcome focus to community health services (CHS) and the role of community nursing. We outline the proposals contained in the plan which furthered the quasi-marketisation of the NHS and increased commissioning of health care at the local level of Primary Care Trusts (PCTs)—replacing Health Authorities (HAs) and Primary Care Groups (PCGs). A further review by Lord Darzi and subsequent policy, *Transforming Community Services: Enabling new patterns of provision* (DoH, 2009) instigated the separation of commissioning/provision and laid out timetables for how PCTs were to do this. The long held roles of the district nursing service continues in this era, although not always clearly defined, understood or acknowledged and policy attempts to expand their remit feature heavily. This included more clinical tasks as well as focusing on such things as public health/health protection and promotion programmes that improve health and reduce inequalities. This chapter also describes the uncertainty for frontline nurses that the Transforming Community Services (TCS) brought in terms of who their employer would be or what management arrangements they would work under given the establishment of some standalone Trusts, some third sector and some combined acute/community Trusts. The aims of the TCS programme were bold but in reality achieved little by the end of the era.

Keywords Transforming Community Services • Darzi • PCTs • commissioning

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6.1 Historical Context

Lack of attention and years of underinvestment led to a focus on community health services and the whole NHS and social care system in this era. This was initially acknowledged at the start of the new millennium with the publication of *The NHS Plan* in 2000 (DoH, 2000). The plan outlined ambitions to again modernise the NHS with 'a plan for investment, a plan for reform' (DoH, 2000, p. 1). Again, there was an emphasis on joining up services and breaking down barriers between multi-disciplinary staff in order to better serve the needs of patients and the public. It was noted in the document that where traditional boundaries and hierarchies were replaced by new and flexible ways of working, for example in community clinics (p. 82) where different professionals such as district nurses came together to deliver care, the resultant reduced lengths of hospital stay and enabling more people to stay at home was measurable.

The Plan also suggested the possibility of a radical redesign of the whole care system (in areas which wished to experiment), including bringing provision of local health and social care services together into one organisation as Care Trusts. Giving 'nurses and other health professionals even bigger roles' (ibid., p. 15) commensurate with skills and qualifications was also espoused, as was introducing greater accountability, performance management and incentivisation into the system. Another radical proposal was encouraging private health care sector entry into the NHS quasi-market in order to increase the volume of care provided and to give patients more choice. *The Plan* also outlined that there would be less central governmental control of the NHS and that more responsibility for commissioning health care was to be devolved to the local level of Primary Care Trusts (PCTs). As mentioned in the preceding chapter, Primary Care Groups (PCGs) were to be developed into PCTs by 2004. In the event, this was bought forward to 2002 following the publication of the *Shifting the balance of power within the NHS* (DoH, 2001) White Paper. According to *The NHS Plan* (DoH, 2000), PCTs were given substantial financial resources which would allow new services to evolve bringing primary and community services under one clinic/surgery roof.

This however, as Imison (2009) pointed out, was problematic given that PCTs were both providers and commissioners of services such as community care, creating conflicts of interest. Thus *The Next Stage Review* (DoH, 2008) conducted by Lord Darzi, instigated the separation of provision and commissioning of community services from PCTs with an

emphasis on 'world class' commissioning/quality in patient-centred care. As documented in the *Transforming Community Services* documentation, this was seen to afford an opportunity for better alignment between services while 'delivering improved quality and productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications' (DoH, 2009b, c:4). Darzi's review (DoH, 2008) put a renewed focus onto the organisation and modernisation of CHS (community health services) for realising the aims of the 2000 *Plan* (DoH, 2000) with a commitment to developing them as successful provider services and giving them greater autonomy, which they had so far lacked.

Darzi's recommendations led to the Department of Health requiring PCTs to formulate strategies for community services, including district nursing, by October 2009. Therefore in 2009, the government launched the programme *Transforming Community Services: Enabling new patterns of provision (*DoH, 2009a*)*, in which it laid out its new 'vision' for primary and community services that involved structural changes to how services were organised and delivered (DoH, 2009b). The TCS *Enabling New Patterns of Provision* (DoH, 2009a*)* set out the timetable for separating commissioning and provider functions of PCTs, and outlined different organisational forms that PCTs could consider for delivering primary and community services. These included leaving the NHS and becoming independent social enterprises as well as for profit firms (ibid.). It was anticipated that by April 2011, all PCTs would separate their commissioning and provider functions and move towards an 'any willing provider' model, bringing more competition and choice into the health care market. However, the frequent structural and organisational changes in primary and community care, particularly the transfer of Community Health Services from PCTs to other providers—such as larger mental health and community trusts that covered much larger areas or social enterprises (QNI, 2006)—led to further impact on district nurses.

6.1.1 The Role and Function of Community/District Nursing Services

Again, it appears the traditional tasks, function and practice of the district nursing service continue although attempts to expand them feature in this era. The companion Paper to the *NHS Plan (*DoH, 2000), *Liberating the Talents: Helping Primary Care Trusts and nurses to deliver The NHS Plan (*DoH, 2002*)*offers proposals in this direction, providing a

framework for the planning and delivery of nursing services in primary care to meet the objectives that had been set out in *The NHS Plan*. The Paper referred to nurses in the broader sense to be inclusive of all nurses providing care outside of 'the hospital setting' (p. 4). Outlined in the Paper are a number of areas in which nurses' role would be extended, for example by taking some work currently done by GPs, by providing more secondary care in community settings and having a greater voice in decision making. In addition, nurses in primary care were expected to focus on prevention and tackling health inequalities with more opportunities for skill mix and leadership. The changes proposed by *Liberating the Talents* suggested that there was also an expectation that nurses' role would further expand to take on more clinical roles involving prescribing and specialist approaches to community care.

Three core functions were at the heart of the new framework for nursing care regardless of setting, employer or title, pointing to the integral role of nurses in a one-service approach (ibid., p. 8):

- First contact / acute assessment, diagnosis, care, treatment and referral
- Continuing care, rehabilitation, chronic disease management and delivering NSFs
- Public health / health protection and promotion programmes that improve health and reduce inequalities

However, there was some criticism of the Paper as exemplified by Howkins and Thornton's (2003) discussion of it in the Journal of Nursing Management. As Howkins and Thornton proffer, the proposals try to address the 'handmaidens to doctors' (p. 219) stereotyping of nursing but they go on to point out that this would require significant overcoming and blurring of professional boundaries between practitioners that might even perpetuate the ideal. In 2002, The QNI published a report, *District Nursing—An Invisible Workforce* (Low & Hesketh, 2002) in which it offered the sector's perspective. It claimed that the service was under considerable pressure from an overload of demand and complex patient needs, with much financial and professional uncertainty surrounding district nurses' roles. Many of the district nurses questioned for the report lamented the loss of the hands-on aspects of their role, lost with the blurring of the boundaries between what is health and social care (Pollard, 2002). Many had taken on the assessment and management

responsibilities espoused by policy, although by grade promotion not necessarily by choice (Low & Hesketh, 2002). The report concluded that the workforce needed to be more visible and take an active approach to shaping and influencing the national policy agenda. It was a controversial report as not all district nurses agreed they were an invisible force. However, what the document did was to highlight the important policy context in which the workforce was increasingly operating and the corresponding concerns. Namely; 'workforce issues, integration into community teams; development of skill mix within those teams; greater management responsibility; challenges to caseload and workload management; earlier discharge from hospital to community services and a corresponding 'loss of a clear identity' for district nurses' (QNI, 2014, p. 5).

This was further challenged by the introduction of Community Matrons (CM) in 2004 to manage the increasing caseload of patients with complex long-term conditions in the community. Building on the aspirations of the *NHS Plan* for more patient centred, at home care, the *NHS Improvement Plan* (DoH, 2004a) introduced the new role of the CM as 'clinical specialists' posts. These were supposed to provide a local and co-ordinated care service delivered with other professionals (mainly in primary care), who would 'help, anticipate and deal with problems before they lead to worsening health or hospitalisation' (DoH, 2004b, p. 37). Many of the roles were taken by district nurses because of their extensive experience of working in the community. Whilst this enabled district nurses to enhance their careers, it introduced concerns over role clarity, confusion and tensions with regard to overlap in responsibilities (Dossa, 2010). The approach was part of a growing trend in primary care whereby case management was increasingly an integral feature in health policy in England (Boaden et al., 2006). While these policy initiatives constituted important developments in primary care, the role of district nurses was not always clearly defined or understood.

The publication of the White Paper—*Our health, our care, our say: a new direction for community services* (DoH, 2006), signalled a renewed focus on prevention and early intervention, particularly in the context of changing demographics with growing new needs. *Our health, our care, our say*, in particular, set out a new strategic direction for primary and community care centred around prevention and early intervention, extending choice for patients, addressing inequalities through better access to community services and supporting people with complex and long-term needs to live independently. The suggestions were built around the idea that care

planning and co-ordination must be contingent on integrated health and social care information systems to avoid duplication across different agencies. A 'skilled individual' was supposed to act as a case manager organising and coordinating services from a wide range of providers (ibid.). The White Paper sought to create multi-disciplinary networks and teams operating on a sufficiently large geographic footprint and involving social services, NHS primary, community and secondary care services and housing (ibid., p. 116). Again, there was limited evidence that initiatives from the White Paper were successfully implemented or continued beyond implementation (Salisbury et al., 2011) possibly because the Paper was too vague.

Later on in the decade, whilst the Darzi Report (DoH, 2008) did not directly refer to district nurses, it acknowledged that nurses and other allied health professionals played an important role in providing personalised care. Darzi suggested that staff should be allowed to use their skills to transform community services so that these are flexible and responsive to local community needs. The report reaffirmed the greater role for community services including nurses and encouraged practice-based commissioning involving a wide range of health care professionals. *Transforming Community Services* (DoH, 2009a) was a rare attempt to give national policy focus to CHS in a co-ordinated way. It focused on empowerment of 'front-line' staff, clinician collaboration and integration of service pathways. Practitioners closest to patients were expected to lead change. Six transformational 'best practice' guides were published for front-line staff based around 'ambition, action and achievement'. Each guide is themed on a key area of nursing care such as end-of-life or rehabilitation and provides a section on how to take actions forward. District nurses were included in the role of taking on these actions and implementing policy. TCS also introduced a programme of professional development introduced to 'strengthen clinical skills and clinical leadership', developing a 'productive community services' programme. 'These programmes will review the evidence base for care pathways (initially focusing on wound care, continence services and stroke services), help free up more time for direct patient care, and improve quality and patient outcomes' (DoH, 2008, p. 43). It addressed concerns about flux and fragmentation of services and the need to find new ways of working with other health and social care providers to deliver patient care, support and management within the community.

The government also published another White Paper—*Healthy Lives, Healthy People: Our strategy for public health in England* (DoH, 2010b)—in which it outlined the role of local government in preventing ill health and 'promote[ing] active ageing' (p. 47) so that people could live independently at home for as long as possible. District nurses and allied health professionals were seen central to this agenda delivering advice and support around falls prevention and nutrition to enable people stay safe and well. At the same time local government was 'closely linked with the NHS through its role in supporting re-ablement through social care' provision (DoH, 2010b, p. 49). However, despite much emphasis on strengthening and promoting local and joined up provision, the government did not explicitly acknowledge the role of nurses.

It could be argued that the *Transforming Community Services* agenda was curtailed by the 2010 election (see next chapter). As noted above, the document set out an ambitious plan for quality improvement, based around 'best practice' guides, alongside the separation between the provision and commissioning of community services. However, in practice its publication in 2009 meant that PCTs were beginning the work required to develop this agenda in late 2009/early 2010. Divesting PCTs of their so-called community-based provider arms required considerable work around employment rights (TUC, 2009), which had to be dealt with before the quality improvement agenda could be addressed. However, in July 2010 the newly elected coalition government published their new reform agenda for the NHS, *'Equity and Excellence: liberating the NHS'* (DoH, 2010a) (see next section). This proposed the abolition of PCTs and their replacement by GP-led Clinical Commissioning Groups (Checkland et al., 2012).This meant that the transfer of community health services to new forms of organisation had to be completed quickly, as PCTs' focus shifted to winding up their own activities and transferring their responsibilities to the new organisations. The intended quality improvement agenda therefore received little attention and the TCS agenda would eventually fade away achieving little (Edwards, 2014).

6.1.2 The Management of Community/District Nursing and Population Covered

As set out first of all in the 1997 White Paper—*The New NHS; Modern, Dependable* (DoH, 1997)—and again in the NHS Plan of 2000 (DoH, 2000), the management of CHS came under the auspices of Primary Care

Trusts (PCTs). These bodies had statutory responsibility for the purchasing and provision of care for a geographical population including commissioning primary and secondary care services; providing CHS; and being responsible for population health via a public health function. The size of PCTs varied over the years, with a tendency towards increasing in size with a wave of mergers in the mid-2000s, when the number of PCTs in the country reduced to around 150 (Walshe et al., 2004). PCTs were managed by an Executive team, which usually included a nursing lead. At the same time, each PCT had a Professional Executive Committee (PEC), which had an advisory role and was made up of representatives of all of the local health care professions, including GPs, nurses, pharmacists, optometrists and dentists. The PEC had little power but considerable influence (Checkland et al., 2011). In general, within PCTs, there was a separate Directorate with responsibility for providing CHS. An allocated budget was managed by the Directorate, with oversight coming from Strategic Health Authorities, which managed the performance of PCTs (Lorne et al., 2019). This management structure ensured that, as had been argued for over decades, nurses were managed by nurses rather than by doctors.

Transforming Community Services (DoH, 2009a) disrupted this structure, requiring a separation between commissioning and provision of CHS, as mentioned earlier. The options for transfer included: the creation of a standalone Community Foundation Trust; the transfer of services to a Social Enterprise; the integration of CHS into another NHS organisation; or the commissioning of different types of Community Services from a variety of different providers including for profit firms (Spilsbury & Pender, 2015). A mapping of the resulting change in organisational structures found that 67% of Community Service providers were integrated with another type of NHS provider, either an Acute Hospital Trust or a Mental Health Trust, with only 15 standalone Trusts and 15 Social Enterprises created (Spilsbury & Pender, 2015). Importantly, two thirds of those services which integrated with another NHS organisation were essentially taken over by Acute Trusts. This had the advantage for the parent Acute Trust in that should the promised shift of care from hospitals into the community occur, Trusts would not lose income.

It is also possible that this outcome—which was to some extent counter to the intentions set out in TCS, which emphasised the possible advantages associated with social enterprise and other ownership models—arose in part out of the speed with which the changes needed to be introduced once the abolition of PCTs was announced. The transfer of services to an

existing Trust was easier and quicker to achieve than the setting up of a separate new Trust or Social Enterprise or running a procurement exercise and contracting with an existing for profit firm, such as Virgin. There has been little research exploring how CHS managed under the umbrella of an Acute Trust perform compared with those which standalone either as Community Foundation Trusts or as Social Enterprises, or as for profits. Notwithstanding this, a study published in 2021 confirmed that there were no differences in use of emergency hospital services by frail elderly patients associated with the different models of ownership of community service providers (Wyatt et al., 2021).

Spilsbury and Pender (2015) highlight the disruption associated with these changes, with considerable uncertainty for frontline nurses about who their employer would be or under what management arrangements they would work. The new framework for commissioning community services in a more competitive market as set out both in TCS and following the 2010 White Paper (see chapter below) (DoH, 2010b) was also said to risk increasing fragmentation and rivalry amongst different health and social care providers (RCN, 2010a). The RCN (2010a, p. 3) highlighted the initial absence of the Chief Nursing Officer (CNO) in the plans for the establishment of GP-led commissioning bodies, suggesting that nurses were frequently an afterthought in the policy process. They also called for 'designated nursing posts on commissioning consortia boards, Public Health England, and local health and wellbeing boards' to be established in order to strengthen the nursing component in the public health policy (RCN, 2010b, p. 3).

In terms of community nursing practise, community nursing services continued with a mix of geographical teams and attachment to GP practices. The tensions that we have highlighted between these different models remained, with commissioners negotiating locally specific ways of working, emphasising skill mix diversity, with senior nurses managing teams of less-qualified nurses, and local mechanisms for liaising between district nurse teams and GP practices which were not always particularly functional (Speed & Luker, 2006).

6.1.3 Financing Community/District Nursing Services

Under PCTs, CHS received a budget that the Provider Directorate had to manage. These budgets were largely based upon historical activity. In the more competitive market introduced by TCS (2009), commissioners used

a block contract mechanism to commission services, with providers paid a set amount, again usually based upon previous activity. This gave them little incentive or opportunity to increase service provision or to innovate (Allen & Petsoulas, 2016) and made them subject to considerable financial pressures (Robertson et al., 2017). This was in contrast to the 'payment by results' activity-based contract used to commission acute services(Rogers et al., 2005). In discussing these different payment mechanisms, a report by the Nuffield Trust (Marshall et al., 2014) highlights the impact on ambitions to shift care from hospitals to the community:

> The predominance of activity-based payment in the acute sector, introduced at a time of long waiting lists, encourages activity in hospitals; at the same time, block budgets in community services and capitated budgets in primary care offer little incentive to increase activity or efficiency in these settings. (Marshall et al., 2014, p. 3)

There was a persistent policy intention to move CHS towards a more activity-sensitive form of contract (Sussex, 2010), but this has proved difficult due to the lack of consistent and accurate data about community services activity and the difficulty in assigning meaningful activity codes to the work of community staff (Monitor, 2015).

6.1.4 Summary

Transforming Community Services had two main aims: to move CHS towards a more competitive model, with innovation and improvements in efficiency driven by competition; and to use quality improvement methods to improve the care provided, including increasing integration between CHS and other community-based services such as social care and local multidisciplinary teams. In practice, the intended 'transformation' of services heralded by the TCS agenda was arguably undermined by the need to rapidly transfer services to other providers once the abolition of PCTs was announced in 2010. The complex negotiations required to transfer staff to new organisations and the uncertainty and concern that this engendered left little energy for more 'transformative' quality improvement work. In spite of a policy push towards more competitive markets and a multiplicity of providers, there is no evidence that one particular ownership model of community service provider offers benefits over others (Bramwell et al., 2014). The continued lack of good data about

community service activity and consequent use of block contracts limited the potential for services to innovate or expand.

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