Please can we have our nursing teams back?

WE CAN'T PUT A PRICE ON REPUTATION, TRUST, AND PATIENT EXPERIENCE

The recent history of healthcare planning is such that the distinction of being the clumsiest has several nominees. For me, however, that dubious honour belongs to the decision to move district nursing and health visiting out of practices and into community clinics. How ironic that, while the rhetoric is about interprofessional working, the reality is that a central diktat is promoting silo working.

When I first arrived at my practice just under two decades ago, we were in the throes of assembling an outstanding integrated healthcare team. Practice nurses, district nurses, health visitors, midwives, counsellors, and physiotherapists were all based in the surgery with the GPs, facilitating ready, often informal communication about patients. In addition to core clinical care, we learned, taught students, researched, and published together. Clinicians gained knowledge of areas outside their usual expertise to such an extent that roles eventually overlapped; for example, the practice nurse would be confident helping the district nurse support dying patients at home. We moved on from triage to have all nurses competent in managing acute illness, and chronicled that learning experience.[1] Another significant success was end-of-life care, which allowed over 50% of deaths to occur at home.[2] Yet these developments, which vastly improved the patient experience, were ripped asunder by the then-PCG, on the dubious grounds that health care needed an egalitarian model; we and other practices saw health visitors and district nurses moved to community clinics, and equality achieved by levelling down. Despite the efforts of dedicated staff, what followed has been an inferior, fragmented, and bureaucratic model.

Multidisciplinary meetings are now formal matters, squeezed in at lunchtimes, with high rates of non-attendance due to other commitments. High staff turnover and sickness absenteeism is rife, indicative that nurses' morale is, if anything, worse than that of doctors. Although they are not measurable monetarily, professional attributes such as reputation and trust are vital, especially in areas such as end-of life care, but they take years to develop and cannot do so if nurses become short-stay, dispensable workers not bonded to their communities, which I fear is the pattern emerging.

Underpinning this is that current structures are not supportive of primary care. Though GPs dominate CCG boards, their power is illusory for it is secondary care that calls the shots. The £1.85 billion deficit in 2015–2016 was the largest in NHS history, almost all racked up by acute trusts at the expense of general practice,[3] yet we are repeatedly asked to make 'efficiency savings' via micromanagement of referral and prescribing. This not only assumes a reductionist role for general practice — how depressing in comparison with fundholding, which genuinely supported innovation and service development[4] — but it is also a failing strategy. My local trust has just issued a statement that eight specialties are unable to see new referrals. What beggars belief is that the response of planners to a failing strategy is to persist with it with ever-increasing fervour; why not swallow the pride, admit the error, and move on to Plan B?

PERSISTENT AUSTERITY IN THE PUBLIC SECTOR IS A FALSE ECONOMY

Any discussion of nursing must acknowledge the recruitment crisis. The Hertfordshire hamlet in which I practise is typical of the affluent, respectable, if often sterile, Home Counties commuter towns. It is also illustrative of how the UK's worsening socioeconomic divisions have led to the spread of that recruitment crisis from poor post-industrial areas to desirable areas where hardly anyone can afford to live. When I first arrived here a diverse cross-section of the middle class prevailed. Fast forward to today, and the GPs, hospital consultants, nurses, teachers, lecturers, and vicars have all but vanished and the place is occupationally homogenised to financiers and those in real estate, testimony to the flawed economic strategy of skewing reward to a handful of areas. Doctors remain among the best-paid public sector workers, yet the long pay freeze is beginning to bite, and few can settle inside the M25 unless possessing a substantial private practice. For nurses this is much worse, and many decamp to management roles not, I aver, because bureaucracy is more interesting than clinical care but because it is remunerative.

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The clinical–managerial pay gap is a perverse incentive to leave clinical care, and should be abolished to help retain staff on the front line. Persistent austerity in the public sector is a false economy, for what is saved on the wage bill is eroded by poor morale and recruitment problems leading to reliance on expensive agency staff.[5] More specifically, denuding general practice of resources to bail out acute trusts solves nothing, and one must hope that under the new Prime Minister's watch there is a rethink.

ADDRESS FOR CORRESPONDENCE

Edin Lakasing
Chorleywood Health Centre, 15 Lower Road, Chorleywood, Hertfordshire WD3 5EA, UK.

E-mail: edin.lakasing@nhs.net

Edin Lakasing,
GP, Tutor, and Trainer, Chorleywood Health Centre, Chorleywood, Hertfordshire.

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