



“ARE YOU THERE NURSE?”

Involving Nurses in Commissioning: How to Get it Right

Introduction

In this recent round of reforms, we have once again had to conduct the ubiquitous debate with policy makers and others about the value of nurses on Boards of organisations. Since this report was commissioned David Nicholson has confirmed the appointment of a Chief Nursing Officer to the NHS Commissioning Board and the Government has accepted the NHS Future Forums recommendation that Clinical Commissioning Groups (CCG's) should be required to have a nurse on their board. However this requirement is not in legislation and will only be set out in the regulations and concerns remain that this role could be seen as 'tokenistic' not only by CCGs but by nurses themselves this limiting its impact.

The purpose of this briefing paper, which was originally commissioned by the Department of Health, is to reinforce why it is important to properly involve nurses throughout the commissioning cycle, and what needs to happen in order that such involvement can maximise the tangible benefits for patients and local populations. The focus of this paper is unashamedly on nurses and midwives, and the skills and perspective that they bring to the commissioning table, although it is recognised that the conclusions may well apply beyond nursing and midwifery and may well resonate for the many other clinicians who should also be part of any effective and truly clinician led and patient centred commissioning process

The NHS Alliance launched its Nurses in Commissioning Network in May 2011, and worked with members of this group to produce this paper and its sister document on the contribution of nurses to Public Health.

Background

Nurses and midwives have been involved in commissioning in a number of ways ever since the creation of the term in the early 1990's. Sometimes these nursing roles were mandated e.g. since 2002 PCT's were required to have a nurse on their board, but in addition many nurses were also employed in clinical governance, quality, service redesign and patient engagement roles. Further, nurses and midwives in provider organisations have been leading service improvements and redesign initiatives for decades. For example, in the 1970's male catheterisations were only carried out by a Doctor but nurses identified this task as something they could provide to avoid patients having to go to hospital, and this is now common practice. This type of service change is clearly a part of what we now call commissioning. However, the commissioner/ provider split role has sometimes stagnated these initiatives and nurses can be deterred by the technicalities of developing business cases and presenting them to commissioners etc. There is a need to harness and reignite these skills and enthusiasms and CCG's can unleash this potential by working through their board nurse and their networks to encourage creative solutions to current issues for patients.

How and why to involve nurses

1. On the board:

Although the Nurses in Commissioning Network was pleased that the NHS Future Forum supported its view the Clinical Commissioning would be most effective if it engaged the widest possible clinical community and specifically the requirement to have a nurse (and medical consultant) on each CCG 'board'. However, nurses recognise that there is a danger that these positions will be seen as 'tokenistic' without real power or influence. The NCN believes that this would be a missed opportunity and that CCG leaders would be wise to think through the requirements they have from this role, and match the post to the right person, and then give them real authority and serious job to do. Commissioning consists of a complex range of activities and the board nurse can play a crucial role, not only as individuals but as conduits to a network of other experts and perspectives. The NCN believes that CCGs need to have a senior nurse, who is fully aware of the whole health system locally – someone who has the credibility and leadership skills to influence, challenge and network across the health and social care community and hold to account the local system. Doctors, nurses and AHP's are all trained to see different aspects of the human condition. Therefore, by including a nurse in commissioning, the Board's understanding of the myriad needs of their communities would be deepened. Commissioners require this range of perspectives as much as providers need to enlist the skills of their multi-disciplinary teams when caring for patients.

2. As part of the wider commissioning agenda:

Nurses have an enormous amount of clinical and local knowledge to contribute to commissioning, and a breadth of experience that is able to articulate the patient experience at an individual and population level. Commissioning requires creative problem solving and risk management strategies based upon professional experience, intuition and understanding; and it often demands a different approach from traditional professional practice. The whole emphasis of the new commissioning arrangements is on patients – their needs, their priorities, and their place at the centre of all healthcare decisions. Nurses have a particular contribution to make in this area.

CCGs will be expected, through clinical commissioning and monitoring, to improve the quality of patient care. Recent reports have highlighted the importance that the experience of nursing and midwifery care has, not only to both patient/carer experience of care, but also to clinical outcomes. It will be vital that CCGs are able to include the range of quality initiatives and practices specific to nursing and midwifery in contracts and quality measures. How many GP's or commissioning managers would have sufficient knowledge of the 10 High Impact Changes for Nursing (NHS Institute for Innovation) in sufficient detail to develop suitable metrics to be used in CQUINs? Or know the Productive Ward programmes, Essence of Care audits, or that nurse staffing levels, development and job satisfaction link directly to improved patient outcomes (Aitken et al, 2000). These important quality improvement tools could be missed without effective nursing leadership and expertise in CCGs and commissioning support.

Some important, in terms of the range of perspectives contributing to the CCG, nurses are linked into a number of specialist networks covering areas such as wound and palliative care; cancer; stroke etc. Whilst many of these networks are multi-disciplinary, nurses will bring their expertise from this table to the Commissioning Board and add to the richness of the debate.

Nurses have particular contributions to make in ensuring that the highest quality services are commissioned. They already play a key part in helping patients to navigate their way through the system, and to choose for themselves those services that meet their needs. Most have considerable experience of day-to-day quality assurance, down to the level of dealing with individual complaints and comments. From this, many have followed the traditional route into clinical governance teams, where they developed an expertise around policy, frameworks and outcomes for quality and patient safety.

Nurses also operate within a tradition of team working and fluid leadership, as well as a long history of continuing professional development. They are used to stepping in and out of particular roles or concerns – flexibility is a key part of virtually every nurses' job, and the ability to build strong relationships quickly is at the heart of good nursing. The new era of partnership working will demand this as never before. Hierarchical leadership has largely been the tradition within the NHS and cultural change is often difficult. Nurses should be in a position to help CCGs foster new relationships and develop a number of ways of involving others, building on existing networks which are likely differ from those of their GP colleagues.

Contribution to the Commissioning Cycle

Nurses have a particular contribution not least to emphasis on clinical outcomes. Nurses working in provider services have first-hand experience of the requirements of the Care Quality Commission, which include clinical quality as a strong theme. Overall, it is a fundamental part of their job to bring a patient- and family/carer-focused perspective and voice to the information that is needed to inform commissioning decisions. They often play a pivotal role in co-ordinating care in a manner that is centred on the patient, keeps the patient safe, achieves the best outcomes and gives the best experience. This is a crucial skill set for commissioners.

Figure1. The commissioning cycle in World Class Commissioning (DH)



Figure 1 depicts the commissioning cycle as described in World Class Commissioning. Whilst WCC itself is no longer applied, the commissioning cycle remains a useful tool. The NCN identified nurse (and midwife) involvement and contribution in each of these activities in this cycle including:

- contributing to needs assessments
- defining and redesigning services and clinical pathways
- procuring new services
- ensuring provider performance
- managing risk
- ensuring good governance
- supporting the public/ patients/ carers' involvement planning
- allocating priorities
- maintaining safety
- safeguarding vulnerable adults and children
- monitoring outcomes
- implementing and communicating change and audit

In summary therefore, at Board, local service commissioning level, and commissioning support organisation level, nurses have the clinical, technical and local knowledge that commissioning groups will need to deliver improved outcomes in these challenging times. They are in a position to assist with the identification and mitigation of key risks (in terms of both individual health and the overall health system), because they know individuals and families well, understand how delivery systems work, and are used to engaging with a wide range of communities and backgrounds. Specialist and community nurses in particular, have a deep knowledge of vulnerable groups (to an extent that goes beyond their immediate health-related needs). As part of this, they are also accustomed to networking across professional boundaries – something which is going to become increasingly important with the development of CCGs . At the same time, they are fully aware of the need to comply with overall regulations, and understand the importance of transparent governance. Their voices will add value to the process and CCGs need to think about creative ways to harness these views.

How to maximise the nursing input to commissioning.

Nurses and midwives are as interested as other clinical colleagues in improving services for patients but also, like others, often do not recognise this as 'doing commissioning'. Those who attended the NCN workshops clearly did understand this, but also acknowledged that they are probably in the minority. They came from General Practices, PCT's, Public Health: community providers, professional bodies, and others. They travelled long distances, and some came in their own time. There was no lack of commitment, energy or enthusiasm, but they were also clear about what needed to happen to secure good quality nursing and midwifery advice for the future, and to ensure that they were able to get started, and find the right routes and contacts to begin to influence this agenda.

Those in the group that already had such a role in CCG's felt that they had been given only minimal time to do this, had no proper role/ job description, and didn't feel that the training and development package or formal support and supervision that was being offered to GP colleagues was equally available for them. Since PCT's and now SHA's have clustered, it is not apparent that anyone at a strategic level is responsible for overseeing the development of the new tranche of nurses in commissioning roles, and support can feel very distant. It was agreed that many CCG's will need help to clarify the role and responsibilities of their nurse leads, and select and recruit accordingly. SHA Chief Nurses traditionally sat as external assessor on the interview panels of all Directors of Nursing in their patch, but it was not clear if this standardised approach to the role would exist in future. Whilst some may see this as unnecessary bureaucracy, there is a danger that nurses will be appointed on their clinical performance rather than benchmarked against the requirements of a strategic role, and there is a risk that they will be set up to fail. CCG's (and ultimately patients) may never experience the very real impact nurses can have on their commissioning activities if they don't harness the skills of their nurses and other clinicians, and welcome them to the table as full and equal members.

Nurses and midwives in provider organisations may not recognise that they have a role to play in working with commissioners, and indeed many provider organisations will need to review their own ways of working if they are to be successful in a clinically led NHS. The Clinical Senates/Networks may well help to address this, but nurses will need support (in terms of time as well as more broadly) from their organisations to come forward, and step up to the mark, by sitting on these groups and being able to actively participate and contribute to the wider agenda of service improvement and clinical redesign. Whilst the function and responsibilities of Senates and Networks are still unclear, the NCN welcomed their development and hoped that they too would be vehicles for multi-professional leadership.

The NHS Commissioning Board and the Nursing Contribution

It is also worth remembering that under the future arrangements the NHS Commissioning Board will itself be responsible for commissioning a range of services including national specialist services, prison health services and, most crucially, primary care services themselves. The NCN believes that all the arguments for nursing and midwifery leadership outlined within this paper apply to the NHS CB and its future national and regional structures

In addition the NHS CB will be responsible supporting the development of CCGs as well as the more formal processes of Authorisation and on-going assurance of CCGs and therefore will need the appropriate expertise to undertake these key tasks.

Recommendations

The Nurses in Commissioning Working Group have drawn up the following set of recommendations to aid CCG's and the wider system to think through the next steps. The NHS Alliance Nurses in Commissioning Network will continue to grow and offer practical support and expertise to nurses and CCG's who wish to contact them. The recommendations are as follows:

Overall recommendations

- Nurses who become part of the new commissioning consortia need to access tailored development programmes, including leadership as well as an enhanced commissioning skill set;
- To achieve this role they need to be afforded equal status on the Board and given parity in terms of time and remuneration with their CCG colleagues;
- That the NHS CB ensures that assesses the reality of nurse and wider clinical engagement and leadership within the authorisation process and continues support it throughout CGG development
- That the NHS CB also models this leadership in its own operating framework, structures and leadership

- In order to be able to model, develop and sustain clinical leadership at all levels and across all disciplines, it is important that a CCG uses the multi-disciplinary Board to undertake talent spotting and create succession plans to ensure sustainability of expertise for the future;
- Provider Trusts need to recognise the value of their staff supporting the commissioning process-conflicts of interest need to be managed but involvement is crucial to ensure the best service for patients;
- The opportunities and benefits of collaboration need to be understood and supported at all levels of the decision making process. Consortia should invest in developing an organisational culture that models collaboration with partners and patients with wide representation at all levels of commissioning (from service to pathway to Board);
- Whilst CCG's begin to welcome nurses to their groups, it is imperative that nurses step up to the mark, recognise their responsibility to contribute, and embrace these new opportunities.

Recommendations for Cluster PCT Nurse Directors

- The current Cluster Nurse Directors need to work collaboratively with emerging CCGs in influencing and promoting nursing input into those groups, helping them to design the roles if required, and identify potential;
- The Nurse Directors should provide mentorship and support to nurses taking up their first Board role.

Recommendations for CCG lead nurses

- CCG lead nurses should be confident about their contribution and be clear at the outset of the roles and responsibilities before they take up their post;
- They need to ensure that they will have an identified development plan to meet their needs, and access to on-going development and support;
- Their remuneration should reflect their role, time commitment and remit on parity with their colleagues on the CCG. This time commitment must be realistic to enable them to discharge their responsibilities as described in their job description.

Conclusions

The NCN welcomes the Government's commitment to put patients and clinicians at the heart of decision making in the new NHS. However it believes that unless active steps are taken to ensure that the rhetoric of 'clinician' becomes the reality of 'multi-professional' than the potential to deliver the best possible care for patients will not be realised.

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