With such an NHS staff shortfall, who will work on the ‘mothballed’ wards?

I was interested to read your article about Lord Carter of Coles’ report on saving the NHS £5 billion a year (analysis, February 17). However, the article and Lord Carter’s report fail to mention the £4.5 billion wasted on the NHS internal market, which adds nothing to patient care according to independent and parliamentary reports into the NHS since 2010.

Nor does Lord Carter refer to the huge amounts spent on management consultants running, for example, Healthier Together and ‘vanguard’ exercises around the country, whose aim seems to be to close down services and reduce their accessibility – not to mention the inquiry into junior doctors’ morale, following their protests, which is rather like an arsonist asking people who have been run over by a fire engine why they are looking a bit fed up.

Lord Carter’s report also referred to slack attitudes in the NHS, where office space has been expanded while wards have been ‘mothballed’.

The Office for National Statistics has just published a report. It says the NHS is short of 50,000 staff, begging the question of who will staff these ‘mothballed’ wards. Patients need not only wards, but nurses, doctors, physios, occupational therapists, porters and clerical staff. I am concerned that Lord Carter’s quest for efficiency will mean further staff cuts and a dilution of the skill mix, as care hours include those of a healthcare assistant (HCA).

HCAs do valuable work, but studies repeatedly show that qualified nurses give better care – and give patients better outcomes.

We should not be thinking of the NHS as a drain on our resources. For every £1 spent on health care, the wider economy benefits by £5. We should be thinking of it as an investment, and as a mark of a civilised society.

Karen Chilver, palliative care clinical nurse specialist, London

NURSE ROLES SHOULD NOT BE AT THE ‘WHIM OF THE POLITICAL CLASS’

If assistant practitioners are doing the work proposed for nursing associates already then fine, but let us formalise who is responsible for what, right here and now.

So great is the debate about which healthcare professional does what for patients that I am getting confused. If I am getting confused when I have been a nurse for 40 years, what chance has a patient in all this?

To clear all confusion, let us ensure that training, education and importantly regulation are standardised so we know exactly what skills we have.

But my question to nursing leadership is this: why has it been left to Shane Byrne (letters, February 17) to highlight the duplication of responsibilities? Surely our leadership should have a strong and forthright voice in what might be a fundamental professional shift? That said, if Wales can bring in a law that mandates safe nurse staffing levels, then surely that is where we should be starting? Only when we have determined this in workforce planning terms can we possibly look at roles other than nursing.

Let’s not get into yet another mess when we could, and should, ensure that whatever comes is done with the full voice and agreement of nursing, and not at the whim of the political class. If we do not engage strongly, it will be undoubtedly thrust on us and it will be too late.

Professor Kevin Davies MBE, by email

COULD ITALY’S NEW PRIMARY CARE MODEL BE THE WAY FORWARD?

I was interested to hear of Italy’s new model of care in managing chronic conditions. The country has the most rapidly ageing population in the world, and is confronted with an already overstretched healthcare system. Sound familiar?