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COMMUNITY PRACTITIONERS' &
HEALTH VISITORS' ASSOCIATION

Structural Changes in the NHS in Wales: a consultation document

These are the comments of the Community Practitioners' and Health Visitors' Association (CPHVA) in response to the above document.

The CPHVA is the UK professional body that represents registered nurses and health visitors who work in a primary or community health setting (district nurses, school nurses, practice nurses). The CPHVA is an autonomous section of the MSF trade union.

Ann Owen, Professional Officer Wales from comments received, has prepared this paper by our members working on all levels in the health service throughout Wales.

Introduction

The proposed agenda for the renewal and change in the NHS, heralded by the *'Improving Health in Wales – A Plan for the NHS with its Partners'* presents quite substantial challenges and opportunities for the professions represented by the CPHVA.

It is the Associations' wish that we are able to maximise the opportunities available to improve the services we offer to clients and thus improve the health of the people of Wales. In order to do this most effectively the NHS needs to establish a principle of real partnership from within the organisations as well as partnership with organisations without the NHS.

The CPHVA's response will concentrate on issues within the paper that have the most impact on the professions in its discharge of duty and the impact on services offered by our members to patients and clients.

The contribution of health visitors, school nurses, community nurses and practice nurses to the health improvement agenda must be the most well kept secret in Wales. We would like to take this opportunity to highlight the great potential that there is in the nursing workforce and how it can contribute to achieving the aims of the new NHS in Wales.

We welcome the emphasis on strong and cohesive leadership to take the changes forward and wish the consultation to note the findings of the review of Professor June Clarke's Assembly sponsored review of Health Visiting and School Nursing in Wales and its critique of the number of health visitors in leadership roles within Trusts and the detrimental effect this has had in the last few years on development of services.

We welcome the emphasis on a corporate NHS that tackles inequalities and provides the best possible service reflecting the needs of local populations. Community nursing, indeed nursing in general has a great deal to offer both the leadership and the partnership agenda. We would look towards full involvement of the nursing voice at all levels of governance within the new structures. Without a strong nursing voice the NHS will be in danger of relying on an over medicalised model of health care delivery that is not used to addressing the 'big picture' of health improvement, preventative health care and working with other social and voluntary agencies.

We very much welcome the emphasis on public health in this and other documents. Improving health is everybody in the NHS's business – doing this from a public health perspective has been the business of health visitors and school nurses for well over a century.

Local Health Groups

We have voiced many concerns regarding the development of LHG's. As an Association we welcomed their introduction and the principles underpinning their establishment. However we had grave reservations regarding what we believed were flaws in the original Guidance establishing the LHGs and the subsequent difficulties these flaws caused for nurses undertaking some of the very demanding roles within LHGs.

Accountability issues, time, compensation of Trusts and remuneration continue to be some of the problems that distract our members from their commitment to the LHG work. Nurses are generally very disillusioned with the present membership structures, the appointment procedures and the continual obstructions placed in the way of full participation by professional barriers.

We would hope to see a much more open and democratic structure to the LHBs. We feel that the appointment of 'Chair' should be open to the professions or lay person subject to Nolan principles. All appointments to the board should be open and the membership should reflect the diverse expertise needed on the new body to ensure that the proposed key accountabilities are fully met.

We agree that there is a need to have a balanced membership of the Board and to aid the meeting of the LHB's objectives there should not be domination of the board by those with a financial interest (or other direct interest) in the decisions that it makes.

The CPHVA appreciates that the Board membership cannot be too large, however a smaller executive would be able to balance a fairly large full board. It is good practice for LHB's to co-opt expertise when necessary and ensure robust liaison with the public and other interested bodies.

We would suggest that all members of the LHB should be subjected to the same stringent selection process that seeks to ensure that the composition of the Board is balanced and has the necessary experience to fulfil the functions of the Board. To translate the words of the Assembly's strategies into action the Board must have a basic understanding of wider community health issues; a basic understanding of the commissioning process and whole system health care delivery. At this present time in the history of the health service in Wales we feel strongly that an LHB board dominated by GPs would be unable to ensure success for the strategies.

The involvement of representatives of professional bodies as members should be considered as they already have mechanisms in place to ensure wide consultation and representation of their professional groups.

We agree that strong links should be developed with Local Health Alliances, but also to look further to other initiatives and areas that joint working and planning is being deployed effectively such as the Early Years Partnerships.

Health Visitors, Community Nurses and School Nurses have vast experience and expertise of working in partnership with communities and with other social and voluntary agencies. They are also key members of community public health initiatives such as Sure Start and their expertise in Health Needs Assessment is absolutely essential at the local level. It needs to be noted here that because of organisational constraints, lack of and poor leadership in public health at Trust level and an over emphasis on a medical model of health delivery, many health visitors and school nurses fulfil their public health role through voluntary work outside their day to day role at the Trusts.

For present LHG's to change and strengthen to be LHB's there will have to be a commitment to ensuring a robust infrastructure. Especially if they are to move from 'securing' community services to actually holding budgets and possibly delivering community services. We cannot afford to replicate problems in the new structures that community services encounter in the present system.

We welcome the exercise of evaluating the 'Integrated Trusts' and the creation of Pathfinder projects before any final decision on placing of 'community services' is taken and is pleased to be involved in these groups. We must be able to objectively evaluate the contribution of Integrated Trusts to the development of a patient focused health system that moves beyond the disease treatment and management model.

We believe that this process might well identify problems for community services with both the 'Integrated Trust 'model and the 'LHB' model and thus we need to be thinking creatively about the types of community services that we would like to see delivered in Wales and what are the organisational models needed to ensure effective delivery of those services.

Structures and organisations should be planned with the patient and local needs as being central to the service. The patient's progress through the system can be mapped and service planned accordingly. This approach breaks down obstructive sectional barriers and can allow for full integration of the social care and voluntary sector. It will also break down the barriers between primary and community care and secondary care. We need to be looking to other countries in the UK and to Europe for different models and then considering what is suitable for Wales.

Strategic partnerships for Health and Well Being

We very much welcome strategic partnerships at both the national and local levels. We agree that the local plans and strategies should tie in with elements of the Health Improvement Plans and the local health needs assessment. Assessing inequalities in health and health care should be integral to the strategies.

We feel that ideally the leader of this strategic partnership should be a pubic health practitioner/specialist (using the wider definition of public health specialist not restricted to medical practitioners).

We agree that for strategic overview of an area or 'health economy' there is no option but to bring LHB together in consortia. The securing of high quality support services both at the local LHB and the consortia level is absolutely essential.

However questions need to be asked regarding some of the placement of the Functions of Health Authorities. The support services allocated to the Consortia and LHBs would need to reflect their responsibilities in areas such as Child Protection.

It is assumed that this level will take on much of the responsibilities of the abolished Health Authorities and therefore the CPHVA strongly believe that the Health Economies team must have a nurse member and that nurse member has community /public health experience.

Public Health Services

We welcome an emphasis on public health throughout the structures document and in the recognition of the need for component parts of the new NHS to have access to specialist public health skills.

The acknowledgement the 'specialist public health skills' are wider than purely epidemiology and communicable diseases is at last moving Wales in the direction that the other three countries of the UK and indeed European public health policies have been moving for some time. Naturally the NHS will need to secure expert advice in communicable disease but this should be complementary to wider public health expertise at different levels of the service.

Ideally the CPHVA would like to see a 'public health nurse' at the Health Economy that is supporting a lead public health nurse at the Trust level and at LHB level. The nurse would work closely with the director of public health accountable to the CMO or indeed **be** the director of public health once the anticipated accreditation of non-medical public health specialists is secured.

We would see health visitors as the natural profession to take up these lead public health / nursing roles. In all four countries of the UK health visiting is seen as being a major contributor to improving health and to the broader social inclusion agenda.

The role of health visitors as **the** key public health resource was reaffirmed in the UK Government's response to the House of Commons Select Committee on Public Health (July 2001).

The UKCC is presently consulting on draft competencies for health visiting practice which are based on the principles of health visiting (CETHV, 1977) and on the current policy documents in the four countries. The main points considered by their report were the health visitors',

a) focus on social groups with the family being one social group
b) providing a service to address the factors that are likely to affect health and well being (i e often the pre-need stage)
c) acting as an interface between groups and individuals in the population and population based approaches
d) a health- focused perspective with health being treated as a process (not a state of being) and a consideration of health in its overall sorce-cultural context
e) developing the capacity and confidence of groups and individuals to improve their own health and well being
f) maintaining an openness to others' concepts of health and wellbeing and how they wish to live
g) ability to assess risk in complex situations
h) ability to develop effective relationships based on trust and openness
i) ability to work in a range of settings acting flexibly with other services
j) providing an accessible non-stigmatising service
k) Improving health provision for groups and communities.[i]

The National Assembly

The CPHVA welcomes a direct line of accountability between the Assembly and the LHBs and the Trusts. However from an organisational perspective this must mean an increased investment in nurses as leaders.

The are few nursing officers at Assembly level compared to the medical personnel within the health directorate. Considering the breadth of policy involvement of nursing and the size of the nursing workforce at large this is baffling and we believe that the nursing team at Assembly level needs to be strengthened substantially as a matter of urgency.

There will naturally need to be a robust nursing voice at the new primary care policy division and we need to have nurses at policy level that are enabled to fulfil both an advisory and a leadership role.

We need to ensure a robust and effective nursing voice at all levels of the new health service. Arms length health bodies such as the Wales Centre for Health should also have a nursing leadership/voice and presence.

The emphasis on organisational development is greatly welcomed as is greater accountability and development of NHS managers. Personal development plans should be the building blocks of the organisation and thought needs to be given to bringing together educational establishments and NTO's. There has been an acute and detrimental lack of strategic overview of the training needs and workforce planning in Wales. We would hope that these structural changes and the present reviewing of changes in the regulatory bodies of NHS professions will result in much better cohesion and clearer direction for professional development.

Finally, the CPHVA regrets the lack of a nursing voice on the Structures Task Force and the weak nursing voice on many of the other Task Forces and we would seek assurances from the NAFW that this oversight will not be repeated in future strategic projects.

ANN OWEN, Professional Officer, Wales
October 2001

[i] Requirements for programmes leading to registration as a health visitor, Consultation document, UKCC. August 2001