Evidence to the Pay Review Body
For Nursing Staff, Midwives and Health Visitors

Community Practitioners'
and Health Visitors' Association

Community Psychiatric
Nurses Association

Manufacturing
Science and Finance

September 2001

Community Values - Valuing the Community
Profiling Community Nursing

INDEX

CPHVA LABOUR RELATIONS

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Chapter One
INTRODUCTION

1.1 The Community Practitioners and Health Visitors Association (CPHVA)[1], as a member of the Staff Side of the Nursing and Midwifery Staffs Negotiating Council (NMNC) endorses the evidence submitted collectively to the Pay Review Body (PRB) by the Staff Side.

1.2 Our supplementary evidence looks at some of the specific issues for the 18,500 Community Practitioners and Community Nurses represented by the CPHVA, the Community Psychiatric Nurses Association (CPNA)[2] and Manufacturing Science Finance (MSF)[3].

1.3 Last year, our evidence:

- commented on the 2000 report of the PRB;
- set the context for the 2001 review;
- bought further evidence regarding the failure of Discretionary Points to meet their objectives;
- addressed recruitment, retention and morale;
- raised a number of grading issues relating to Community Practitioner professions.

1.4 This year's evidence:

- comments on 2001 report of the PRB;
- sets the context for the 2002 review;
- outlines the new primary and community care agenda;
- addresses recruitment, retention and morale;
- raises a number of grading issues relating to Community Practitioner professions.

CPHVA proposals

- a substantial increase for all Community Practitioners which we define as being above the cost of living and that will rest comfortably in the upper quartile of the range of salary increases for second quarter of 2002 in order to continue the momentum of the Pay Review Body in restoring nurses real spending power;
- measures to improve career progression and retention of skills for senior nurses including a review by the Office of Manpower Economics into the introduction of the position of Consultant Nurse;
- the consolidation of the remaining two Discretionary Points into the salary scale, with automatic progress through to the top point of the newly extended scale;
- follow up the helpful statement of the last two years regarding the clinical grading criteria with explicit recommendations on appropriate grading levels and in particular a C grade for Community Nursery Nurses.

[1]The CPHVA is a professionally autonomous section of the Manufacturing Science and Finance trade union (MSF).
[2] The CPNA is a professionally autonomous section of the MSF trade union.
[3] MSF represents over 60,000 professional, technical and scientific staff in the NHS.

Chapter Two
THE 2001 REPORT

2.1 The key recommendations for the CPHVA members of the PRB[4] report were:

- a 3.7 per cent uplift on the 2000-01 salary scales;
- a reminder to Trusts on their obligations under the nationally agreed grading criteria;
- the consolidation of one discretionary point into the pay ranges of Grades F to I;
- a 3.7 per cent increase in the flat rate elements of London Allowances, and on-call and standby payments.

2.2 The CPHVA initially issued a cautious welcome to the 3.7 per cent increase. With the fullness of time and the continued fall in the rate of inflation, the uplift looked more favourable. The 3.7 per cent figure was larger than the level of settlements being enjoyed by other employees in the economy and therefore represented a small step in restoring the relative spending power of nurses. Our seemingly churlish initial response was perhaps created by some unhelpful 'spin' from inside the Department of Health that focused on headline figures and over raised expectations that were not fulfilled by the report.

2.3 Our initial view was perhaps informed by a belief that the 3.7 per cent uplift may have been larger had it not been for the proposal by the Government to introduce a cost of living supplement for London and South East England. In the words of the PRB (para.1.32):

"*In the same pragmatic way, we do not consider that we can ignore the impact of these supplements ….*"[5].

This confirmed our fear that the Supplement was more about dividing the cake up in new ways, rather than baking a bigger cake and this in turn may have effected detrimentally levels of basic pay.

2.4 The CPHVA acknowledged the PRB's recognition that measures have to be introduced to retain senior nursing staff on the top of the scale grades F-I. However, this was done by consolidating one of three discretionary points into the pay scale. The remaining two still being open to discretion. This was in the face of overwhelming evidence from the Staff Side and the CPHVA that Discretionary Points had failed and were potentially discriminatory[6].

2.5 The recognition of the faults with this system were very much welcome. However, the consolidation by the PRB of just one discretionary point, whilst leaving two open for discretion was described by CPHVA Director Jackie Carnell as being "*an unsatisfactory half-way house*".

2.6 The effect of the recommendation was to boost the salaries of scales F-I with ones years service by between £420 and £450.

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[4] Eighteenth Report on Nursing Staff, Midwives and Health Visitors 2001.
[5] As 4.
[6] What's the Point? Discretionary or Discriminatory Points. CPHVA/MSF - June 2000.

2.7 The CPHVA noted the 3.7 per cent increase in London allowances and the Government's promised Cost of Living Supplement of up to £1,000 supplement per nurse towards housing costs, but is worried that this is not enough to solve the key public sector worker housing crisis in the metropolis. This is an issue recognised by the Government and the Greater London Assembly.

2.8 We also welcome the PRB's acceptance of our arguments around the question of affordability. The PRB said (Para.4.10):

"It is disappointing that much of the Departments' and employers evidence on affordability tends to give precedence to the Government's investment priorities for the NHS as a first call on funding, with the implication that the pay for staff should be somehow limited to what is left over. …. the Government's objectives cannot be delivered without numbers of qualified and well-motivated staff. Ensuring fair pay for nursing staff remains our primary role and we reject the idea that we should be constrained to a fixed funding envelope….. [7]".

2.9 On the attempt by the Health Departments and employers to link the PRB recommendation with that agreed by non-PRB staff, the PRB comment could have been taken from the CPHVA's own evidence (Para.1.29).

"The three-year deal for non-review body staff was part of that evidence ….. However, we find unacceptable the implication that our recommendations should somehow be tied to that agreement. We are required to apply our judgement to the question of fair pay for nurses. On whatever basis the award for non-review body staff was reached, it could not have been that of ensuring fair pay for nurses"[8].

2.10 In effect the PRB ignored an unofficial pay policy in the NHS and complied with its own remit. We congratulate the PRB on its bold statement of independence.

2.11 We welcomed the PRB's repeated recommendation that the nationally agreed grading criteria should be adhered to (Paras.3.74-3.75). As a result we are making progress in challenging grade drift.

2.12 We welcomed the PRB's recognition of the argument that we were making that Community Nursery Nurses (CNNs) where appropriate should be on a C grade. The PRB said (Para.3.76):

"We have noted comments from the staff bodies concerning the appropriate grade for Community Nursery Nurses. This issue was raised with us during some of our visits. In evidence, the Departments confirmed that where these staff met the national grading criteria for Grade C they should be so grade"[9].

2.13 The report further cited (para.3.77) Community Nursery Nurses as an example where bad practice has taken place in the application of the national grading structure by employers.

2.14 On quiet reflection the Eighteenth Report of the PRB had much to commend and we hope to build on this in the Nineteenth Report.

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[7] As 4.
[8] Ibid.
[9] Ibid

Chapter Three
CONTEXT FOR THE 2002 REVIEW

Agenda for Change: Modernising the NHS Pay System

3.1 The pace of the Agenda for Change (AfC) talks have now accelerated and will have moved from the technical stage to the negotiation stage by the time this evidence is submitted. We were right to question the ambitious initial deadlines for completion of the discussions as they have not been met. We are content that as a result the talks have been done 'better' rather than 'sooner'. The discussions have progressed in a true spirit of partnership that bodes well for future working relations both between Management and the Staff Side as well as between Staff Side organisations.

3.2 Because of the delicacy of the situation Staff Side Organisations are strictly adhering to confidentiality arrangements agreed during the discussions. Therefore we are not in a position to reproduce negotiating documents that may still change. However, we can in broad outlines give details of negotiations to date and help to begin to outline the shape of the new pay system.

3.3 The Job Evaluation scheme is progressing well and as a result we will have a pay system that is transparently fairer and equality proofed in so much that relativities will be determined by more objective factors rather than historical factors and gender based determinants. CPHVA/MSF has two concerns, firstly whether smaller or evolving nursing specialisms will be covered by the benchmark jobs. Secondly, during the process of assimilation onto the new pay scales whether some employers may still try to produce grade drift by using inappropriate benchmarks. We are still seeking to tackle these issues and understand that once the scheme is in place relative advantage in terms of salary uplifts in the future will be determined by recruitment and retention (R&R) factors and developments in clinical practice.

3.4 On pay progression the Staff Side is committed to developing a Knowledge and Skills (KSF) framework. This is a competency-based framework. Management have proposed that staff pass through the pay scale until they reach a KSF gateway at which point they will have to prove their competency at that level to progress further. The Staff Side has not agreed to a link between the KSF and movement through the salary scales. Technical work on the KSF is continuing. There is a very strong commitment to Continuing Professional Development (CPD) backed with access to training in the draft documents which is very welcome.

3.5 There are substantial differences with Terms and Conditions. These are not based on the principle of UK wide harmonisation of Terms and Conditions but on the detail. These centre on premiums and allowances for working unsocial hours. There are also some differences on items that will form part of the national agreement and those that will be discussed locally. However, we it is recognised that nearly all Leads and Allowances are likely to disappear as a result of the Job Evaluation exercise and as a result the pay system will be more transparent and hopefully as a result fairer.

3.6 CPHVA/MSF is hoping to see substantial progress in terms of coverage by the PRB of NHS professions. Unhelpful historical anomalies will be removed and whole groups of new staff will at long last be seen as clinical professionals. The fact that CPHVA/MSF have pursued this matter rigorously is a reflection on the value that we put on your work. This does open questions on how you will conduct your work in future years. The CPHVA very much welcomes the opportunity to submit written evidence and give oral evidence to the PRB and wishes to continue with these facilities in the new pay system.

3.7 We still have serious concerns about the Department's commitment to linkage between spines two (covering nurses, midwives and health visitors; Professions Allied to Medicine (PAMs) and the new PAMs) and three with spine one (Doctors and Dentists). In the context of the desire to establish a fair and equality proofed pay system for the whole NHS the attempt to treat any group differently on non-objective grounds which jeopardises the equal value pay agenda will ultimately prove to be self-defeating. This will be met with an appropriate trade union response.

3.8 We hope to conclude negotiations by early Autumn 2001. Then the matter will go for consultation amongst Staff Side organisations. Many organisations are not in a position to complete this process until Spring 2002 and therefore we envisage that implementation can only be phased in from mid-2002 at the earliest.

3.9 The employers in their evidence may suggest that this year's recommendation should not be too generous because of the potential cost of Agenda for Change. We would hope that modernisation of the NHS pay system should have been budgeted for alongside other items. The continuation in the trend of recent years of restoring nurses relative spending power will have the effect of reducing any additional cost of implementing Agenda for Change. Further many staff may not enjoy any benefits of Agenda for Change until 2004 and possibly even later.

Primary Care Trusts

3.10 On the 1at April 2001 124 new Primary Care Trusts (PCTs) were created. The new wave of PCTs brought the total number of trusts in England to 164, which means they now cover 47 per cent of the population of England. By 2004, all the population in England will be covered by PCTs. There are different arrangements for Wales, Scotland and Northern Ireland. The impact of PCTs cannot be underestimated since by 2004 they will have for at least 75 per cent of the NHS budget in England.

3.11 The biggest impact will be first felt for those who work in community trusts in England but those who are in acute trusts and mental health trusts will also have their working lives influenced by the development of PCTs.

3.12 For staff in community trusts which will be replaced by PCTs, the transfer arrangements which were first promulgated provide for full protection of terms and conditions under the normal TUPE arrangements. Equally important is the requirement of each PCT to fulfil the national requirements for the human resource agenda and objectives set for the NHS.

3.13 The 164 PCTs which have been established in England are essential to the government's proposals for the modernisation of the NHS. Part of that will be the outcomes arising from the Agenda for Change talks. There are some important implications in this for PCTs. They will be receiving transferred staff from community trusts and this may include more than one trust and health authority staff. As a consequence, there may be a variety of terms and conditions of service applying to different groups of staff within each PCT. The advice that we are giving representatives is that there should be no harmonisation of terms and conditions ahead of Agenda for Change.

3.14 PCTs will also be recruiting new staff and the clear recommendation in these circumstances is for new staff to be taken on with Whitley Council terms and conditions of service. There is no purpose to be served by PCTs developing their own terms and conditions and creating trust contracts of employment. This is backed up legislative provisions which enables the Secretary of State to require trusts to place staff on national terms and conditions of service which will be developed by Agenda for Change.

NHS funding

3.15 We are now witnessing the largest ever-sustained increase in resources in the history of the NHS.

- An extra £4.5 billion for the year from April 2001.
- A 29 per cent cash growth over the period 2000/04.
- A 20 per cent increase in real terms over the same period.

3.16 However, this welcome increase will still not bring the UK up to the average level of expenditure in other European Union countries.

3.17 Pressure will come to direct these extra resources to service provision at the expense of continuing the process of the last reports of the PRB to addressing the historic decline in the spending power of nursing staff. Firstly, this view ignores that in a people centred service such as the NHS, the contribution of staff cannot be ignored. The attempt by the Health Departments to juxtapose salary costs versus service provision was effectively addressed by the PRB is last years report. Secondly, in an era of relatively low inflation the NHS can use these greatly expanded resources to both improve the salaries of nursing staff and invest directly in other aspects of service provision.

Economic considerations

3.18 Inflation is comfortably low with the underlying index having remained below the Government's target figure for the whole of the previous financial year. The all items index for June 2001 is 1.9 per cent. The Treasury's inflation target for RPIX remains at 2.5 per cent and forecast to be at 2.25 per cent for the first quarter of 2002. However, independent forecasts are predicting that inflation is set to increase throughout 2001 and 2002[10].

[10] IRS Pay Intelligence.

3.19 Earnings growth remains buoyant at 4.5 per cent for May 2001 but compatible with the Treasury's forecast growth in the GDP of between 2.25 and 2.75 per cent. Independent forecasters are predicting earnings growth have peaked and will remain at current levels through to the second quarter of 2002[11].

3.20 Public finances have been in surplus for the last three years. The Budget surplus in the fiscal year 2000-2001 is set to be £16.4bn. This is expected to fall to £6bn in 2001-2002. Public sector national debt as a proportion of gross domestic product is set to fell from 36.8 per cent to 31.8 per cent in 2000-2001 and set to fall to 30.3 per cent in this financial year. Departments including Health are under-spending both in public investment and current budget.

Discretionary Points

3.21 Our arguments on Discretionary Points have been well rehearsed.

- Our Survey[12] highlighted the possible discriminatory impact of Discretionary Points.
- Trusts that implemented Discretionary Points based on national agreements often took the view that the difference between the six national criteria and the interpretation of existing G and H grade criteria was so slim that although it is evident that staff are working at this higher level no extra points were awarded.
- Others believed that the phrase 'discretionary' meant that they could choose whether to implement the agreement, whilst in reality the discretion was based on whether the criteria was met.
- Perhaps most importantly, the perceived need to limit their award due to cash limits in some employers, some applicants were 'failed' even though they met the criteria.

3.22 Last year the PRB also made a very apposite (Para.9.30) comparison between the lack of central funding for discretionary points and that for the cost of living supplements.

3.23 CPHVA/MSF is presently surveying the implementation of the revised agreement on Discretionary Points that consolidated one point into the salary scale thereby creating a new grade maximum. We fear employers are denying those who successfully applied for a Discretionary Point their award by claiming this has now been consolidated. In our view any Discretionary Point awarded should be over and above the new grade maximum.

3.24 The Office of Manpower Economics earnings data collection exercise indicated at the time that Discretionary Points were proposed that 49 per cent of Grade F nursing staff, and 75 per cent or more of Grades G, H and I were at the top of their Whitley pay scales. As a result they were dependent on the PRB recommendations for their annual pay increases. The PRB considered this an "*unhelpful constraint*" on the scope for career progression.

3.25 We simply ask have Discretionary Points helped experienced staff over this 'unhelpful' constraint? We believe that you gave us part of the answer with last year's recommendations that consolidated one discretionary point into the salary scale. Now is the time to put this scheme to rest and consolidate the remaining two points.

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[11] Ibid.
[12] As 6.

Cost of Living Supplements (COLs)

3.26 This is an initiative that conflicts with the partnership approach to creating a modernised pay system for the NHS. No doubt staff who have enjoyed the benefit of the Supplement are satisfied. However, we would suggest that is a far greater number of staff that are disenchanted. Their concerns are based on occupations that receive the Supplement, differences between registered and non-registered occupations that receive the Supplement and its geographical spread. We have cases of members undertaking the same job living and working in neighbouring counties and in one case getting the Supplement and in the other case not getting it.

3.27 A 'triple whammy' of discontent is possibly a first even for the Department of Health. Frustratingly there was no prior consultation with the Staff Side as we do have a certain amount of expertise in payment systems. The Supplement was obviously 'backloaded' with the criteria drawn up to meet the available pot of money. There may be a need for such a Supplement but this should be devised in another way with Staff Side involvement and fairer criteria in order to avoid creating as many labour market irrationalities as the Supplement tackles. The issue of local market supplements should have been focused within the Agenda for Change talks.

3.28 We sense your share our frustrations with such ad-hoc initiatives. Your comments in last year's report could have been written by the CPHVA. (Para.1.33):

"Overall we found that we could not give full informed consideration to the supplements when it seemed that the idea itself has not been totally thought through, and when staff bodies have raised a number of, on the face of it, legitimate concerns."

And (Para.1.34):

"In addition, the Departments asked us not to jeopardise the discussions on Agenda for Change by making changes to the existing pay structure. It is difficult to see how the proposals for Cost of Living Supplements sits with this request"[13].

HR Strategies and non-pay solutions

3.29 The Government has introduced a whole series of initiatives such as Working Together and Improving Working Lives that are intended to improve the recruitment, retention, morale, motivation and effectiveness of staff. The CPHVA welcomes many of these initiatives. We also welcome the fostering of greater social partnership.

3.30 The real problem is not what these initiatives are seeking to achieve, but whether it is actually being implemented in the workplace.

3.31 CPHVA/MSF has published a pamphlet[14] identifying 29 measures that Ministers have told NHS employers that they must implement by April 1st 2000. An associated survey of local staff representatives, which was not published, reveals a poor record of implementation of these various HR strategies.

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[13] As 4.

[14] The 29 Steps – MSF/CPHVA

3.32 This does raise serious questions about the capacity of local Human Resources to implement a broad swathe of new initiatives. The introduction of the Improving Working Lives Standard is a very welcome step forward and combined with NHS Professionals should make a real change to the working environment. These are a declaration of intent from the Department of Health that they want to move matters forward. However, once again the proof of this intention will be in the experience of the staff. We also understand the beneficial effect of any positive changes may take some time to work through and improve workplace morale. The CPHVA will work positively with employers to make this a reality.

3.33 In the absence of effective performance monitoring of new HR measures, it would be wrong for some to claim that there is no need for the PRB to be so 'generous' with this year's recommendations as many staff have yet to experience an improvement in the workplace environment. Besides many of the recent initiatives will simply bring workplace standards in the NHS on a whole range of HR issues up to the level of other modern employers providing a people based service to the public.

Consultant nurses, midwives and health visitors

3.34 The CPHVA has always feared that this new post would be introduced on the cheap and not benefit those working in Primary Care.

3.35 These fears have been borne out by a breakdown of the first two waves[15] of nurse consultant appointments, where the CPHVA estimates that no more than 20 of 232 (just 9%) are from Primary Care. This confirms our fears that the development of the post was driven by the medical model of health care, rather than the social model.

3.36 We also support the contention put forward in the Staff Sides evidence that many of these posts have been introduced on the cheap. The maximum of the grade for these posts garnered some positive press for the proposal but once the spin had died down for many Consultant Nurses there was little difference with the salary that they were already receiving as senior and experienced nursing staff. A survey of advertised starting rates for Consultant Nurses carried out by Health Service Report[16] revealed that 39 per cent of posts were advertised at rates that were below the grade maximum for an I grade nurse. Only 12 per cent were advertised at a rate above £35k per year. There were some regional fluctuations in the average minimum and maximum salary.

3.37 We asked Health Service Report to extract from the database the most current information of starting rates for Consultant Nurse posts as advertised during 2001[17]. It revealed the following information:

- Average minimum advertised salary is £32,757.
- Average maximum advertised salary is £40,288.
- Median minimum advertised salary is £32,760.
- Median maximum advertised salary is £40,000.

[15] Department of Health Press Releases 2000/0030 and 2000/0363
[16] Health Service Report: Issue 28 Autumn 2000 - 'Nurse consultants' pay - who gets what, and where?'
[17] Health Service Report Nurse Consultants Database.

3.38 The distribution of starting rates is as follows[18]:

Salary Range	Number of posts	Percentage
29,450 – 30,594	8	14%
30,595 – 31,754	0	0%
31,755 – 32,759	12	21%
32,760 – 33,764	9	16%
33,765 – 34,799	5	9%
34,800 – 35,839	16	28%
35,840 – 36,879	2	3%
36,880 – 37,929	2	3%
37,930 – 39,024	2	3%
39,025 – 40,149	1	2%
40,150 – 41,304	0	0%
41,305 – 42,509	0	0%
42,510 – 43,744	0	0%
43,745 – 45,050	0	0%

3.39 This may be part of a wider pattern of the undervaluing of senior women's pay in the NHS as evidenced by the successful equal value claim of a Regional Nurse Director which was backed by CPHVA/MSF (Buttigieg v NHSE).

3.40 This underlines the case we are making regarding the need to retain experienced staff by additional measures to advance career progression and our criticism of Discretionary Points.

3.41 The CPHVA is seeking a review by the Office of Manpower Economics into the introduction of the position of Consultant Nurse. This review will include looking at starting salaries, salary maximum, regional distribution of posts and variations in salary ranges, area of work such as primary care, acute or mental health, and equal value issues.

[18] **Ibid.**

Chapter Four
THE NEW PRIMARY AND COMMUNITY CARE AGENDA.

4.1 Over the last five years there have been many policy developments across the United Kingdom. Many have been country specific but all with a common aim to improve the health and well being of the population by targeting resources. This has included a significant shift to a more community development and public health orientated approach to services provided by health visitors and school nurses.

4.2 The changes in the NHS and primary care are about doing things differently. Taking into consideration what knowledge, skills and expertise is required to deliver care in the 21st century. This opens up new roles, new areas of responsibilities, new teams and new partnerships for Community Practitioners.

4.3 Health Visitors and School Nurses (as set out in National policies) will be expected to lead, delegate, and manage a team of others who's functions support the health enhancing activities of that locality or practice. These teams could be made up of clerical support, health care assistants, nursery nurses, community staff nurses and other Health Visitors or School Nurses. The concept could also embrace partnership arrangements with statuary and voluntary organisation.

4.4 Leading teams requires the Health Visitor and School Nurse to:

- Undertake a leadership programme, such as 'Leading an Empowered Organisation – LEO'.
- Understand Delegation and Professional Accountability.
- Being able to provide clinical supervision, undertake performance reviews (appraisal), and develop with the direct reports their personal development plan (PDP).
- Communicate effectively to the team and with local managers.
- Empower team members to develop their skills and expertise within a competency framework.
- Be able to set clear objectives within local priorities and audit/evaluate their outcomes.
- Understand change management.
- Embrace evidence based practice and clinical effectiveness.

4.5 Health Visitors and School Nurses will be the 'grass roots' public health practitioners. They will be expected to work with a defined population to improve the health of the individual, families and the community. The identification of health needs and agreed (with the individual, family or community) strategies to meet these needs will be essential. Health improvement measures will be key performance indicators in the future and the work that Health Visitors and School Nurses undertake will become an important contribution to the local plans.

4.6 In some PCT/Gs there is a move away from General Practice attachment to locality team working. This is to facilitate a community development approach to service delivery. The CPHVA fully supports this model.

4.7 Many areas are introducing co-operate caseloads as a means to manage the wide health agenda that needs to be addressed. This method of workload management gives individual practitioners the opportunity to focus on their areas of expertise, as well as maintaining the core functions of the services. The CPHVA supports this model of working when it is introduced to help meet the assessed needs of the population and is considered in the wider context of a whole systems approach to service delivery.

4.8 Nurse prescribing is part of the Health Visitor and District Nurse functions; this area of expertise is going to develop in the coming years and will have implications for practice. The CPHVA supports this development but appropriate, regular training and updating must be available.

4.9 Comprehensive health needs assessment of the local population will be required. Health visitors and school nurses are the appropriate people to lead on this activity with support from the Public Health Lead of the Primary Care Trust/Group, Local Health Group or Local Health Care Co-operative. Targeting services to those clients who are disadvantaged by working with them, their family and the local community.

- Health Visitors and School Nurses have a major contribution to make in the prevention, and the early identification of mental illness. They will also be providing primary interventions to the identified client groups.
- Domestic violence is a hidden health need that has significant health implications for the victim and any children who witness this distressing behaviour. Proactive support and the development of services for this client group will be a key focus for health visitors.
- A change in child health screening and surveillance is expected from the Department of Health.
- An increase in behaviour training programmes such as Parenting Groups, Sleep Clinics, Smoking Cessation, Life Style Groups and other as required.
- School Nurses will be running health clinic in those schools with a poor health status, the aim being to reduce the number of teenage pregnancies, to reduce the smoking population, to provide life style advice, and other health issues as identified in the school health profile.
- All clinical and public health practice will need to reflect the National Service Framework Standards, particularly those that impact on the community and primary care.
- There will be more nurse led clinics in the future with nurse undertaking diagnostic investigations and making direct referrals to a wide range of consultants and other professionals.

4.10 There are a number of Nurse Led Personal Medical Services (PMS) initiatives that are new models of service delivery to meet a particular client group or local community. The CPHVA supports these innovative models of care as they usually focus on disadvantaged groups such as the homeless, asylum seekers, isolated communities, or a poorly doctored area.

4.11 Other PMS models of primary care have focused on the General Practitioners, practice nurse and support staff working in a different way, to enable services to be targeted to the local populations needs. PMS plus has included the secondment of community nursing staff into the new service. Practitioners need to consider the PMS and PMS plus proposal carefully, if the changes are beneficial to the Patient then any personal anxieties must be set aside and the new patient/client orientated initiatives developed.

4.12 Sure Start programmes were set up to tackle child poverty and social exclusion. These programmes work with parents and parents-to-be to improve children's life chances through better access to family support, advice on nurturing, health services and early learning. Some health visitors are working as Sure Start co-ordinators, others are leading programmes, whilst others are providing interventions and support as required. The Sure Start model of practice is likely to become a norm in the future.

4.13 The public are being encouraged to take an active part in their health and management of any illnesses they may incur. NHS Direct, [NHS 24 in Scotland] On-Line technologies, Walk In Centres and personal expectations are changing the public's view of the NHS. All Practitioners in Primary Care will need to be aware of these changes and how to help people understand the important health facts.

4.14 The public are also expected to be involved in the decision processes about the priorities of health care in their locality. There maybe 'Expert Patients' used in the commissioning of services, there may be focus groups set-up to consider how to change current services. However if the public are to be involved in these changes, Community Practitioners need to influence, negotiate and respond to them.

4.15 As Primary Care Groups in England change to Trusts the nursing voice on the Professional/Clinical Executive Committee (PEC) and the Trust Board will change. The CPHVA would wish to see a minimum of two nurse members on the executive committee elected/selected by the body of the nursing workforce. One of these nurses would then be the nurse on the Trust Board.

4.16 The PEC will provided professional practice based information that will influence the development of the services, the staff and the organisation. The organisation is likely to have a Head of Nursing whom may lead on professional issues and be accountable for the provision of nursing services. We would advocate that this person be a co-opted member to the executive committee and the Trust Board. The same principles of nurse leadership and practitioner participation at Board level are the same for LHCCs and for LHGs

4.17 Integrated teams have been introduced in a number of areas as a means to cut management costs. However it is acknowledged that integrated teams (with recognition and remuneration for individual new responsibilities) can enhance service delivery.

4.18 In England there is an intention that Primary Care Trust will become where health and social care are organised and managed by one provider.

4.19 'Making a Difference' the English Health Department's proposals for strengthening the nursing, midwifery and health visiting contribution to health and health care (July 99) has as a key focus the need for all Community Practitioners to developing a nursing strategy locally. This should be undertaken with the organisation, a wide range of practitioners and others.

4.20 'Nursing for Health: A review of the contribution of Nurses Midwives and Health Visitors' to improve the Publics Health from the Scottish Executive describes new public health roles for Health Visitors and School Nurses.

4.21 This Chapter highlights a few of the key areas of clinical and public health practice that is changing and will impact on primary care and Community Practitioners. All of these must be underpinned by a good management of change strategy, which includes staff involvement, frequent communications and a reasonable amount of preparation and time for the implementation of the changes to take place.

Chapter Five
RECRUITMENT, RETENTION MOTIVATION AND MORALE

5.1 The CPHVA supports the broad thrust of the evidence submitted by the Staff Side. However, the problems facing the recruitment and retention of Community Practitioners are somewhat different in nature.

5.2 The CPHVA remains concerned that the Community Practitioner professions have markedly older age profiles than other nursing professions and that younger women are not joining the profession in sufficient numbers to counteract the effect of those older women going into retirement at increasingly lower ages than previously. The average age of Community Practitioners has increased from 47.48 in 1996 to 47.82 years in 2001[19].

Age Distribution of Community Practitioners[20]

	1996	1998	2000
Under 40	16	14	17
40-49	41	42	38
50+	43	43	44

5.3 The age profile of Community Practitioners is backed up by data from the Department of Health. As you can see Health Visitors and District Nurses have a more aged profile than nursing staff in general.

Age distribution of nursing, midwifery and health visiting staff[21]

	<30	<40	<50	50+
All nursing staff	15.5	33.0	29.5	21.9
Health Visitors	2.5	24.9	39.6	33.0
District Nurses	4.6	27.8	38.6	29.1

5.4 14 per cent of Health Visitors and 12 per cent of District Nurses are over fifty-five according to Department of Health NHS Hospital and Community Health Services Non-Medical Workforce Census (England: 30 September 2000) and therefore could retire at any time. This is an increase of 1 per cent in both cases on the previous year.

5.5 There is some doubt whether the number of training commissions will produce sufficient numbers to replace those who may choose to leave the service. These numbers are rising but much too slowly.

[19] The Health Visitor Omnibus: A Telephone Survey of 500 Health Visitors, Durdle Davies Business Research 2000.
[20] Ibid.
[21] Department of Health NHS Hospital and Community Health Services Non-Medical Workforce Census (England: 30 September 2000)

5.6 There has been a welcome increase in the trend of numbers eligible for Registration.

Specialist Practice and Traditional Community Programmes 1996-2001[22]
Numbers eligible for registration

	1996/97	1997/98	1998/99	1999/00	2000/01
Health Visiting	516	577	599	578	611
District Nursing	468	505	572	542	567
School Nursing	75	90	114	87	118

5.7 Only 709 Community Practitioners joined the UKCC's professional register (part eleven) in the year to 31st March 2000[23]. This is not sufficient to replace those who are leaving practice.

5.8 The CPHVA welcomes the strong emphasis now being placed on recruitment and retention in the 'Making a Difference' nursing strategy document and the setting up of the task force for each region to have responsibility for implementing these recruitment polices. The promise of specific career-boosting measures for Community Practitioners is particularly welcomed by the CPHVA. However, the Pay review Body said last year (Para.2.62):

"Overall, our interpretation of the evidence is that it would not yet be wise to claim that the NHS has turned the corner."

5.9 The Staff Side evidence makes some valid points about the ambitious targets in the NHS Plan for recruiting additional nurses to the NHS. This is relevant to Community Nursing because this is the pool of staff from which most Health Visitors, District Nurses and School Nurses are drawn. The latest Department of Health Vacancy Survey[24] reveals that there has been a deterioration in the Health Visiting and District Nursing vacancy rate in England over the last year. Whilst rates remain below many other nursing specialisms it should be remembered that these cannot be readily addressed by the Department of Health's current international recruitment strategy or there is no strong tradition of agency working in the Community.

5.10 Community Practitioners are facing a time of great change and have very little in the way of new resources to be able to deal with that change. The question of any new resources is not directly addressed in the National Plan, the focus of which is very much based on the acute sector.

5.11 The whole thrust many of the new Government initiatives, whilst being welcome, place a great onus on the commitment and professionalism of Community Practitioners who are a small section of the overall nursing workforce. Conspicuous from its absence from this process is any form of workforce planning on the number of Community Practitioners needed to deliver the Government's new health agenda.

[22] English National Board for Nursing, Midwifery and Health Visiting Annual Report 2000-2001.
[23] Statistical analysis of the UKCC's professional register November 2000.
[24] Department of Health Vacancy Survey March 2001.

5.12 Any cursory examination of the figures for the number of various Community Practitioner professions reveals that they have remained remarkably static throughout the period of the development of these new policy initiatives. Unless proper workforce planning takes place, there is a propensity to load these new policy initiatives onto the existing workforce. This is in a context where this workforce is ageing and sufficient new numbers are not coming into the service to replace those that are leaving will result in local services responding by prioritising across policy initiatives and in effect create a community form of the postcode lottery.

5.13 The CPHVA questions whether the old measures for determining the staffing levels (if such things exist) for Community Practitioners are any longer valid in view of the new additional roles that have been given. Unless this question is addressed that the Government runs the risk of putting existing Community Practitioners under a great deal of additional stress and thereby may unwittingly accelerate their exit from the profession.

5.14 The NHS Plan has heralded the largest sustained increase in funding in the history of the NHS. In the Plan are figures for increases in the number of staff. However, this has been back-loaded and resourcing decisions have determined the overall number of increased staff within quite broad definitions of staff.

5.15 Detailed plans of what specialism or the new balance between staff employed in the acute versus primary care sector has not been determined. This is an obvious gap between Government intentions and achieving the shift in resources that we know will improve health in the longer term. The problem for politicians is that they are faced with short-term political objectives and when the public responds positively to expanded nurse numbers in effect they typically reside in the acute sector.

5.16 The expansion of resources for the NHS means that both primary care and the acute sector can be expanded but at the same time we need to shift the balance of resources in favour of the former rather than the latter in line with the Government's healthcare strategy.

5.17 The Pay Review Body has previous questioned the CPHVA in oral sessions over the number of Community Practitioners that we believe are necessary to undertake the Government's new public health agenda.

5.18 Last year's Report said on workforce planning (Para.2.63): “We have been unable to establish from the evidence on NHS funding and the output targets, any explanation for the staffing targets or skill mix required. We reiterate the view we expressed last year, that it would be helpful to receive evidence on how output targets relate to workforce planning in the service.”

5.19 Quite. The CPHVA has responded to the PRB's challenge and is seeking to fill the gap by commissioning research into the number of Community Practitioners we believe are necessary to carry out the new public health agenda. We hope to have something tangible to report in next year's evidence.

Chapter Six
FAIR PAY, COMPARABILITY AND PAY PROGRESSION

6.1 Traditionally the CPHVA details in this section our evidence where we believe that employers have not applied the Clinical Grading criteria fairly and as a result grade drift has occurred. Equally traditionally the employers have denied that this has taken place.

6.2 The CPHVA welcomes the statements from the PRB in the last two reports that employers should adhere to the Clinical Grading criteria.

6.3 The Agenda for Change talks were established to create a properly evaluated and equality proofed pay system for the NHS or at least that is the theory. Therefore as a result one would presume that many of our grading concerns would evaporate with the introduction of the new pay system.

6.4 We hope that this will prove to be the case. However we also have some reservations that employers may still seek to distort the outcome of the talks. We have identified two possible problem areas. Firstly, some of the smaller nursing specialisms have yet to be evaluated. This may end in local evaluation and the problem that these nurses may be inconsistently or unfairly treated. Secondly, employers may choose inappropriate benchmark jobs in the process of assimilation, undertaking this on the basis of grade, rather than what someone does and in this way reproducing 'grade drift' in the new system.

6.5 This year we will once again identify inappropriate or unfair application of the Clinical Grading criteria, backing up this up with data to justify our claims and outlining steps we are taking to remedy the situation.

Community Nursery Nurses

6.6 Community Nursery Nurses are employed alongside Community Practitioners as part of skill mix in the community. The grading of these staff appears to be purely arbitrary, varying from trust to trust and the grades given do not reflect there level of qualification attainment or the value of their work as part of a community based team. This is confirmed in a survey of the MSF's Community Nursery Nurse membership, with the results from forty-one trusts showing a disparity in the levels of pay across the country in the NHS[25].

6.7 The Clinical Grading structure for Scale C applies to posts in which the post-holder provides nursing care under the direction of a registered nurse, midwife or health visitor. Community Nursery Nurses:

- provide care under the direction of a Health Visitor;
- participate in the assessment of care needs by surveillance of developmental progress through play; completing their own records, referring back to the Health Visitor as appropriate;
- promote positive parenting and participate in the assessment of the 2-2 ½ year old development checks;
- assist in implementing programmes of care unsupervised when demonstrating skills of appropriate play and play stimulation with children and carers within the home;

[25] **Bought In - Sold Out?Community Nursery Nursing in the NHS: CPHVA - March 1999.**

- support programmes of care established by Health Visitor such as sleep, toileting and feeding programmes;
- have a responsibility to be aware of child protection issues, the Childrens Act 1989 and may work unsupervised with children in need.

6.8 In the Government's White Paper, Saving Lives – Our Healthier Nation, Community Nursery Nurses are referred as being crucial players in family and community centred activities to promote health and prevent illness. They are being delegated to implement a range of health improvement activities to support this Government programme.

6.9 They are qualified (normally Cache Diploma in Nursery Nursing) to the level equivalent to an NVQ level 3 and recognised by UCAS as the equivalent to 2 'A' levels or BTEC National Diploma in Childhood Studies. Other nursing staff on a B grade do not have this qualification.

6.10 Community Nursery Nurses meet the clinical grading criteria for C grade.

6.11 CPHVA/MSF is undertaking a new survey of salary rates for Community Nursery Nurses and organising a series of seminars to put forward grading claims on behalf of our members.

Community Psychiatric Nurses

6.12 Research has shown that a greater percentage of the community mental health nursing workforce is graded at more junior grades than ever before. The 4th quinquennial national community mental health nursing survey of England and Wales, demonstrated that the grade mix of the workforce has changed markedly from that of a previous survey in 1990.

District Nurses

6.13 District Nurses who are qualified to an equivalent level as Health Visitors have seen their grading change dramatically. There have been many proposals to change the grading of District Nurses that have been cost driven grade mix, not health driven skill mix and this is why the number of G grade District Nurses has dropped dramatically in recent years[26]. These moves have left the profession feeling particularly demoralised.

Practice Educators (Community Practice Teachers)

6.14 These staff have faced systematic attacks on their pay. The Clinical Grading criteria makes it clear that H Grade is the appropriate grade for staff who are Practice Educators. The central role of the Practice Educator is to facilitate the post graduate students to attain professional competence through experience in practice.

6.15 Our most recent survey of 372 Practice Educators reveals that only 50% receive H grade permanently in accordance with the clinical grading criteria, 27% receive H grade when they have a student, 19% receive G grade and 3% receive other (not stated)[27].

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[26] See First Assessment p.75 - a review of district nursing services in England and Wales: Audit Commission - 1999.

[27] Protecting the grade: Community Practitioner Journal - October 2000 and included in Professional Briefing, Practice Educators preparing for new roles in the new NHS: CPHVA - October 2000.

6.16 Some employers are seeking to introduce mentorship schemes as means to replace, rather than complement, Practice Educators and avoid paying the H grade.

6.17 The CPHVA is successfully challenging the erosion of the H grade in a number of Trusts and ensuring that mentorship is complementary to the role of a Practice Educator. We will be re-issuing our professional brief and grading guidance. A meeting of Practice Educators is being planned for late Autumn 2001.

Practice Nurses

6.18 Practice Nurses remain employed by GP practices. Therefore, for many, their pay does not follow the recommendations of the PRB. They are not always given increments, nor are they always graded appropriately. Practice nurses in some practices are still experiencing difficulties over pay and conditions. Even though the PCG's have said in some areas that all nurses in the PCG should have the recommended pay award still some GP's have not taken any notice.

School Nurses

6.19 According to our most recent survey[28] 86% of School Nurses work term time only and as a result are often seen and treated as part time employees in the NHS. This is not equitable with other professions who work on a term time basis, such as teachers.

6.20 The training and competencies of school nurses are comparable to other Community Practitioners, yet School Nurses are employed principally on E (24%) or F (52%) grades with only 12% on a G Grade[29]. Taking into account the 'term time factor' of their work, this equates to remuneration on the level of grade D or E.

6.21 There are some regional fluctuations in grading levels that cannot be rationally explained by the Clinical Grading criteria.

6.22 The CPHVA is meeting Regional Nurse Managers to outline our case for a common training programme and grading for School Nurses and Health Visitors. The Scottish Executive has followed this approach and has created the post of the Public Health Nurse[30]. The modified Public Health nursing education programme will begin in the autumn to respond to new service demands. The Scottish Executive has increased the number of places available from 90 to 130 for the first cohort, that is 80 health visitors and 50 school nurses[31].

6.23 The CPHVA has been involved in producing a strategy for practice for School Nurses[32] to help promote discussion.

6.24 CPHVA/MSF will be issuing grading guidance as part of a grading campaign that will be launched later this year[33]

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[28] School Nurses Salary Survey 2001: CPHVA - June 2001.
[29] Ibid.
[30] p.29 Nursing for Health: Scottish Executive - 2001.
[31] Announced by Susan Deacon MSP, Scottish Minister for Health at the CPHVA Conference: "Public Health in Scotland - the Braveheart Solution?" 2001.
[32] School Nursing within the Public Health Agenda: CPHVA, the Queen's Nursing Institute and the RCN - 2000.
[33] Making the Grade: CPHVA - Spetember 2001.

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