

Nurses and the wider public health agenda

Introduction

This paper was originally commissioned, early in 2011, by the Department of Health from NHS Alliance, in order to inform and advise policy makers on nurses' role in the new commissioning arrangements within the wider public health context. The NHS Alliance asked its Nurses in Commissioning Network to lead the production of this document. In order to do this it held a series of workshops and involved nurses, midwives and health visitors working right across the current system including specialist public health nurses, nurses working in Primary Care as well as nurse leaders from PCTs.

Since the paper was originally commissioned some aspects of the commissioning reform landscape has changed. The Future Forum Report recognises that improvement in patient care is based on input from those closest to the patient, as well as the importance of clinical leadership and leadership skills. The Government response is also encouraging for nurses and midwives (and other health and social care professionals) with a new language of a health system led by a range of frontline professionals in partnership with the public, patients and carers. We see real benefits to patients (and the health system overall) in this involvement. The NHS Future Forum discussions have also resulted in the language moving from 'GP-led' to clinical commissioning, and recommends that nurses and other clinicians should be more involved. The entire healthcare system should be open to greater input from nurses and midwives, and put nursing and nurses at the centre of the way that health provision is organised.

However, not everything about this new landscape is entirely clear at present and this briefing hopes to inform policy-makers, CCGs and nurses about some of the key points, which should be addressed in order to make the new public health agenda benefit everyone. It focuses on nurses – including (and sometimes emphasising) community nurses, school nurses, health visitors, nurses working in specialisms such as cancer or stroke, mental health nurses and learning disability nurses. Many of the issues it touches on are also relevant to other partners delivering the public health agenda. Nurses are only one element and we recognise our contribution very much in the context of the whole.

This paper describes some of the key aspects of the new system, the key contribution that nurses are bringing and can bring to the delivery of the agenda and how that contribution can be maximised.

Background

The prime aim of the changes to the NHS is to put improving the health of the population front and centre of the new system. The reasons for this are in many ways obvious: every developed nation is facing an unsustainable 'tsunami' of need driven by;

- Demographic changes especially an aging population
- An explosion of long term conditions
- High cost interventions and technologies
- Implications for long term care and social care

In a response to this many nations are exploring ways not only to improve the quality and efficiency of the healthcare system, but also to reduce the burden of disease by focussing on improving the public's health.

In England this desire is being implemented in a number of ways including focus on quality, innovation and productivity and placing improving outcomes at the heart of the system. However it is in the area of public health itself that some of the most radical changes will be seen. This include

- Re-focussing the Department of State to refocus on Public health and to ensure that health and wellbeing are better delivered across government
- Providing dedicated budgets for Public Health
- Creating Public Health England – to provide national expertise on emergency planning and resilience as well as support to local PH arrangements
- Transferring the key responsibilities for public health at a local level from the NHS to Local Authorities
- Strengthening local accountability and partnership mechanisms via the establishment of Health and Wellbeing Boards (HWBBs)

The new public health agenda – covering the health and social care system and beyond – will require the whole system to move to a new set of cultures and behaviour, which engages patients and the public in a range of new ways that does not raise the spectre of either exclusion or the so-called 'nanny state' It needs to be led by professionals across the whole field of health, who see improving public health as 'their business'. Services need to recognise that every encounter has the potential to be a public health intervention; and it needs to be delivered in a manner that puts patients and the public at the centre of decision-making.

From both a commissioning and professional standpoint, clinicians need to maintain strong links with the wider public health agenda. In addition to a high level of competence in the technicalities and processes of commissioning, they will also need to be able to change the nature and outcomes of clinical interactions and behaviours. Ultimately, their responsibilities extend to the way patients and the public experience and engage with their own health and with the care system itself.

The Nursing Contribution to Specialist Public Health delivery

a) The Joint Strategic Needs Assessment

Getting the JSNA right will be crucial to helping the new commissioners and HWBBs make better decisions about how to improve the health of their populations. Nurses are in a critical position to contribute to improving the quality of JSNAs. This is not just because of their understanding of the individual but also at the community level they know the 'soft intelligence' which will add depth and richness to data within a JSNA. They see the families and the homes of the individual patients they visit and can also bring information about the *resident* as opposed to the *registered* population – about the wider community, across the boundaries of GP surgeries, and the potential public health issues which are emerging. They provide some universal services, such as health visiting and school nursing, which operate across social and economic divisions and which deal with a huge range of patients including people who are *well* (this is as important, in a public health context, as seeing those who are unwell). Nurses in the community see at first-hand what is happening to the changing population. In effect, every encounter is a public health encounter. They also work with marginalised populations such as those with learning disabilities, the homeless or sex workers; in fact the some of the most disadvantaged populations who have the most to gain from a focus on improving health outcomes and life expectancy.

The public discussion of NHS leadership – and in particular commissioning – needs to be extended to cover the full range of health care professions across health and social care. In practical terms, this means bringing the experience, knowledge and skills of the wider multidisciplinary clinical team in to inform the commissioning structures and their decisions. The full range of community clinicians – district and community psychiatric nurses, consultants, allied health professionals and other community workers – is central to the multi-professional system that informs the Health and Wellbeing Boards and to their ability to carry out the Joint Strategic Needs Assessments which are fundamental to their work.

b) The Specialist Public Health/Health Protection Nursing workforce

There are a number of branches of that are recognised as being part of the specialist public health nursing workforce. As well as health visitors, school nurses, and occupational health nurses there are nurses already working in sexual health services, infection control, immunisation services and health protection who are important components of the resource available to support the new public health agenda. It is likely that some of these specialists will be transferring with other Public Health function into the LA or PHE. LA will also retain responsibility for commissioning Substance Misuse services, sexual health services, children and young people's public health services as well as the broad range of public health services.

Many of these services are already delivered through new models that are increasingly shifting the focus from a solely 'medical' model to a wider, more social one, where 'lifestyle' is as – or more – important than 'symptoms'. The new arrangements consolidate this, with a significant area of health commissioning now moving into the heading of 'public health' and covering a whole range of specialists. This has the potential to provide enormous benefits to patients, but if it is to work most effectively it needs to be delivered specialists who understand this area. There is a risk that instead of overarching relationships and networks, different health areas will be isolated; and that the more vulnerable groups in society, such as children or people with dementia, will be treated as a standalone public function rather than integrated into the critical areas of commissioning responsibility.

Nurses are in a prime position to make these links, especially through a nursing leadership role which encompasses public health. In fact, nurses have always operated in this context, where practical relationships on the frontline of healthcare delivery are as important as the specific 'medical' care they provide. Nurses are centrally involved in programmes focused on family engagement and lifestyle change: for example, family nurse partnerships, and the national pilot programmes currently working with vulnerable families to improve the outcomes for children up to the age of five. In some specialisms, relationships with practitioners in completely different fields of social welfare are of paramount importance: for example, collaborative working between housing support workers and Community Psychiatric Nurses to keep a vulnerable tenant housed will prevent that person's health and welfare spiralling into crisis.) They have the skills and experience to build the relationships which are a key element of the new health agenda.

c) CCGs and the Public Health Agenda

In the sister paper to this the NCN* discusses the broader case for nursing engagement and leadership in clinical commissioning, however there are a number of specific arguments that are relevant to the delivery of public health.

Commissioners need to ensure that in working to increase choice they do not unintentionally create fragmentation as a result. While 'multi-agency working' has been a key part of all public health work to date, shifting the responsibility – and the funding – to the local authority's remit could potentially break this down. This is not a significant risk for services which offer a discrete episode of care or treatment to a patient with a defined end point: but it is a substantial problem for patients with long-term conditions and for a number of other services. The nurses and other health professionals involved in caring for and supporting long-term patients need the remit to ensure that seamless care is being provided across organisational boundaries. Similarly, district nurses, practice nurses and health visitors all operate at interfaces between different agencies. They need clarity, and accountability, about the way they work and how to continue to bridge the different agencies effectively.

In order to ensure that every clinical encounter is also seen as a potential health improvement then commissioners will need to develop ways to recognise, incentivise and reward such practice. There is a danger that a narrow focus on productivity could have opposite effect.

* [Involving Nurses in Commissioning- How to get it right](#)
[Nurses in Commissioning Network](#)
November 2011

Recommendations

- Health and Wellbeing Boards should make full use of nurses' contributions to a JSNA. As part of this, they should make it a priority to have a membership that models and reflects their objectives around integration.
- Both public health bodies and clinical commissioners need to invest time and effort into gathering 'soft intelligence'.
- Nurses and others need to commit to feeding back 'soft intelligence' to the relevant bodies in order to inform their decisions.
- Local plans need to address the specific needs of the people in that area – with both commissioners and providers engaging, early on, to discuss what is feasible in order to create 'bespoke' health provision locally. This should focus on ensuring improved health outcomes for traditionally marginalised groups.
- Commissioners should assess the risk of fragmentation in all their commissioning activities and actively work to avoid or mitigate this.
- Commissioners should ensure that they commission all services so as to ensure that the health improvement opportunities are both recognised and rewarded. This should also be considered by those responsible for developing tariffs.
- National guidance and best clinical practice should be shared through clinical pathways.
- Nationally and locally, there needs to be clear governance agreements and systems to support the commissioning of appropriate education and training for everyone involved in servicing the new public health agenda. This will require constructive, clinical challenge from commissioning nurses, who will have access to a wide range of clinical expertise and skill mix knowledge. Nurses across the country have close links to education institutions and other training organisations which can provide the training necessary to develop a workforce which has the necessary skills and competencies to deliver clinically safe services and individual care.
- Clinical commissioning boards should ensure that they are able to access a wide range of advice and expertise to ensure their contribution delivering the wider public.

Conclusions

Nurses are already at the forefront of delivering health improvement whether as specialist public health practitioners or as part of everyday care. If the aspiration and indeed the necessity to put improving population health is to be realised, then nurses need to be at the heart of both commissioning and delivery.

Members of the Nurses in Commissioning Network who contributed to this report:

Linda Aldous, Nurse Manager Partner, Bromley by Bow Health Partnership

Allison Arlotte, Specialist Practitioner/General Practice Nurse

Sandra Bailey, Senior Nurse Manager, West London MHT

Tina Bishop, Practice Nurse Supervisor, NHS Outer London

Denise Boyd, Director of Service Development, Pennine Care NHS Trust Foundation

Lisa Cheek, Divisional Chief Nurse, Surrey & Sussex Healthcare NHS Trust

Fiona Colins, Tissue Viability Consultant, Tissue Viability Consultancy Services Ltd

Jim Connolly, Deputy Director of Quality, NHS Northamptonshire

Filipe da Silva, Practice Nurse Representative, Imperial College Health Centre

Julia Dutchman-Bailey, NHS West Sussex

Kath Evans, Programme Lead Children & Young People Emergency Care Pathway, NHS Institute for Innovation & Improvement

Allison Ferdinand, Practice Nurse Supervisor, NHS Outer North East London

Rose Gallagher, RCN

Hilary Garratt, Executive Director Nursing Quality & Performance, Greater Manchester

Katherine Gerrans, Practice Nurse Representative NHS Tower Hamlets, Shadow GP Commissioning Consortium

Cath Gleeson, Nurse Consultant in School Health/Practice Nurse

Joan Gordon, Practice Nurse Representative, Lisson Grove Health Centre

Jan Gower, Lead Nurse, The Moat House Surgery

Alison Halliwell, Mental Health Practitioner, Fleetwood

Georgina Hicks, Deputy Director of Nursing, Camden & Islington NHS Foundation Trust

Kathryn Jones, Programme Director Modernising Nursing Careers, NHS London

Anna Jones, Designated Nurse Consultant Safeguarding Children, NHS Outer North East London

Donna Kinnair, Chief Nurse, NHS South East London

Vicki Matthews, MS Nurse Specialist, Southampton Neurosciences Centre

Sue Pascoe, Clinical Lead Consortium Development & Service Transformation, NHS Ealing

Alessandra Peck, Policy & Development Officer, The Queens Nursing Institute

Alison Pointu, Director of Quality & Safety, NHS North Central London

Lynn Poucher, AD Quality/Strategic Nursing Lead, North East Lincolnshire Care Trust Plus

Sarah Price, Head of Education & Development, Wye Valley NHS Trust

Bev Reilly, Quality Improvement, NHS Tees

Ann Riley, Nurse Clinician, Wirral PCT

Gill Rogers, Director of Primary Care Strategy, Londonwide LMCs

Yvonne Sawbridge, Senior Fellow Health Services Management Centre, University of Birmingham

Hilary Shanahan, Director of Nursing & Midwifery, Newham University Hospital

Louise Silverton, Royal College of Midwives

Jo Thomas, Chief Nurse, Surrey & Sussex Healthcare NHS Trust

Lizzie Wallman, Primary Care Nurse Lead, NHS Outer North East London

Jonathan Webster, Deputy Director Quality & Corporate Assurance, NHS Outer North West London Sub Cluster

Emma Whitford, South West Essex

Debbie Wright, NHS Central Lancashire

Babs Young, Representative of School and Public Health Nurses Association

Acknowledgements:

I would like to thank the Department of Health for providing the funding for the creation of this report. I would also like to thank: Julie Wood, Director NHS Alliance Clinical Commissioning Federation; Mike Sobanja, Chief Executive NHS Alliance; and Kay Locke, Head of Administration NHS Alliance for their support with the development of the Nurses in Commissioning Network and the production of the first of these reports.

I would also like to thank Radikha Holstrom for her expert assistance in the writing on the manuscript and her patience with our efforts.