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The Health/Well being Agenda in Wales.

In Wales the electoral system means that it is unlikely that any government is going to be able to impose its agenda by virtue of a sizeable, unassailable majority. With this in mind, involvement of communities in decision making has got to be A GOOD THING. I use community in its widest sense, to include communities of interest – nurses, midwives, opticians etc, charities, the elderly, young mums, diabetics, fishermen, builders, welsh speakers, as well as geographical/social communities such as Solva and Hakin or Pembrokeshire and Carmarthenshire.

One of the things that seemed attractive to me about the LHG and therefore one of the reasons I applied to become a member of the Pembs LHB Board was not just the recognition of the obvious; that good health depends on a multiplicity of inter-related factors, - education, housing, self image, employment status, income etc etc which can be summed up as 'well being', but that the Labour administration in Cardiff seemed to be setting up a system that was designed to address the problem.

It was a real attempt to ensure that the relevant organisations should work together to deliver 'seamless care'. The LHG would work with the Local Authority, the Third sector and with any others involved, both in the long term, strategically and in the immediate short term day to day delivery of the service, in an attempt to address the whole rather than just deal with the illness/need as presented.

Another founding principle was a recognition of the need to take decisions based on assessments of need in each area- to research and collect evidence, to consult with members of the public and to formulate policy and processes which would deliver a Health and Well Being service to meet the expressed needs of the community as efficiently as possible.

Thirdly, there was a recognition of the primacy of primary care in most people's experience of the Health Service and the importance of supporting, funding and delivering care as close as possible to where people live, preferably, especially for the elderly, actually at home. For most patients the divide between primary and secondary care was totally irrelevant except when diversions in the care pathway resulted in delays and inefficiencies in treatment and care.

Additionally, the importance of involving the practitioners in the planning/delivery process was recognised in that GPs and other professions allied to medicine were represented on the Group. They were able to inform the decision making process and to familiarise their colleagues with the work of the Group. This also encouraged exchange of information, awareness of other practitioners and an improved understanding of how all the parts relate to the whole.

These principles are as valid today as they were then and are given greater force by the urgency of the inequalities agenda.. We need to retain and strengthen those elements – keep up the efforts to secure integrated delivery , assess and respond to need as locally as possible, strengthen primary care and keep the professionals/practitioners involved. At the same time, as socialists, we need to include measures which directly recognise and begin to address the link between poverty and the inequality agenda.

Particularly in primary care, the nearer you can get the Service to the patient, the better. The closer a patient is to home, the better. We need to retain the community focus . If LHBs continue to concentrate on what services are needed and how best to provide them in the local context - local professionals and patients working together on new care pathways, then WAG can focus on Public Health issues and health inequalities.

Income inequalities are surely best combated through universal well funded services and redistribution of wealth best achieved through universal benefits and benefits in kind – free public services, free school meals, the removal of all health charges and raising the levels of child benefit and pension payments.

We need a system that encourages a questioning approach, responsiveness, co-operation and collaboration in the work force. There is a great need for a flexible responsive system to enable a truly patient centred approach and enable organisations and individuals to play to their strengths and be innovative.

We should re-commit to the Public Service ethos and encourage it to develop not just keep on delivering the standard service – we need to get away from the idea that the NHS is only good at the bread and butter stuff and if you want some really good jam you have to turn to the private sector. We should stop all further PFI initiatives and look for other more flexible ways of financing major projects.

The current system rewards efficient delivery which is a good thing but we should also reward innovative approaches and encourage their dissemination. In the same way we should value and reward quality of care as well as quantity, making staff partners in delivering quality rather than units delivering quantity.

Before proposing changes, we should look at what already exists and make sure it is fit for purpose, sufficiently resourced and staffed and being properly used. New structures may not always be necessary it may be more appropriate to change the way things are done, to change attitudes, to make the changes in response to patient need rather than administrative/professional requirement and use change incrementally to consolidate progress and build on success.

As the service develops and changes result, we need to get better at passing on what has been learned. We need to get away from the idea of change as something to be avoided, disruptive and stressful and therefore to be opposed, subverted or unwillingly tolerated. We need to foster the idea of the continuity of change, of change as positive development. We should make more use of legacy statements to inform the next stage of the change process with outlines of what was done by whom, why, how it turned out and how it might have been better so that change becomes organic and part of the process - an opportunity rather than a nightmare.

Staff Relations
We should work with the Unions to improve working conditions and to support staff. The Management/Staff relationship is often poor – staff think management don't care about quality and feel that they are not consulted about changes which directly affect them. Management suffer from the public perception that 'money is wasted in admin' and would be 'better spent on 'front line services'. Lack of capacity to respond to a variety of needs has been a perennial problem for the LHBs. We should recognise this deficit and ensure that staffing is adequate to support the administrative requirements of local, regional and national initiatives.

We need to do something which will involve clinicians in the change/reform process – they are often seen as empire builders, jealously guarding their preserve, resistant to change - we need initiatives which involve all NHS staff in positive moves towards integration and joint working and a more flexible approach to delivering patient focussed integrated care.

PPI
We must make a real effort to keep the patient/public at the centre of the whole process not just as part of the patient/doctor relationship, but part of the decision making prioritising process. Practises should be asked to demonstrate what they have changed as a result of patient comment. Boards should have to demonstrate that they have taken account of public/patients views on a range of issues including monitoring quality, needs assessment, deciding priorities etc

Boards and management structures need patient/public representative members whose job it is to represent that interest, to act as Champions, to ask, and keep asking 'How will this affect the public/patients?' what difference will this particular project make to the individual?

This also means that we need to keep the public informed and involved and we should acknowledge this by increasing funding for this work, offering incentives for innovative projects which result in real public involvement and in real change as a result of that involvement.

Accountability
We should examine the process by which people become non officer members of the various Management Boards. Local Authority representatives claim to be democratically accountable and therefore to carry more credibility than appointed Board members but low turn out and the high proportion of uncontested seats at Community Level does not give one much confidence in the system overall. Currently, LHB members arrive on the Board by a variety of processes - some have answered an advertisement and been interviewed, others are nominated by their professional colleagues, some are there by virtue of their role in another organisation and so on. If non - officer members are to hold Officers to account we might wish to consider a scrutiny system which enabled in depth analysis of decisions and outcomes akin to the Parliamentary select committee system

The extent to which GPs, Trusts and other professional groupings feel themselves accountable to their patients is questionable - and while many patients might accept that the GP/specialist was responsible for their treatment, few are prepared to hold them to account when things go wrong – even, perhaps especially, when the fault is apparently small and insignificant.

We should be working to strengthen the opportunities for patients and the public to complain about poor and inadequate service. It is still true that many patients are unwilling to register an official complaint, fearing that they will be struck off a GP register or that their hospital treatment or that of a close relative will be adversely affected. CHCs have a vital role in public consultation, monitoring of services and delivery and on behalf of patients. We should support and strengthen these organisations and encourage them to develop this work.

We need to shift the focus – management and staff tend to focus on and be responsive to the demands coming down from the national NHS despite the fact that every public document issued starts with a commitment to put the patient and or the public 'first' or 'at the centre'. They feel and are more directly accountable to the NHS than to the patients. This means that much time that could be spent in responding at a local level to local needs working with local communities, is in fact spent responding to national initiatives and meeting nationally imposed deadlines for the purposes of national government. Patients are not, in fact 'at the centre'.

This is not to deny the importance of the national perspective, or the duty of national government to ensure parity and equality of provision and as holders of the public purse, to hold organisations accountable. Nor does it deny the responsibility of regional, local and professional groups to work with National government . We need to address this balance. A system which brought managers/Board members face to face with patients/the public on a regular formal or informal basis might have positive outcomes.

Integration

Primary/Secondary Care

Proposals to integrate Primary and Secondary Care are long overdue and will help to remove the entirely unhelpful and artificial divide between the two. Single organisations with single budgets can only strengthen efforts to improve the patient care pathway and deliver a seamless service

Health/LA/Third Sector

We need to maintain and strengthen the link with LAs and the Third Sector in order to keep the integrated service/ holistic delivery notion alive. Joint needs assessment and planning processes have worked well in many areas and should be developed through pooled/shared funding arrangements to facilitate inter-agency working. We should ask LA s to appoint a Health/well being Champion whose brief it is to scrutinise policy decisions. Similarly LAs , National Government and Planning Authorities should be required to commission Health impact assessments of their policy decisions especially in such areas as public transport, advocacy and advice services, recreational facilities and social services.

Geography

The move towards regional units reflects the difficulties of delivering a range of services at county level in the rural environment. Economies of scale and the reduction of duplication of effort and staffing will be achieved and cross boundary work on public health measures and the inequalities agenda will be facilitated. However, this should not be at the expense of a community/locality focussed delivery of the health and well being agenda as assessed in each area.

Things to Do (Not exhaustive!!!)

Emphasise quality of service delivery over quantity
Welfare rights advice offices in surgeries
Abolish all NHS charges (including dentist and optician)
Incentivise integrated care
Support emphasis on local innovation
Focus NHS emphasis on community it serves not on Health Ministry
Set up system so that managers face patients and community
Incentivise collaboration between Gps and Clinicians to encourage Primary/Secondary collaboration.
Restore the school nurse – integrate this service with the local GP practices
Co-ordinate IT systems between different parts of the system to ensure effective patient record access and information transmission
Incentivise more flexible opening hours for GP Practises
More mystery shopper initiatives to check the reality against the policy
We need to fund and incentivise prevention not just cure
Well trained well funded universal Health Visitor service to support parents and under 5s.

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