Modernising Health Visiting and School Nursing Practice

An Account of the PHAAR (A Public Health Approach A Reality) Programme in Central Derby PCT

The PHAAR Development Team
February 2003
Professional and organisational change: “…it’s like walking through a maze whose walls rearrange themselves with every step you take” (Gleick, J 1987)

The Development Team

The PHAAR development team, responsible for writing this report, designed, planned, implemented and evaluated the programme. Specific responsibilities taken on by team members were as follows:

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**Annette Hogarth:** Formerly PCT programme facilitator, with day-to-day responsibility for the running of the programme throughout the pilot period.

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**Neil Brocklehurst:** Now Senior Lecturer at City University, commissioned as an independent evaluator to provide an external assessment of the impact and effectiveness of the programme.

**Graham English:** PCT Chief Executive chaired the project board throughout its 18 months of operation and other members of the PCT, including Sue Cox, Jenny Yates and many health visitors and school nurses also contributed significantly to the programme.
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Acknowledgements

We would like to thank the following individuals and organisations who supported us in producing this report:

Pat Cantrill and Maggie Boyd of Trent Regional NHS Executive Office who funded the programme and offered continued support and interest in the outcomes.

Kate Billingham and Monica Duncan at the Department of Health, who also supported the programme and facilitated the sharing of learning with others.

The Modernisation Agency who have funded the printing of this report.

Maureen Morgan for all her work with the Management Team and newly formed teams across the PCT in facilitating self managed team workshops.

Members of the PHARR project board who supported the programme facilitators and ensured that decisions made were approved by the PCT board.

Professor Ros Bryar, St Bartholomew’s School of Nursing & Midwifery, City University, London who kindly gave Neil Brocklehurst time to continue with this project and to contribute to the writing of this report following his appointment as Senior Lecturer at City University in September 2002.

Carolyn Clifton, Chief Executive, Eastern Leicester Primary Care Trust who enabled Annette Hogarth to have time to contribute to writing the final report following her appointment as Strategic Nurse Lead in September 2002.

Finally we would like to thank the health visitors, school nurses, staff nurses, nursery nurses and administration staff of Central Derby PCT whose ideas, enthusiasm and, at times, criticism of the programme helped to shape the content and process of change.
Foreword

This report details a programme that attempted and achieved real change – in working practices, in the impact of healthcare staff on health delivery and in the attitudes and capabilities of those staff - transformational change – modernisation.

The lessons for this PCT were undeniable and difficult – that change of this type is hard to map and plan, that it takes time, effort and perseverance at all levels, that not everyone agrees and that not everyone can see the (or even a) way forward. It is difficult, perhaps impossible, to get such processes ‘right’ so the processes themselves have to change and adapt too.

Real improvements were made and real risks were run. There were dilemmas at all levels – for staff, how to remain consistent with professional and ethical values and to create systems of prioritisation – for managers, how to encourage staff empowerment without doing this in a way which itself disempowers. Staff were not ‘trained’ but engaged in a developmental programme which proved to be challenging for some.

This report outlines the process, the theoretical model (complex adaptive systems theory), an external evaluator’s analysis and the changes that have resulted from the programme. It is an honest and open account which is intended to help others who try such change. I am sure the gains were worth the effort and commitment shown by staff, managers and facilitators. Nothing would have been done, and nothing achieved without each of their inputs, so this report is also one way to thank all those who have been involved with PHAAR and to recognise the support of other agencies, especially Trent Regional Office who were instrumental in establishing the programme and in providing supporting funds.

I hope you find this report informative and useful.

Graham English, Chief Executive – Central Derby PCT
Executive Summary

This report summarises and discusses the main issues arising from a programme designed to facilitate change in the professional behaviour and service delivery of health visitors and school nurses in an inner city Primary Care Trust in the East Midlands.

The programme was developed in response to major policy changes associated with public health practice in primary care in England, which were announced in 1999. Health visitors and school nurses were singled out as key players in improving health and reducing health inequalities at a local level. The programme was developed collaboratively between Central Derby PCT and the University of Sheffield and the aims were:

• To develop the new family/child centred public health role for health visitors and school nurses within a PCT and identify the key elements of that role;
• To identify what helps to make the change to this way of working possible.

Using a ‘whole systems’ theoretical framework and informed by the research evidence and theoretical approaches from the fields of change management, public health practice and changing professional behaviour, the programme was developed and managed over an 18 month period. The full report details the activities of the programme, discusses the issues raised during its course and presents the findings from the independent evaluation. However, the key findings from the programme are presented below and relate to three specific areas; the process of change and modernisation, the professional issues raised for health visitors and school nurses and the organisational issues which needed attention in order to support continued change.

The Change Process

The following elements were found to be especially helpful:

• **A whole systems approach** to planning and implementing change which anticipates both the potential risks and benefits of the change at a range of levels (e.g. organisational, managerial, professional and personal) simultaneously;

• **A programme which uses evidence-based and theoretically sound change management techniques** including a thorough environmental assessment, visioning, creation of a desire for change and comprehensive and pro-active action planning;

• **Active senior organisational support** for the change programme, which includes the chief executive and others members of the executive and non executive team;

• **A dedicated programme facilitator** with positional power and professional credibility to ensure the programme is operationalised effectively and sustainably;

• **High levels of fieldworker involvement** to ensure engagement and commitment to planned changes;

• **Diagnostic analysis** of the enabling and resisting forces to change at the outset of the programme;

• **Early and sensitive involvement of key stakeholders** (e.g. GPs and practice managers) but take care that their views do not override those of the fieldworkers;

• **Regular formal and informal learning and reflection opportunities** for field staff and managers throughout the period of change;

• **Early wins** to provide encouragement and support for further change;

• **Ongoing formative and summative evaluation**, of sufficient objectivity, to assess progress against expectations and to provide an honest account of how things might be improved;
• **An appropriate balance of challenge and support** to ensure continued enthusiasm and willingness to change, even when things become difficult;

• **A willingness to ‘have a go’** and do things differently, even if the way forward is not always as clear as people might prefer.

Be prepared for:

• A tendency for the status quo to predominate, meaning that large injections of energy may be required to prevent a natural reversion to this position;

• Challenges to become major dramas which then lead to a lowering of morale and fear of ‘grasping the nettle’;

• Opposing views from practitioners about the need for change. Do not assume that there is professional consensus, especially on major issues relating to policy and practice;

• Those most hostile to change rallying powerful forces to minimize the impact of change on practice;

• The need to adjust the pace and content of the change programme as unforeseen issues arise.

**Professional Issues**

The following elements were found to be especially helpful:

• **Community Health Needs Assessment** including work with local people;

• **Agreeing to stop as well as start**, in order to expand work in new areas, some existing work will need to be undertaken more efficiently, reduced, stopped or delegated to others;

• **The debate and identification of:**
  – custom and practice: evidence based practice, which things are being done because they always have been and which have been shown to be effective?
  – universal services: services targeted to need how much of the service will be delivered equally to all and how much targeted to ensure equity of outcome?

• **Work with others**, other agencies, new initiatives such as Sure Start or healthy schools and local people;

• **Shared workloads**, either working together in teams or working with corporate (shared) caseloads.

**Organisational Issues**

The following elements were found to be especially helpful:

• **Creation of appropriate organisational structures** to enable fieldworkers to respond flexibly to local needs within agreed local priorities and to ensure team accountability for practice;

• **Changing the distribution of staff** to ensure those communities with greater needs have higher resource levels;

• **Creation of multi-skilled teams** to create greater flexibility and cost efficiency;

• **Effective communication** to all involved and affected by the proposed changes;

• **Collective management of risks of change**, equally shared between different levels of the organisation.
Introduction

This report summarises and discusses the main issues arising from a programme designed to facilitate change in the professional behaviour and service delivery of health visitors and school nurses in an inner city Primary Care Trust in the East Midlands.

The programme, locally known as PHAAR (making a Public Health Approach A Reality) was one of four national pilots set up to examine the effects and implications of implementing recent changes in government policy relating to the roles of health visitors and school nurses (Secretary of State for Health, 1999; Department of Health, 1999: this is OHN and MaD). It was funded jointly by the former NHS Executive (Trent) and the host site, Central Derby Primary Care Trust and ran for 18 months from Oct 2001 to March 2002.

This report is divided into five main chapters:

**Chapter One**
– provides an overview of the development and key components of the programme.

**Chapter Two**
– provides a discussion of the key issues arising from the programme.

**Chapter Three**
– focuses on the outcomes of the programme as identified by the independent evaluation.

**Chapter Four**
– describes key initiatives which have either continued from the pilot or have emerged as a result of it.

**Chapter Five**
– identifies key factors which appear to be associated with effective change and which may be of benefit to others engaged in similar work.
Chapter One: an overview of the programme and its implementation

1.1 Background

The publication of ‘Saving Lives: Our Healthier Nation’ and ‘Making a Difference’ in 1999 confirmed earlier indications that the Department of Health was seeking a change in the role of health visitors and school nurses.

“We are modernising the role of health visitors to enable them to respond effectively to the challenge of the Government’s new policies. So we are encouraging them to develop a family-centred public health role, working with individuals, families and communities to improve health and tackle health inequality” (DoH, 1999a, p132)

“We need to develop the public health role of the school nurse too, building on the opportunities their contact with children and young people provide” (DoH, 1999b, p62)

However, despite these policy statements, many were unclear about the real intent for these professional groups. What was a ‘public health’ role and how was that different to the roles health visitors (HVs) and school nurses (SNs) were currently fulfilling? The growing number of voices requesting more detailed guidance from their regional DoH colleagues, led the then Regional Nurse Director at the NHS Executive (Trent) Pat Cantrill, to provide funds which led to the setting up of the pilot programme. Its aims were twofold:

1. To develop the new family/child centred public health role for health visitors and school nurses within a PCT and identify the key elements of that role.

2. To identify what helps to make the change to this way of working possible.

Ann Rowe was commissioned by the former NHS Executive (Trent) to lead the development and Central Derby PCT agreed readily to become joint partners (and funders) in the venture. This was an ambitious programme having many elements and influences on its development. The approach taken to the work is outlined below.

1.2 Approaches

The broad approach taken to the programme was largely developed at the outset. A specific theoretical framework (whole systems) provided the overarching context, with programme areas informed by available research evidence and expert opinion.

1.3 Theoretical Frameworks

1.3.1 Meta theory: Whole systems/ complex adaptive organisations

Systems thinking grew from original work by biologists in the 1920s when the inter-relatedness of the parts of a complex whole (or system) was recognised. This concept has been taken up by numerous other disciplines and has been applied to human interactions in a variety of settings, where the analogy of a living organism continues to be used (Morgan, 1997). Systems are recognised as having properties arising from the combination and inter-reaction of multiple parts, in addition to those arising from the constituent parts themselves (Senge, 1990). In terms of an organisation, systems thinking suggests that the various parts are inter-related and co-dependent and that effects can arise from this complex network itself.
Iles and Sutherland (2001) in their review of the evidence suggest that in relation to change management, systems thinking highlights that:

- A system is made up of related and interdependent parts, so that any system must be viewed as a whole;
- A system cannot be viewed in isolation from its environment;
- A system which is in equilibrium will change only if some type of energy is applied;
- Players within a system have a view of that system's function and purpose and players' views may be very different from each other (p17).

Plesk (2001) expands this thinking, proposing that the mental model of the organisation as a machine, developed by Fredrick Taylor at the beginning of the last century, is now outdated. Instead he encourages the view of the organisation as a 'complex adaptive system', where creativity and potential for change are found during interactions between the different parts. Therefore, to achieve change he advises creating an environment within which innovative behaviours can emerge. Such an environment can be created by establishing "...minimum specifications necessary to point the direction, set absolute boundaries, provide resources for generative relationships and give permission for trials of innovative approaches" (p7). This theoretical perspective provided the overarching rationale for the programme developed and heavily influenced its design.

1.3.2 Change management

The programme summarised here was intended as a transformational change process (Iles and Sutherland, 2001), in as much as the end result was unknown at the outset and its impact on both organisation and individuals was expected to be significant. A variety of management tools were utilised eclectically during the course of the programme. For example initial diagnostic analysis (see below) was informed by use of the force field analysis tool and a project management approach was utilised for identified sub-sections of the programme.

As this change process was not one sought by practitioners at the outset, initial reactions to it were expected to be varied. Senge (1990) differentiates between commitment, enrolment and compliance as levels of engagement with a change process. The programme facilitators aimed to have as many fieldworkers and PCT senior staff committed to the programme as possible, but expected that the whole spectrum of engagement would be represented.

1.3.3 Changing Professional Behaviour

The programme was also influenced by the growing body of evidence concerning changing professional behaviour. In their review of the evidence, the NHS centre for reviews and dissemination (1999) identified the following as likely to enhance the chances of success:

- a ‘diagnostic analysis’ of the initial situation to identify factors likely to influence the proposed change;
- a multi-faceted change process should be designed;
- the process should focus not only on individuals but also on the environments within which they practice.

All three of these elements were incorporated into the programme. There is less conclusive evidence that local opinion leaders could have a significant impact on their colleagues' practice. Nevertheless, partly to add to this evidence, it was decided to recruit local 'change activists' and so make this a formal part of the programme.

1.3.4 Public Health Practice

Evidence and expert opinion regarding the PH practice of health visitors and school nurses was also
utilised during the study. At the outset of the programme there was a dearth of conclusive evidence on the effectiveness of a defined PH nursing role, but there were a range of expert views on the content of such a role, often in conflict with one another (Cowley, S, 1999, Craig, 1998, Caraher, 1996, Goodwin, 1991). The common features of most commentaries were that strategies were employed to:

- Assess community health needs;
- Address health inequalities at a community level;
- Actively involve community members;
- Develop interagency partnership work.

All these elements came into play to a greater or lesser extent within the programme and influenced the expectations of all concerned regarding the nature of the expected public health role. Despite the lack of evidence for PH nursing roles as a whole, effectiveness evidence relating to many of the elements of PH practice is available. Arlbaster et al (1996), in their review of the evidence on effective interventions to reduce inequalities in health were able to identify a number of characteristics of successful interventions. Similarly evidence is growing on the effects of social capital, the positive health benefit derived from being a member of a ‘socially connected’ community (Cooper et al, 1999, Campbell et al, 1999). More specific evidence can be derived from a recent review of systematic reviews of public health nursing interventions focusing on health promotion (Scottish Executive, 2001) and a systematic review of the effects of targeted pre and post-natal home visiting programmes (Kendrick et al 2000). Both provide useful evidence of effective interventions and approaches. These reviews were used by programme leads and practitioners to influence the direction of the programme and plan for specific working practices.

1.4 Organisation of Work

1.4.1 Management of the programme

The programme was overseen by a project board consisting of Graham English, Chief Executive of the PCT, Maggie Boyd from Trent Region, the project leads and facilitator, a local GP, and a Trust Board Nurse. In addition a representative from the neighbouring PCT, a Social services manager and the programme evaluator were invited. This group was tasked with overseeing the programme and ‘ratifying’ key decisions taken on behalf of the PCT. A smaller ‘operational’ group met more frequently to share and discuss day-to-day issues and plans.

1.4.2 Project plans

Project plans for specific areas of work were created by the external programme lead for each phase of the programme and agreed by the project board. These had agreed timescales and named leads for each area of work in order to co-ordinate what was a complex and multi-faceted programme of activities.

1.4.3 Evaluation

The evaluation, which was ‘utilisation focused’ in its approach (Patton, 1997) was designed to both give feedback as the programme unfolded (process) and an indication of the results of the work at its close (outcome). The process evaluation played a key role in providing an independent view of the progress and difficulties of the programme and led to regular stock takes of plans and processes. Key outcome findings are presented in Chapter Three. The evaluation aimed to address three key evaluation objectives:

a. To determine the extent to which a model of practice based on the Vision for a public health approach to health visiting and school nursing had been adopted and operationalised by the PCT by the end of 2001.
b. To assess the level of satisfaction amongst key local internal and external stakeholders with the model and its implementation.
c. To appraise the effectiveness of the Programme as a means of achieving intended changes to Central Derby PCT’s health visiting and school nursing services.

1.4.4 Sustainability
Although the programme was funded for 18 months, it was always intended that this would only be a ‘kick-start’. At all times during the programme attempts were made to integrate the work with existing PCT structures and aspirations. On many occasions the PHAAR programme added additional impetus to already existing plans or acted as a catalyst to bring together various PCT proposals and working practises. As a result, although the separate funding has finished, the work of PHAAR continues as mainstream PCT work (see Chapter Four).

As the work commenced external support agencies such as the Modernisation Agenda and NatPact were not yet in existence and the Health Visiting and School Nursing resource packs were yet to be produced. We would advise those undertaking a similar change programme in future without additional financial support take full advantage of these supporting mechanisms.

1.5 Local Circumstances
1.5.1 Central Derby PCT
The PCT, which was established in April 2000, is responsible for an ethnically diverse inner city and suburban population of about 120,000. At the inception of the project it employed 250 staff, was responsible for 56 GPs operating from 16 practices and managed a budget of £84.5 million. For the last ten years Central Derby has been a focus of significant regeneration, reflective of its ranking of 65th most deprived local authority area out of 354. Poor health indicators include high levels of infant mortality (13.5 per 1000) and the lowest life expectancy in Southern Derbyshire. During the programme it employed about 30 health visitors and 7 school nurses. A major theme and challenge for the PCT throughout the pilot period was the implementation of a major change initiative during a period of unprecedented organisational growth and development. This turbulent backdrop to PHAAR provided an extremely challenging context for the work throughout its 18 month existence and is explored in some detail throughout this report.

1.5.2 Practitioners experience and skill levels
Like many other inner city areas the PCT had inherited a workforce of health visitors and school nurses who, through self assessment had acknowledged their low PH skill levels (see Chapter Three for more details). The HVs felt they had been given few opportunities to try new developments by previous managers, many practitioners had been working in the same environment for some considerable time (although within a different organisation) and the PCT was experiencing difficulties in recruiting new staff. As a result morale was low. The SNs, in contrast, had recently undergone a period of reflection and change. They, however, had longstanding feelings of being undervalued by managers, primary care colleagues and education staff and were dissatisfied with current grading arrangements.

1.6 The Stages of the Development
Programme development was undertaken in a twofold manner. The key elements of the change programme were agreed as a result of the review of theoretical perspectives and research evidence (see above). However, many elements of the programme developed in an iterative way in response to issues as they arose. Inevitably this sort of project does not have a simple linear progression. The expected end product was largely unknown at the outset, part of the purpose being to create and
describe new roles. In addition there were many unexpected twists and turns in the process, with
delays in some programme areas for reasons beyond the control of programme leads. Nevertheless
we have attempted to outline here the main elements of the programme in a logical and largely
progressive sequence.

1.7 Stage One: Preparing the Ground (15 months):

1.7.1 Visioning
The programme began with two ‘visioning’ workshops. All health visitors and school nurses were
expected to attend and were joined during the mornings by managerial and strategic staff from the
PCT. These workshops were designed to:
• Challenge the status quo (as dissatisfaction with the here and now is an impetus for achieving
  change);
• Create a joint vision, so gaining ownership and commitment from practitioners and service
  managers to proceed with change in an agreed direction.

During these workshops the new policies, expected professional roles and key elements of PH
practice were reviewed. Practitioners were asked to consider potential future challenges and
identify the strengths and weaknesses of current working practices. Practitioners then worked in
small groups to debate and agree a vision for the future that took into account the policy
imperatives, but also their own assessment of realistic and effective practice. The results were
remarkably similar, across both days. The key elements of the vision, which were to provide the basis
for the independent evaluation, were:
• Increased population-based rather than individually focussed work;
• Increased focus on addressing inequality, decreased amount of routine, universal service provision;
• Flexibility to work from and with the agenda of local communities responding creatively to areas of
  need;
• Increased inter-agency working;
• Contributing to strategic PH plans e.g. HiMP.

It was clear to all workshop participants that although there was broad consensus about key elements
of this vision, some staff questioned the appropriateness of the new policy direction. There were also
large question marks about the detail of the proposals developed and the best route to achieve the
desired outcomes within Central Derby. Practitioners also indicated clearly that some current working
arrangements would not be suitable for the future role (in particular GP attachment) and that they
wished to be able to “sort out our own problems” rather than defer all decisions to managers.

1.7.2 Diagnostic analysis
Following the visioning days, two half-day workshops were organised for a mixed group of senior
PCT staff and HV and SN practitioners. During these workshops participants were invited to identify
the challenges for the organisation arising from the change programme, consider the type of
organisation they would need in order to facilitate the more flexible working styles envisaged by the
fieldworkers and identify the local forces that would facilitate and obstruct change. This ‘diagnostic
analysis’ of the current position was used to modify and add to the existing project plan.

1.7.3 Change Activists
At this point ‘change activists’ (see above) were recruited. Four health visitors and two school nurses
within the existing workforce were “recruited” to this role. They were to be provided with
additional resources (i.e. backfill) to enable them to take on their ‘change agent’ role whilst
continuing to provide a core service to clients.
1.7.4 Stakeholder views
A number of presentations and informal discussions with other stakeholders commenced at this stage and continued throughout the life of the programme. Attempts were made to regularly update and consult with stakeholders such as midwifery managers, social services, lay PCT board members, primary care colleagues and Sure Start staff. This was critical from a ‘whole systems’ perspective, since it was evident that changing health visiting and school nursing practice would have implications for a wide range of local professionals and organisations.

1.7.5 Developing the vision
Following the visioning days a number of small working groups of practitioners were established to debate and develop the ideas and concepts agreed on the visioning days. The groups considered:
• School nursing and public health;
• Public health approaches to Child protection;
• Child Health promotion;
• Health Needs Assessment;
• Resource distribution.

This process took some time as the debates were rigorous and great attempts were made to make the groups as inclusive as possible. Overall, seventy eight percent of field staff were involved in these working groups. Others were kept informed of developments through regular lunchtime ‘update’ sessions, which also had good attendance levels (average of 70% staff) and regular bulletins.

1.7.6 Skills/learning
Three months into the programme a self-assessment audit of the skills of practitioners was undertaken using a newly-validated public health skills audit tool (Brocklehurst & Rowe, in press). This was used as a baseline measure in the summative evaluation and also to give an indication of the current skills deficits of staff. A varied learning programme was developed, in consultation with staff, using this information. This was multi-faceted, attempting to cover a diverse variety of learning styles (e.g. training days, informal workshops and seminars, a journal club and team-based facilitated workshops). The audit was repeated at the end of the programme (i.e. after 15 months). Results are presented in Chapter Three.

1.7.7 PCT managers’ involvement
During the initial period of assessment, discussion and professional decision-making PCT managers took a ‘hands off’ approach, encouraging practitioners to work things through for themselves. However, as the complex nature of the changes which were required began to emerge, managerial involvement increased significantly and became critical to the success and longer term sustainability of the programme. Some of the challenges this posed for the PCT’s limited managerial resources and capacity are considered in Chapter Two.

1.7.8 Public Health Team involvement
From the outset of the programme efforts were made to involve the PCT public health team in the work. For a number of reasons discussed in Chapter Two, effective collaboration took several months to achieve. By the end of the programme, however, health visitors, school nurses and specialist public health practitioners were working more closely together. This achievement was considered a major breakthrough and a key benefit of the programme.

1.7.9 Plans and decisions taken
The decisions taken by staff to effect change, as expected, impacted across the ‘whole system’ of the PCT. The major decisions for change are outlined below:
i. Teams
Many field staff involved in the programme recognised the value of working in teams and sharing workloads. There was also a management desire for teamwork as the PCT had already expressed an interest in the concept of self managed teams. Working in a team enhances decision-making and enables all staff to work to their strengths (West, 1994). This was considered essential if staff were to meet the demands of a Public Health approach. It was also anticipated that teamwork would increase efficiency, so enabling more time to be available for community-based work.

ii. Geographical areas
After a detailed review of current GP practice boundaries in Derby and a frank assessment of the advantages and disadvantages of remaining ‘attached’ to GP populations, the health visitors decided that they would be better able to carry out their new role with a defined geographical community. Plans were made to retain positive communication links with GPs that would not cause them undue difficulty. Planning and implementing this major change presented major challenges to the PCT and key stakeholder groups and is discussed in some detail in Chapter Two.

iii. Resource allocation
Following an audit, staff recognised that the current working arrangements were reinforcing the ‘inverse care law’ (i.e. those who need services least receive them most and vice versa). Insufficient weighting had been given to deprivation as a known associate of poor health and to the time resource required to work with non-English speaking communities. A crude ‘weighting formula’ was created which was shared with staff and the public health specialist team in the PCT. This proposed giving a greater geographical area to those teams working with less deprived communities. At the close of the funded programme the PCT board was actively taking this proposal forward.

iv. Standards to principles
On commencement of the programme the HVs and SNs were confused about the status of a number of ‘standards’, which they had inherited from their previous employer (a community trust). A number of the standards were outdated and some were felt to be too prescriptive. A key element of the new role was increased flexibility to work with local neighbourhoods on local health issues and field staff felt that prescriptive rules governing their behaviour were denying them the opportunity to work creatively. In addition the PCT managers were moving towards the concept of autonomous work teams, free to make their own decisions guided by some general agreement about priorities and principles. It was therefore decided to replace the standards with an agreed set of principles, which would guide decision making in the teams. These were agreed by the PHAAR board and the PCT Trust Board. Changing from rule to principle-based work proved to be a major challenge, not just for practitioners but for the wider organisation and is considered further in Chapter Two.

v. Targeted CHP programme
Practitioners were supported to review the evidence on child health promotion set out in the website version of ‘Health for all children’, (Hall, 2002) and decided to work more consistently to the recommendations laid out in that report. A programme of child health promotion emphasising a minimum universal element, with large variations possible dependant on the professionals’ assessment, was agreed after lengthy discussions. This again was assessed by the PCT Clinical Governance committee and agreed by the PEC and Trust Board.

vi. Health Needs Assessment
Following a review of all available local HNA material and a range of research evidence in the field, it was agreed that all teams would add to existing data regarding the health needs of the
neighbourhood they were to work in, in order to develop locally sensitive activity plans. The data generally missing was that of the views of local people and it was agreed that teams would concentrate on this area.

Work was also undertaken to review practice in relation to child protection, record keeping, post-natal depression, and decisions in relation to these areas were taken. A small trial of family health plans was undertaken (Garside, 2002) and a good deal of debate was undertaken regarding new working practices generally.

1.8 Stage Two: Beginning to Act (Ongoing)

1.8.1 Health Needs Assessment

Each team was offered a series of workshops to support their work on HNA. Facilitated jointly by the external project lead, the internal PH facilitator and a member of the PCT PH team, these workshops were designed to take the teams through a process based on the rapid appraisal model. Teams were encouraged to participate and enthusiastically created tools and methods for gaining the views of local people and staff from other agencies and voluntary groups. By the end of the funded programme, all teams had either completed or were nearing completion of local rapid appraisals.

1.8.2 Team decisions

As a result of the HNA work each team was expected to agree priorities and outline community-based programmes they were planning to undertake. A proposal form had been developed during the programme and each team was asked to complete these for each piece of work proposed. This was then to be confirmed by the PCT ensuring a two-way flow of ideas and information.

1.8.3 Corporate Caseloads

A number of teams began moving away from the model of individual workloads and priorities to an actively collaborative model of corporate or shared caseloads. Here fieldworkers identify a shared client group as recipients of their services and between them agree priorities, action plans and workloads. Practitioners choosing to work in this way reported raised levels of innovation and reduced stress levels and appeared to be a popular development amongst many health visitors in the PCT.

1.8.4 Team leaders

After considerable discussion and review of the evidence it was agreed that the teams should have facilitative team leaders to co-ordinate decision-making and action planning. The five posts were advertised nationally and filled with both internal and external candidates. Against a background of problems recruiting new staff, this was seen as a significant benefit of the programme, although the nature of their role was the subject of some debate, and is still being developed.

1.8.5 New initiatives planned

A number of new initiatives followed as a result of this work. Teams began to work more collaboratively with other groups of staff, both within and outside the PCT, and began initiatives such as; a women’s health group for asylum seekers, a messy play group, a fitness initiative for women in the Sure Start area, a teenage parent group and an exercise group for Asian women. This process of change was in its early stages at the conclusion of this project.

1.8.6 Organisational Change

Due to the need for PCT Trust Board agreement and the amount of consultation required the plans agreed for geographical team working have yet to be fully implemented. This has frustrated some field staff and raised anxiety levels generally about the impact of this change. Nevertheless, both the
PCT Trust Board will consider formal adoption of these arrangements early in 2003 and the majority of health visitors remain committed to this plan and feel it will increase their opportunities to work more closely with local people.

1.8.7 Additional Activity
In addition work continues to be progressed to:

- Implement the new child health promotion programme;
- Develop information packs for parents;
- Employ hearing test technicians;
- Work collaboratively with the healthy schools initiative;
- Provide IT training for all staff;
- Develop clinical supervision;
- Equip managers to facilitate empowered work teams;
- Continue to engage internal and external stakeholders;
- Develop leadership within the newly formed teams.
Chapter Two: Key themes and lessons learned

2.1 Introduction

A number of issues arose from the development and implementation of the PHAAR programme. These issues and the measures taken to address them are discussed on the following pages, together with summaries of key lessons learned.

This section of the report has been written using the evaluation data gathered through various methods, including:

- A pre and post public health skills audit of health visitors and school nurses;
- Six focus group interviews with key internal and external stakeholders;
- Four individual interviews with members of the project team;
- Participant observation of key meetings and events associated with the programme;
- Analysis of email correspondence with the facilitators;
- Documentary analysis of official PHAAR reports and papers;
- A practitioner evaluation event attended by 32 members of PCT staff which included 5 ‘user’ led focus groups (in addition to those listed above);
- Informal discussions with members of the project team.

Each area is discussed below with background and commentary on the issue alongside notes on the inputs made within PHAAR.

2.2 Primary Care and Public Health

2.2.1 Background

In describing the new role of health visitors as a ‘family-centred public health role’ and that of school nurses as a ‘child-centred public health role’, the Department of Health were restating their commitment to roles which encompassed both individual and family based work and community or neighbourhood programmes.

Public health is most commonly defined using Acheson’s (1998) words:

"the art and science of preventing disease, promoting health and prolonging life through the organised efforts of society"

A public health approach "takes the population as its starting point" (DoH, 2001, p11), assessing need, identifying health inequalities and planning and providing programmes that promote and protect health. This is at odds with current health visitor and school nurse practice, which commonly begins with individual or family rather than community or whole school assessments of need (Rowe & Carey, 2000). In order to aid acknowledgement of the change in focus the health visitors and school nurses were introduced to the ‘continuum for public health practice’ (DoH, 2001, p13), at the outset of the PHAAR programme. This model identifies the actions that can be taken by practitioners at a number of access points; community, neighbourhood/school, group and individual/family.

Immediately, however, health visitor members of the programme raised the issue of the dissonance between this approach and that which they, and their primary care colleagues, currently took. At the outset of the PHAAR programme the overwhelming majority of health visitors were ‘attached’ to GP practices. Each worked predominantly with individuals and families registered with a specific GP practice. This arrangement had ensured common ground with other primary care colleagues, but had made community based work difficult. GP practice ‘attachment’ meant that in many cases the
health visitors were seeing families who lived right across the city and into the suburbs. These families often lived in separate and very different neighbourhoods, making community concerns very different for each. Health visitors were unsure whether these disparate collections of families constituted a ‘community’ whose needs they could assess or whether they should look to develop links and work with a specific geographical neighbourhood. A small number of health visitors in Central Derby PCT had moved from GP attachment to work purely within the geographical boundaries of a Sure Start programme. These health visitors were already experimenting with new ways of delivering services and demonstrating how a public health approach could be provided using a ‘neighbourhood’ model. The debates around the best models for delivering the complete range of public health approaches continued between health visitors, GPs and practice managers through much of the first phase of the programme.

School nurses, working within a school-base had felt marginalized from the ‘primary care-led’ NHS of the nineties, but now felt themselves to be in a better position than their health visitor colleagues to undertake whole population work. They had always made contact with primary care colleagues when required and although they felt frustrated at the lack of knowledge of their work in primary care, there was no conflict of interest for them.

2.2.2 Measures taken within PHAAR
A number of measures were taken within the programme to highlight, debate and attempt to resolve these issues.

• Raising awareness within the PCT of practical tensions for health visitors between the demands of primary care work and the demands for community based initiatives;
• Ensuring both public health specialists and GPs were represented on the PHAAR programme board;
• The development of an alternative model within which HVs could maintain Primary Care practice whilst also developing Public Health approaches. This model proposed HV teams (resource-weighted for deprivation) with a geographical responsibility for community-based initiatives and a ‘caseload’ of all families with children under 5 years in that area. The teams would also maintain strong links with primary care colleagues, each having responsibility for attending GP practices regularly and responding to and initiating communication regarding children and families as necessary;
• Seeking and gaining the active support of public health specialists within the PCT for PHAAR and the activities of HVs and SNs;
• Communicating the population based inequalities agenda for the PCT to GP and other primary care colleagues and offering presentations of the work of PHAAR to PHCTs;
• Continually emphasising the importance of both community and individual public health activities to contradict the commonly-held misconception that public health solely concerned population-based activities.

2.2.3 Issues raised
Marrying the agendas of primary care as it is currently organised in this country with population based public health approaches is currently an issue for many PCTs. Primary care groups and the PCTs which followed were intended to "develop around natural communities" (DoH, 1998) and work with them to develop appropriate health care services. At the same time PCTs are charged with developing the services provided for patients registered with the GP practices sited within their boundaries. The functions of level 3 PCTs have recently been reiterated as
 a) To improve the health of the community.
b) To develop primary and community services.
c) To secure secondary care services (DoH, 2002b)
Recent statements on the new role of directors of public health appear to emphasise a concentration on neighbourhoods:

"The focus of their activity will be on local neighbourhoods and communities, leading and driving programmes to improve health and reduce inequalities" (DoH, 2002a)

However, a number of PCTs may be experiencing, as Central Derby did, a tension between planning local community health improvement programmes and delivery of these through a primary care structure that has many patients living outside PCT boundaries.

Within Central Derby PCT a large percentage of GP practice populations live outside the boundaries of the PCT, e.g. 40% of 0-4 year olds. This issue caused tension for PCT strategic planning of health care initiatives and the health visitors alike. Working universally with families of children under 5 years gives health visitors a unique insight into the concerns and health issues of this group of the population. However, many health visitors felt that they would be able to act on these issues more easily if they came from their contact with families in a specific geographical neighbourhood.

The issue of equity also informed this debate and the decisions taken. Equity in health is concerned with:

"...creating equal opportunities for health and with bringing health differentials down to the lowest level possible" (Whitehead, 1990)

Creating ‘equal opportunities for health’ often means offering unequal amounts of health care in order to redress the differences in health status created by differing life circumstances. Equity is not about equal services for all, but a fair level of service according to need. Some have labelled this vertical equity:

"..the unequal but equitable treatment of unequals" (Mooney, cited in Hanafin et al 2002)

On a community basis this means assessing which populations are more likely to suffer poor health on account of the well understood link between deprivation and health and weighting service provision to take account of this.

The position inherited by the PCT from the former Community Trust was one of inequity. In terms of local services, it was apparent that within the PCT areas of higher health need and deprivation were inadequately resourced by health visitors compared to more affluent areas of the city.

The decision to move HVs to a position of deprivation-weighted geographical team working with GP linkage, rather than continue with GP attachment, was taken to try to address these concerns. The positive experience of colleagues working with Sure Start and the imminent arrival of further Sure Start programmes also undoubtedly influenced the decision. The choice was difficult, with some GPs and HVs expressing concerns about the proposed new arrangements. Some were concerned about the cumulative effects of this change with the many others already facing primary care practitioners as a result of national NHS policy. It was critical to the future of the whole programme that these new arrangements had the support of the PCT’s executive committee and, after rigorous debate, agreement was reached to enable HVs to operate in the ways proposed. This event represented a watershed for the programme, a point that was noted later by the Chief Executive:

"...I was really pleased the extent like it felt in that meeting, that there was a sense that there were some real achievements here and there was something we needed to support and we need to make a change...clearly the fact that the change has happened substantially without it being catastrophic is actually a real achievement" (transcript 3, p29)

Work continues to ensure that GP colleagues in particular are satisfied with new communication systems before the final move to geographical family work is taken. A crude weighting formula
developed by the programme facilitators was refined by the PCT public health specialists and is being applied to ensure fairness of workload and appropriate targeting of resources. In the meantime health visitors continue seeing GP attached families, but each team has a designated geographical neighbourhood in which to pursue wider health promotion programmes.

2.3 Prioritisation

2.3.1 Background

Difficult decisions regarding priorities for the NHS have always been a feature of health care provision within the UK, where the budget available to the NHS has been limited (Mullen & Spurgeon, 2000). In recent years, however, the issues of rationing, equity of service availability, waiting list times and targeted services to address health inequalities have been more openly debated. Health care organisations are being asked to assess and be sensitive to local needs, ensure the use of evidence-based and cost-effective approaches whilst also responding to an ever-increasing number of centrally set detailed performance targets (Plesk, 2001). The balancing act required to incorporate these three elements into organisational action plans with clear priorities, is considerable. Primary Care Trusts (PCTs), as new organisations with responsibility for commissioning and providing services on behalf of their population, are exploring the use of Health Improvement and Modernisation Programmes (HIMPs) as a way of making priority setting explicit, both for their staff and for local people.

Health visitors and school nurses, as public health professionals, in many ways mirror the expectations now being placed on PCTs. They have always been expected to assess the needs of local people, and plan their service delivery accordingly (Twinn & Cowley, 1992) and both professional groups have increasingly been challenged to demonstrate the effectiveness of their working practices (DoH, 2001). In addition both groups have experience of the challenge of attempting to meet these two requirements when their actions are determined by a range of ‘rules’ (standards, protocols, guidelines etc) which effectively govern their behaviour and limit their freedom to respond creatively to assessed needs.

In their initial visioning activity HVs and SNs within Central Derby highlighted the issue of prioritisation. They expressed a desire to have fewer tasks that they had to carry out with each family, leaving them with more flexibility to assess need and target their efforts with families accordingly. They felt that they were currently providing some services according to custom and practice rather than need and that this time could be used to expand their role into the community setting, particularly in deprived neighbourhoods. As their employer, the PCT wished to find an approach that enabled this responsiveness and encouraged creativity and innovation, whilst also ensuring good quality service provision and responsiveness to local and national targets. In line with ‘Shifting the Balance of Power’ (DoH, 2000a) they were keen to devolve authority for decision making to the frontline staff that they believed were best placed to make decisions regarding neighbourhood needs and priorities. Both practitioners and managers alike were committed to addressing inequalities in health and expressed the view that those population groups suffering the most ill health and risk of future ill health should be a priority for both resources and effort.

2.3.2 Measures taken within PHAAR

The measures that were taken within the PHAAR programmes to address these issues were:

- The establishment of skill-mixed teams with facilitative leaders which would become increasingly self-managing over time. The teams would have an allocation of staff weighted in accordance with the relative deprivation of the neighbourhood served. This enabled some strategic targeting of resources to need;
- The introduction of joint working in teams would ensure some peer ‘monitoring’ of performance, so aiding the assurance of high quality services;
• The replacement of the accumulated standards and regulations with a set of principles to guide
decision making, both day to day and on a strategic basis;
• The agreement that teams would assess the needs of their local population, develop plans with
others to address these and agree these plans centrally with the PCT strategic planners. This would
ensure that team plans were contributing to local and national plans and targets;
• The development of an evidence-based guideline to confirm the minimum contact individual
families were entitled to receive from HVs and SNs;
• The decision to delegate current HV/SN tasks to others in skill-mixed teams e.g. hearing screening;
• The introduction of an external facilitator to work with PCT managers and team leaders on
developing self-managing teams.

2.3.3 Issues raised
This issue created complex difficulties for both the professionals involved and the organisation as a
whole.

The professionals
Although many of the frontline professionals in Central Derby had expressed a desire for more
autonomous decision-making regarding priorities, moving to this position caused some great
difficulties. A few practitioners had a fundamental disagreement with the principle of targeting
resources to areas of deprivation, preferring to offer an equal service to all, whilst the majority
struggled with the day-to-day aspects of managing the change to this position. Arrangements had
been made for staff to share decision-making about priorities and plans within teams, with final
team plans ‘signed-off’ by the PCT managers. Nevertheless practitioners were the ones who had to
change their perception of priorities, negotiate with families who were to receive a reduced service,
become members of a new team and share working practices that had previously been very private.
This was a difficult process and will take some time to become an everyday part of working life for
the staff involved.

The Organisation
For the PCT as a whole priority-setting and appropriate resource distribution also caused challenges.
Everyone involved needed to be clear about the rationale for moving resources in the face of
opposition from some primary care staff. Managers had to walk the difficult tightrope of giving
frontline staff increased decision-making powers, whilst ensuring that the decisions taken were
robust and in line with PCT priorities. The challenges involved in making evidence-based decisions
regarding the best use of resources was demonstrated to senior managers through the process of
reviewing hearing test procedures. This required a complex process of reviewing evidence,
comparing this with current provision and ratifying recommended changes at PCT board level. As
with the decision about geographical working, it was essential that the PCT as a whole was
supportive of redistribution of front-line staff resources and the approach taken has provided a
workable model for other such difficult decisions which will no doubt arise in future.

2.4 Learning
2.4.1 Background
Much of the culture of NHS learning and teaching has been founded upon a “training” model,
where practitioners are offered information and/or skills. Many of the practitioners in PHAAR had
been used to this approach and had an expectation that new learning would come from just such
training rather than workplace discussion and debate.
Influenced by Senge's (1990) work on learning organisations, the frameworks that were used to advance learning in PHAAR were the core disciplines of personal mastery, mental models, shared vision, team learning and whole systems thinking. Adult learning, with its emphasis on the creation of self-directed learners and experiential learning, was key to this approach. Opportunities for problem-centered learning and reflection on real experiences were taken whenever possible to develop skills and understanding. (Knowles 1984).

2.4.2 Measures taken within PHAAR

- A skills audit tool (reproduced in DoH, 2001) was developed to assess practitioner competence/confidence in relation to the new roles and a needs-based learning programme for practitioners was created to enhance skills and confidence levels;
- Use of reflective techniques in group discussions;
- Written summaries of discussions for all practitioners;
- Creation of a multi-faceted learning programme following PH skills audit;
- Use of reviews of evidence within group debates;
- Production of reports for PHAAR board to aid organisational learning.

2.4.3 Issues raised

For Practitioners

From the outset, practitioners were encouraged to become active learners. The task groups (e.g. child health promotion, child protection) were facilitated to consider the current picture of service provision. Practitioners were asked to evaluate this and to recommend an improved approach for their colleagues and the PHAAR board. The facilitators mostly led these groups, challenging existing mental models and frameworks, promoting debate and facilitating the design of models for further work. Regular update meetings discussed the work of each of the groups, the progress made to date and encouraged further reflection and innovation.

The results of the PH skills audit were used to incorporate the needs of practitioners into the development of a Public Health learning programme. This utilized a mix of approaches to accommodate varied learning preferences e.g. experiential learning, interactive workshops, a journal club, theoretical and evidence-based input, reflective writing programmes and more formal ‘training’. Staff unfortunately had no access to clinical supervision and their previous experience of working in the NHS had not always encouraged participation and the use of either experiential learning or reflection in the way that this programme expected. However, after some hesitant early group meetings where many were slow to participate, those attending PHAAR meetings became used to the reflective style and began to engage actively in, often very lively, discussions.

The staff had very poor access to IT and library resources which made it more difficult for them to review the evidence base for practice. The expectations of the programme were, at times, beyond the practitioners’ experience and the culture of unreflective ‘doing’ needed to be overcome. The programme gave practitioners the opportunity to analyse their practice and potential outcomes of their approaches and the facilitators gained a sense of this becoming understood and recognised as the programme progressed.

The effectiveness of this multi-faceted approach emerged towards the end of the programme in two complementary datasets. First, the repeat skills-audit demonstrated significant improvements in self-assessed competence across a range of public health activities. Second, practitioners themselves were able to lead a series of evaluative focus groups during which they critically assessed the success of the programme and identified key areas of practice where further work was required to ensure long-term sustainability of the changes to their public health work. This process was facilitated by
the independent evaluator who was able to compare the practitioners’ approach to problem-solving with that demonstrated in an earlier series of focus-groups held at the end of the programme’s first six months. It was clear, both from the group dynamics in both sets of focus groups and from the skills audit data (see Chapter Three) that a great deal of practitioner learning and maturation had taken place during the period of the programme.

As one senior manager commented at the end of the programme:

"it’s drawn out some of the stars in practice, it’s taken them a while to shine as brightly as they are doing and they are committed and they’ve got the energy. [The staff] have definitely grown in confidence and competence and some are actually challenging [others] in terms of request for what they carry out..." (transcript 4, p15)

For the organisation

Like many other NHS organisations, Central Derby PCT is encouraging Life Long Learning for its staff. The PHAAR programme, with its emphasis on critical reflection and learning, highlighted some potential difficulties with this approach in any organisation. Many employees are now expected to become active self-directed learners. It would appear from the experiences of PHAAR that many will require new skills and confidence in order to take up this challenge. Others may simply fail to act on their own learning needs and the organisational response for these staff will need to be identified.

In terms of Organisational learning, Central Derby PCT used the PHAAR programme as a mechanism to reflect on many aspects of its work. Many discussions concerning the nature, purpose and priorities of the organisation were commenced as a result of issues brought to the PEC, Trust Board or clinical governance group by the PHAAR work. More formal opportunities to reflect on some of the organisational challenges of managing change (e.g. competing cultures, values, styles of management, approaches to risk containment, attitudes to gender and professional hierarchies) were provided through the various confidential reports presented to the project board (chaired by the chief executive) by the programme facilitators and external evaluator at key points during the 18 month period.

During an end of programme interview the Chief Executive noted that PHAAR had helped the PCT to review its approach to devolved teamwork and decision-making:

"I was reflecting on it last night, the fact that we’re creating a new culture around teams within the organisation." (transcript 5, p21)

In particular he commented on the fact that PHAAR had been useful to the organisation because its overall approach complemented his own and his team’s vision for the organisation as a whole. He believed it had helped to:

"crystallize people’s understanding of what we’re trying to do" (ibid. p21)

It is hoped that this reflective approach to organisational work will continue after the lifetime of the programme.

2.5 Professional Personas

2.5.1 Background

As a project tasked with changing professional behaviour, the PHAAR programme inevitably challenged practitioners to reflect on their professional self-image. Health visitors have all undergone a period of extended education (now at degree level) before registration, whereas not all those known as ‘school nurses’ will have a specific qualification in this specialist area. Like any other profession, practitioners from both groups have a range of individual beliefs, attitudes, interests and experience.
The change of orientation that was required of staff within PHAAR inevitably caused practitioners to re-assess their own values and beliefs regarding their professional practice, and thus their professional persona. For some this was a very painful process and the challenge for the project leads was to enable the exploration of the personal impact of a professional change, whilst not allowing this to derail the project.

2.5.2 Measures taken within PHAAR

Within PHAAR the following measures taken to aid practitioner adjustment to new expectations and working practices:

- Practitioners were encouraged to participate fully in the task groups;
- Practitioners were kept up to date with changes proposed through regular PHAAR meeting minutes and bulletins;
- The creation of peer ‘activists’ for the programme who were charged with, supporting, encouraging and ascertaining the ‘undercurrents’ of practitioner feelings to inform programme content and direction;
- New supportive arrangements within teams were encouraged;
- Informal stakeholder engagement was maintained throughout the programme;
- A reflective writing programme with an independent facilitator was commissioned;
- PCT was taking steps to fully implement clinical supervision for fieldworkers.

2.5.3 Issues raised

Working with a group of professionals with a diverse range of values and professional personas to create a more uniform and new professional identity was very challenging. The range of reactions to the programme increased as it unfolded. The relative uniformity of responses gained in the ‘visioning’ activity became splintered as the real decisions about service delivery were taken.

The professionals

The greatest range of opinion was found amongst health visitors. The school nurses were small in number, met regularly and had recently undergone a period of reflection and change. As a consequence they were less ready to consider more change at the outset of the PHAAR programme, but also had fewer outstanding issues to address.

The health visitors exhibited a range of responses to the programme. These included:

- the view that their personal satisfaction in the role came from contact with individual families, which they saw as under threat;
- anxiety about their skills in new areas such as community development or groupwork;
- anxiety about sharing their working practices with others in a team and fears about potential disruption to clients.

The majority of staff worked with the project to overcome these difficulties, however a minority remained unhappy with the changes envisaged. This was especially apparent in relation to undertaking a broader range of activities with groups, rather than just on a one to one basis:

"health visitors traditionally have always had a public health role...but...one to one, that’s where I feel my strength is"  (HV, focus group 3, p2)

“most of us do see our prime duty to that particular patient in a particular consultation: that’s the style we’ve trained with, that’s the style we’ve been used to working with, the style we’ve developed...and I think we find it, on a personal level, we find it difficult to change that way of thinking”  (GP speaking of his primary care team colleagues, focus group 3, p1)
The Organisation

The range of strongly held practitioner views was inevitably an issue for the PCT managers. Staff morale was not high at the outset of the change process and there was a strong possibility that, if not handled sensitively, some staff would become less positive about their working lives. On the other hand the managers were certain that the challenge embodied by this programme was necessary to improve and modernise services. However, managers were taken aback by how difficult the process was:

‘I don’t think I envisaged the amount of problems there would be...I was naïve as to just how difficult understanding this approach is, and moving from traditional skills to asking people to developing different skills or to go back to skills they once had has been hard for some people’

(transcript 5 summary, p14)

With hindsight it is apparent that all involved with the PHAAR programme underestimated the emotional impact of the changes outlined and consequently made too few plans to address this. Even a desired change in practice can personally be very challenging and where one is attached to a current role and at best ambivalent about a proposed future role, an emotional reaction is inevitable. We would recommend that any future programme of this nature takes into account the loss practitioners will feel, and creates a space where this can safely be expressed and explored.

2.6 Empowerment

2.6.1 Background

The PHAAR programme, coinciding with the publication of ‘Shifting the balance of power’ (DoH, 2000a) and ‘The NHS plan’ (DoH, 2000b), was supported by policy as it sought to give increased decision-making power to teams of health visitors and school nurses. An integral part of this change was the continued development of a facilitative organisational culture and a decentralized decision-making structure.

A series of facilitated workshops ensured that PCT managers were able to consider the organisational structures, cultures and approaches to service delivery that would be required by the emerging self-directing teams. Care was required to ensure that the devolved decision making envisaged was more than simply the devolution of managerial work, as has been the case elsewhere (Hale, 2000, Robbins et al, 2002). Field staff were also given opportunities to outline their needs both in terms of structural changes and the support required from senior managers. The focus on staff empowerment highlighted the expectations of staff and managers regarding organisational systems and cultures and produced many challenges for all involved.

2.6.2 Measures taken within PHAAR

Within the PHAAR programme a number of activities were undertaken to ensure that both practitioners and the organisation were prepared for the move to devolved decision-making. These included:

- The involvement of practitioners in decision making regarding required organisational change;
- The creation of a learning programme for practitioners to help them to improve the low levels of confidence;
- The exploration with practitioners of the context of their work and creation of a set of principles to guide team and individual decision making;
- The creation of work teams which would take on increasing decision-making powers over time;
- The exploration of the role of managers within this new organisational structure and culture;
- A programme culture and design which encouraged the questioning of "The way things are done here"
2.6.3 Issues raised

This issue too raised many tensions. The first became apparent as existing work patterns were revealed. Although the PCT had inherited a traditional managerial structure, some practitioners had found a mechanism for working almost outside the organisation. There were varied interpretations of the concept of ‘autonomy’, resulting in a range of levels of commitment to PCT-wide goals and priorities. Indeed, a senior manager described health visiting in the PCT at the outset of the PHAAR programme as ‘autonomous without accountability’.

The PCT wanted to enable an environment of flexibility and self-determination for staff whilst also ensuring a commitment to corporate strategies. However, as the programme progressed it became apparent that many practitioners were insufficiently confident and/or skilled to embrace the decision-making powers they were being offered. This was addressed within PHAAR through the reflective learning approach, combined with shared (corporate caseload) working and a new form of professional leadership within the teams.

In addition to practitioners’ lack of confidence in decision-making, a number of practice-related issues emerged as a result of the programme which needed urgent managerial action. Inevitably this led to tensions between managers and practitioners, with the latter group questioning managers’ real commitment to power-sharing. Nevertheless, from the manager’s perspective, such tensions may sometimes be inevitable:

"by taking the lid off practice you are going to see things that you didn’t know were there…from a clinical governance perspective you can’t put the lid back on and that is hard. People will always want to blame the manager or the project that that happened, but my responsibility is to the organisation…in terms of safe guarding the public. I feel very strongly about that"

(senior manager, transcript 4, p11)

Empowerment of employees and teams does not arise through singular approaches but needs to be a whole organisation approach. In retrospect it is evident that the work of clarifying the changes required by the organisation and its managerial staff should have commenced sooner and been given a higher priority. This would have reduced the uncertainty and consequent anxiety for many staff. Nevertheless in such a large and complex programme with a limited time frame and with the pressures on the PCT and its senior staff, it is important to acknowledge that all staff made great attempts to find the time to debate and resolve many difficult issues associated with the concept of empowerment.

2.7 The Change Process

2.7.1 Background

The NHS has experienced an extensive and accelerated programme of change within the last ten years in which a variety of frameworks, methods and approaches have been applied (Upton & Brooks, 1995). However it is generally agreed that there are a number of key elements desirable in any change programme (Broome, 1998, Taplett & McMahon, 1999):

- Understanding the driving forces for change;
- Agreeing what needs to change;
- Developing a clear and attractive ‘vision’ of the future;
- Clarifying how changes will be made and implementing plans;
- Building the capacity in individuals and the organisation to deliver proposed changes;
- Overcoming resistance;
- Assessing the impact of changes made.
The PHAAR programme worked largely within this framework (see: Stages of the Development, above), attempting to create a logical order for events and stages of the change process. However, the facilitators and leaders of this programme found, as Upton and Brooks state:

"...there is no simple prescription that will ensure success...alongside the systematic planning and practical methods there must be room for flexibility since the unexpected has a tendency to throw things into confusion. When this happens, those leading change must possess additional internal resources- qualities like innovation, humour, endurance and the ability to contain anxiety." (p1)

Attempting to co-ordinate a multi-faceted change programme whilst also accommodating unexpected events, the inevitable delays and the wide variety of professional opinions from the HVs and SNs was a challenging process.

Reactions to a change programme will inevitably be varied (Senge, 1990). Some will feel positively about change, particularly if they are dissatisfied with the current position. Others will react negatively to change because of its destabilising effect, the disruption it will cause them or the personal losses they may suffer as a result of the change. Others may have a fundamental philosophical disagreement with the aims of a change (Bryson, 1995, Upton & Brooks, 1995). All these reactions were exemplified in the PHAAR programme.

2.7.2 Measures taken within PHAAR

A number of measures were taken to manage the change process:

- A theoretical basis for the change process was agreed and plans for many specific areas of work were created;
- A diagnostic analysis process was taken to take account of local circumstances in the change management process;
- Practitioners were invited and encouraged to participate fully in the change process;
- Regular meetings were held between the project leads and facilitator to review the progress of the programme and amend facets of it as necessary;
- Regular meetings were held with the activists to review field staff responses and amend the programme as necessary.

2.7.3 Issues raised

A number of tensions existed within the programme, some of which are common to all change processes and some which were specific to this process.

Programme leadership

The programme was established with external (university) and internal (PCT) leadership. Whilst this brought a range of expertise, energy and operational power to the programme, it also brought tensions of ownership. In addition the internal PH facilitator had a very fluid role which, whilst intended to be flexible, also brought uncertainty over authority and role. These tensions are perhaps an inevitable part of the creative process of a programme such as this and efforts were made on all sides to accommodate the needs of others and work within the agenda and capabilities of the PCT. The CE recognized that the programme was always going to be challenging for the PCT and believed that the external facilitator, in particular, was critical to its effectiveness:

‘there’s a real chance that we wouldn’t have been as brave – having said all that about the tension, the fact that the tension was there was ultimately a constructive thing about pushing the programme into an arena that it could have walked back from and said “this is bloody difficult” and just allowed it to drift…we couldn’t have done it without some form of external facilitation’

(transcript 3, p7)
Top down/bottom up process

This programme came about as the result of centrally determined policy changes and the choice of site had been determined by the Regional nurse, and the senior PCT team. As a result the programme felt very ‘top down’ in its initial period. In order to counterbalance this, it was decided that the process of change should be as inclusive as possible. Throughout the programme individual practitioners expressed widely differing views about the inclusiveness of the programme, with some feeling very positive and others much less so. However, as the table below demonstrates, the majority continued to feel motivated to be involved with PHAAR, even though it has been difficult at times.

Table 1: Level of agreement of 34 practitioners with the statement, Public involvement

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
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<td>11.8</td>
<td>12.1</td>
</tr>
<tr>
<td>Agree</td>
<td>22</td>
<td>64.7</td>
<td>66.7</td>
</tr>
<tr>
<td>Unsure</td>
<td>5</td>
<td>14.7</td>
<td>15.2</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>5.9</td>
<td>6.1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>97.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>System</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Public involvement

A major tension was the timing and level of public involvement in the process of change. As a principle of public health and an increasing marker of good practice in public sector planning, the involvement of local people needed to be actively considered. However, it was felt that initial work with staff had to be undertaken to determine the parameters of possible change, prior to public engagement. In addition it was felt that local people should be encouraged to become involved by field staff rather than managers or transient external facilitators. From the outset, field staff expressed strongly the view that their service should be ‘needs led’ and that a key feature of the programme should be involving local people in developing the service. However, once it became clear that there was disagreement amongst the practitioners themselves about key aspects of service delivery, it was decided that developing a unified approach internally was a critical preparatory step to greater public involvement. Encouragingly, many staff actively took up this challenge later on, during the needs assessment process, and a number of the emerging user-focused team projects were developed as a result of this process.

Pace of change

The rate of change was an ever-present tension within the programme. Some staff felt equipped and wished to make changes in their practice very quickly, whilst others were extremely hesitant, reflecting a range of views, experience and confidence. However, most staff felt that a broad consensus for change should be sought before major changes were implemented, and this was largely the pattern throughout the programme. However, this did result in an extended period of planning rather than doing which was uncomfortable for some:

*It feels very uncomfortable, you know I mean I keep being asked if I feel comfortable with this. I mean how can I feel comfortable with something if I don’t actually know how it’s going to be when we’re actually doing this?’* (transcript 6, p12)
Nevertheless, opportunities arose quite early in the programme for staff to ‘have a go’ at new approaches (e.g. the family health plan, new records, corporate caseloads) and more confident staff took up these opportunities. On reflection, more opportunities for ‘having a go’ could have been built into the programme, since it was often these ‘hands on’ experiences (e.g. via participatory rapid appraisal sessions) that convinced practitioners that it was possible and even desirable to work in new ways with local people.

**Challenge/support**

Another dilemma, particularly for the programme leaders and facilitators, was the appropriate balance of challenge and support to practitioners. In order to provoke the raised energy levels required for change, a certain amount of challenge to the status quo was required. A considerable amount of this energy came from practitioners themselves, many of whom were eager for change. At the same time it was necessary to acknowledge the pain and loss individuals may feel and support those feeling a lack of confidence regarding new roles.

**Wholesale/staged implementation**

At many points in the programme it was necessary to debate whether changes should be made on a ‘wholesale’ or staged/trial basis. A mixture of approaches were used during the life of the programme. However, by and large, experimentation with new approaches by practitioners did not really begin until staff formed into teams. It would seem that working closely with colleagues in teams had a positive effect on practitioner confidence and, along with the rapid appraisal process, encouraged the development of new initiatives.

**Balancing differing needs**

Implementing change inevitably pleases some whilst displeasing others. Those unhappy with the direction of change can be expected to challenge the proponents of change, who in turn need to be prepared to debate the changes with them. Balancing the needs of different groups who would be influenced by the changes to HV and SN practice was a major challenge for the PCT. A number of GPs, although convinced by the rationale for change, remained opposed to the plans for the health visitors. One GP expressed it thus:

‘we are all of us in the middle of a huge change agenda anyway and this is just one more thing, and I think it needs to be born in mind that the change agenda at the moment is so vast that morale in most areas of the NHS is quite poor and that the more change we have, no matter how well-intentioned, and no matter how intellectual, how strong the intellectual base is, may well be the straw that breaks the camel’s back’  

(GP, focus group 3)

PCT managers slowed the pace of change in the face of GP challenge and spent time listening to and attempting to accommodate their needs. However, their continued backing of the HV and SN plans for change, in the face of powerful opposition, was an important indication to field workers that their decisions were supported.

**Limited capacity**

A major challenge, principally in the programme’s first twelve months, was the limited capacity the PCT had to support PHAAR, particularly at strategic and operational management levels. This is a difficulty most if not all PCTs and local stakeholders are likely to face when modernizing health visiting and school nursing roles. The following statement was made in a position paper to the PCT’s Executive Committee in March 2002:

‘Over the last 12 months operational management capacity has been compromised due to health issues in addition to the vacancy factor/s at Director level. Several short term realignments of team roles and responsibilities have ensured a level of cover but this has still resulted in a shortfall of management capacity and continuity’
Another compromising factor affecting the speed, rather than the direction of change was the continuing shortfall in practitioner numbers. PHAAR seemed to help to address this problem. First, a series of innovative posts (e.g. team leaders for multi-disciplinary health visiting teams) were created as a result of PHAAR. Second, several newly trained practitioners and some more experienced from other areas decided to work in Central Derby specifically because of the change programme and its commitment to public health practice.

One consequence of this capacity shortfall across the PCT was an increase in time it took for changes to be ratified at senior level and then overseen managerially by the operations team. Inevitably, this impacted negatively on some practitioners’ motivation, as the following quote from a health visitor reveals:

‘I feel that the shortages of staff throughout the programme has demotivated everyone’
(HV 9, June 2002)

Even amongst those who remained committed to change at practitioner level, attempting to introduce innovations whilst delivering a service was clearly a significant challenge at times:

‘Despite a positive public health environment, and re-written health promotion policy, the pressure of everyday work is still intense: with short staffing and sickness, achieving new, dynamic ways of working is difficult and takes vast amounts of time not normally available in a regular working day’
(HV5, June 2002)

Although there were a range of tensions in the change process, this was expected and is an inevitable part of any change programme. Having an overarching rationale for the change and a theoretical model to work within undoubtedly helped to co-ordinate efforts. Nevertheless, those leading and facilitating the programme needed skill, energy, patience, resilience, resourcefulness and support:

‘I think there have been times when we’ve all, or potentially all, needed someone external to the organisation…to help us analyse and move forward, because of the complexity and I think that was overlooked and I hope it won’t be overlooked in the future’  (transcript 2, pp 25-26)

We would recommend to other organisations that staff in these positions are given external support to ensure that they are able to maintain appropriate levels of all these skills and attributes.

2.8 Risk

2.8.1 Background

Managing risk is an everyday part of the working lives of NHS professionals and mangers alike. As a programme that expected change in professional behaviour PHAAR needed to consider the risks attached to such a change. Practitioners indicated early in the process that they were unwilling to take sole responsibility for changes in direction of services as this would expose them to unacceptable levels of personal risk. It was thus clear that the PCT would need to endorse any proposed changes of priorities and services delivered. The PCT needed to be certain that any changes made were not undermining the viability of the organisation and would produce positive benefits in terms of reducing ill health and health inequalities for the population. Indeed, the chief executive commented that the programme as a whole presented risks as well as challenges to the organisation from the outset and as the following quote indicates, emphasizes the need to take a ‘whole systems’ perspective:

“\textit{I remember a discussion within the first month…there’s a risk here…I began to think it through…thinking there’s some risks here for the organisation, for individuals, for myself…how individuals would be perceived inside and outside the organisation}”  (transcript 6, p 1)
2.8.2 Measures taken within PHAAR
A number of measures were taken to reduce risks to the organisation, to professionals and to the populations served by them.

- A robust mechanism for debating and agreeing planned changes in services developed through PHAAR was created and used to endorse decisions taken;
- Field workers were encouraged to share decisions regarding priorities in teams;
- A framework was created whereby team priorities and objectives could be recorded and shared across the organisation;
- A mechanism for organisational endorsement of team plans was encouraged;
- External stakeholders were kept informed of planned changes.

2.8.3 Issues raised

For professionals
Many fieldworkers were very concerned about the risks involved with change. Health visitors especially felt a strong personal responsibility for the work undertaken with families for which they were the named member of staff. This was particularly apparent in relation to child protection issues. However with the emergence of teams and shared workloads and a greater understanding of the range of possible preventive work, this fear appeared to recede.

For the organisation
The PCT had to manage many risks within this programme. These included; the risk of losing the goodwill of GP colleagues as plans to change HV structures progressed, the risk of consumer dissatisfaction as some existing services were withdrawn and the risk of poor service delivery during the transition to new working practices. However, to balance these new risks, the exposure of current working patterns within PHAAR highlighted many already existing clinical and organisational risks. As one stakeholder observed, it is impossible to know in great detail everything that is going on within an organisation, but by setting up the right conditions, risks maybe more effectively managed:

“It seems far less risky that you then as a team say ‘right, what we want is our practitioners to be problem-solvers, we want them to be making decisions on the hoof, on the spot, with what they are dealing with’. Then, if you set up a system that says ‘there are all these decisions that teams are making, that is what they’re responsible for and you’re giving them the responsibility for them to do it, that is actually much safer than the idea that you have to control everything.” (transcript 1, pp35-36).

Work within PHAAR to provide new skills and confidence for practitioners, organisational structures for decision-making and clarity over levels of accountability has provided Central Derby PCT with new processes which should ensure lower levels of risk in the future.
Chapter Three: Outcomes of the programme

3.1 Introduction

Qualitative evaluation data has been used throughout this report to help explain and validate the conclusions reached by its authors. In this chapter some of the key evaluation outcomes are presented, many of which are more quantitative in nature.

3.1.1 Impact of PHAAR on practitioners’ public health skills and competence

Comparison of pre and post intervention skills audit data indicated that significant improvements in key areas of public health practice had taken place as a consequence of PHAAR and its related activities. The following tables highlight some of the most significant improvements for the 17 health visitors and school nurses who completed both audits:

Table 2: Addressing health inequalities in local communities (HVs)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Mean score* at baseline (Feb 01)</th>
<th>Mean score at time 2 (June 02)</th>
<th>Difference in mean scores</th>
<th>Significance level using paired ‘t’ test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with community groups to help them identify their own health needs</td>
<td>1.846</td>
<td>3.231</td>
<td>1.385</td>
<td>&lt;0.000</td>
</tr>
<tr>
<td>Negotiating with others to move resources to promote service equity</td>
<td>2.077</td>
<td>3.000</td>
<td>0.923</td>
<td>&lt;0.000</td>
</tr>
<tr>
<td>Understanding ways to encourage participation of disadvantaged groups in health care planning</td>
<td>1.538</td>
<td>3.000</td>
<td>1.462</td>
<td>0.001</td>
</tr>
<tr>
<td>Knowledge of theory and practice of community development</td>
<td>2.077</td>
<td>3.231</td>
<td>1.154</td>
<td>0.002</td>
</tr>
<tr>
<td>Experience of involving local people in service developments</td>
<td>2.077</td>
<td>3.154</td>
<td>1.077</td>
<td>0.003</td>
</tr>
<tr>
<td>Understanding of the concept of social exclusion</td>
<td>2.923</td>
<td>3.846</td>
<td>0.923</td>
<td>0.004</td>
</tr>
<tr>
<td>Knowledge and theory of group dynamics</td>
<td>2.615</td>
<td>3.538</td>
<td>0.923</td>
<td>0.004</td>
</tr>
<tr>
<td>Experience of working with hard to reach groups</td>
<td>2.154</td>
<td>3.154</td>
<td>1.000</td>
<td>0.006</td>
</tr>
<tr>
<td>Health advocacy work for disadvantaged groups/individuals</td>
<td>2.462</td>
<td>3.231</td>
<td>0.769</td>
<td>0.006</td>
</tr>
<tr>
<td>Understanding the main determinants of health</td>
<td>3.308</td>
<td>4.031</td>
<td>0.923</td>
<td>0.008</td>
</tr>
</tbody>
</table>

* A Likert-style scoring system was used as follows:
1=“novice”, 2=“advanced beginner”, 3=“competent”, 4=“proficient”, 5=“expert” (see Brocklehurst & Rowe, in press)
### Table 3: Strategic skills associated with delivering health gain (HV's)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Mean score at baseline (Feb 01)</th>
<th>Mean score at time 2 (June 02)</th>
<th>Difference in mean scores</th>
<th>Significance level using paired ‘t’ test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of managing a health promotion programme</td>
<td>1.077</td>
<td>2.000</td>
<td>0.923</td>
<td>0.002</td>
</tr>
<tr>
<td>Multi agency strategic planning</td>
<td>2.308</td>
<td>3.615</td>
<td>1.308</td>
<td>0.004</td>
</tr>
<tr>
<td>Knowledge of local child protection policy and procedures</td>
<td>3.692</td>
<td>4.308</td>
<td>0.615</td>
<td>0.005</td>
</tr>
<tr>
<td>Assisting in planning of immunization programmes</td>
<td>2.231</td>
<td>3.077</td>
<td>0.846</td>
<td>0.005</td>
</tr>
<tr>
<td>Experience of developing large scale health promotion programmes</td>
<td>1.231</td>
<td>2.077</td>
<td>0.846</td>
<td>0.005</td>
</tr>
<tr>
<td>Collating family assessment data for use in local health needs assessment</td>
<td>1.692</td>
<td>3.000</td>
<td>1.308</td>
<td>0.007</td>
</tr>
<tr>
<td>Knowledge of a range of methods to evaluate health programmes</td>
<td>1.769</td>
<td>2.846</td>
<td>1.077</td>
<td>0.009</td>
</tr>
</tbody>
</table>

### Table 4: Involving communities in health improvement work (SN's)

<table>
<thead>
<tr>
<th>Competency statement</th>
<th>Mean score at baseline</th>
<th>Mean score at time 2 (June 2002)</th>
<th>Improvement in mean score*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of involving children, young people, parents and teachers in health service developments</td>
<td>1.80</td>
<td>3.00</td>
<td>1.3</td>
</tr>
<tr>
<td>Health advocacy work for disadvantaged children, young people and their families to improve health &amp; access to services</td>
<td>1.80</td>
<td>2.75</td>
<td>1.0</td>
</tr>
<tr>
<td>Engaging a wide range of stakeholders, including young people and teachers to establish local health priorities</td>
<td>1.50</td>
<td>2.50</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*note that significance levels are not provided due to the small sample size (n=4)
This data makes clear that at the outset of PHAAR practitioners felt they were either ‘novices’ or ‘advanced beginners’ in key areas of public health practice. These results indicate, however, that the PHAAR programme succeeded in the development of these skills within the practice environment. The facilitators also believed that PHAAR helped considerably to raise practitioners’ awareness of the nature and scope of public health practice and that they had gained a great deal of confidence in articulating their public health roles by the end of the programme:

‘What I also think is that they’re now feeling more confident and others around them are beginning to understand how they might relate to that health visiting role, that we have the real potential…to create a very dynamic wider public health influence and I think that that’s potentially a massive gain of the [PHAAR] programme’ (Chief Executive, June 2002)

This was supported by data from 33 practitioners who completed a public health attitude scale at the end of the programme. Specific findings are presented in Table 6:

**Table 6**: Level of agreement of 33 practitioners with the statement ‘I feel competent to work in the new ways now expected of me, regardless of whether or not I have the resources to do so’
The skills which remained undeveloped at the close of the funded programme, such as interagency working and multi-disciplinary teamworking, were in areas where the programme was only just making an impact in everyday practice (see Chapter One).

3.1.2 Impact of PHAAR on practitioners’ public health practice activity

Delivering tangible changes in health visiting and school nursing practice was a key objective of the programme and there was evidence that this was beginning to happen in earnest by June 2002, some 18 months after PHAAR began. Some of these changes were referred to in Chapter One. The following is an extract from the facilitators’ final report to the Project Board:

> ‘All teams except [X} team have undertaken a needs assessment that included some local community consultation. Teams are currently agreeing priorities for action and completing the team programme objectives/community project plans’

> ‘Following a risk assessment…the PCT Board agreed the PHAAR recommendations to employ hearing screening technicians. The operational management team is developing a plan to action this.’

> ‘It has been agreed by the practitioners that the new Child Health Promotion programme will commence in September [2002] when parent information packs have been finalized and clinical supervision is implemented. Mandatory training days have taken place for all health visitors, school nurses and nursery nurses in June 2002’

> ‘Some of the teams have started working with a corporate (shared) caseload rather than an individual caseload. Where this has occurred prioritisation and team functioning has improved’

> ‘The first 2 cohorts of staff have been invited to attend European Computer Driving License training and it is expected that all staff will have access to this training in future’

Whilst these changes are significant, the project facilitators had hoped that greater progress would have been made in the time available. However, in the context of the major organisational change facing the wider PCT as health authority structures were disbanded (in April 2002), the limited management capacity available to the programme and the large amount of ‘remedial’ work required to bring health visiting and school nursing services up to a standard befitting a modern health service, there was general agreement amongst local stakeholders that as much change as practically deliverable had been achieved.

There is little doubt that the considerable changes in practitioners’ competence and confidence, combined with the structural changes made across the PCT, has placed Central Derby PCT in a strong position to deliver the health gain targets set out in its 5 year health improvement strategy.

3.1.3 Collaboration between practitioners and the public health specialist team

By the end of the programme, members of the PCT’s public health team were working closely with each of the newly established health visiting teams set up in mid 2002. The five teams now have a named public health specialist to provide them with support and technical expertise. This represents a major change from the beginning of the programme where there was very little contact between public health generalists and specialists. Indeed, the specialist team believed that PHAAR had raised the profile and status of public health across the PCT, particularly at Board level. As one specialist noted during a focus group interview, with PHAAR:
‘this discussion, which has been useful in terms of the public health role of the whole organisation, would not have taken place. There would have been less awareness of public health within the PCT, both at HQ and the wider workforce…’ (transcript summary, p15)

3.1.4 Programme effectiveness

The effectiveness of any major change programme such as PHAAR must be judged by the extent to which it achieves its intended outcomes and the net effects of any ‘opportunity costs’. Here it is worth reflecting on the key elements of the ‘vision’ for health visiting and school nursing which stakeholders (including the practitioners) identified as critical ‘success’ factors for the programme. To reiterate, these were:

- Increased population-based rather than individually focussed work;
- Increased focus on addressing inequality, decreased amount of routine, universal service provision;
- Flexibility to work from and with the agenda of local communities responding creatively to areas of need;
- Increased inter-agency working;
- Contributing to strategic PH plans e.g. HiMP.

From the evidence provided throughout this report, it can be seen that significant progress has been made in at least four of these five areas. Interestingly, with the exception of the programme facilitators, there was little evidence that practitioners had increased to any great extent their level of interagency working. The most likely explanation for this is the large amount of internally-driven work which was needed in order to modernise the health visiting service before a more external focus could be adopted. Now that this work is largely complete, it is anticipated that collaborative work with other agencies, particularly in relation to needs assessment and community development will become a hallmark of public health practice in health visiting and school nursing locally.

The results of the independent evaluation suggest that in spite of the major challenges facing the project team, significant and sustainable progress towards developing family and child centred public health school nursing and health visiting services has been made in Central Derby. Progress has been slower, for the reasons set out, than the team originally planned for, but the vision for the service which was developed by the practitioners is beginning to manifest itself in tangible change ‘on the ground’. Perhaps most importantly of all has been the apparent sustainability of changes brought about as a result of PHAAR since the programme officially ‘ended’ as a pilot in June 2002. As will be seen in Chapter Four, many new initiatives have emerged, as well as the continuation of existing projects, all of which support the practitioners’ initial vision of the services they wished to provide and are in line with the wider modernisation agenda for health visiting and school nursing as described in Chapter One.

Key factors which appear to be associated with programme effectiveness and sustainability, which may be of help to others working on similar change programmes in PCTs are presented in Chapter Five.
Chapter Four: Ongoing work and ensuring long term change in Public Health Practice

4.1 Introduction

Central Derby PCT believes that its most important resource is a competent workforce able to achieve high standards of care for the communities it serves. Maintaining and developing the workforce is critical to the future success of the NHS and we have continuously considered the workforce implication of service changes and developments in line with the NHS Plan targets and other National imperatives, e.g. Making a Difference, A Healthier Nation, NSFs and Improving Working Lives, Shifting the Balance of the Power, etc.

Central Derby PCT have taken the quantum leap with regards to the planning and development of the workforce and have recognised that what is needed is a whole systems change. This has been the approach taken with Health Visiting and School Nursing in making Public Health Approach a Reality (PHAAR). We are now mainstreaming the objectives and findings from the PHAAR programme of change, these are just some of the examples of how that change will be sustained:

4.1.1 Team Leaders and Skilled Mixed Teams

Team Leaders were appointed in July 2002 and have been actively involved in the recruitment process for newly funded health visiting and school nursing posts. In addition a skill mixing initiative has included recruitment of Community Paediatric, Community Staff Nurse development posts and Community Midwives in to the wider team.

This has enhanced opportunities for other healthcare professionals to work within a Primary Care setting with a Child and Family focus. These staff can positively contribute to Public Health programmes in areas such as:

- Promotion of breast feeding;
- Support of young parents;
- Smoking cessation;
- Reducing incidence of low birth weight babies;
- Postnatal depression;
- Antenatal support for vulnerable women;
- Parenting;
- Close liaison with Midwifery teams trained in Child Protection (one of the Team Leaders is also a Community Midwife by background).

4.1.2 Infant Feeding Advisor

The rationale for this post comes from the extensive research which identifies the health benefits from breastfeeding to both the infant and mother. The postholder will work across the whole of the PCT whilst interfacing with Sure Start areas. The main objectives of this role are to increase breastfeeding rates by 2% annually (NHS Priorities & Planning) and to attain Unicef’s Community Baby Friendly accreditation. Implementation will include the development and implementation of a breastfeeding policy and protocols, accessing GPs, phasing in a staff and peer support training programme, expansion of drop-in support sessions and audit. In addition the removal of artificial milk from all PCT premises has been proposed and the postholder will liaise with other Trusts and ensure communication within the PCT.
4.1.3 Link Nurse for Child Protection
A six-month pilot to support the mainstreaming of the new way of working involving the extension of the Link Nurse role in Child Protection began in September 2002. It has enabled the link nurse to explore clinical governance issues in Child Protection. Following a record keeping audit a one-day mandatory training session was arranged for Health Visiting and School Nursing teams. This resulted in the development of record keeping guidelines based upon recommendations from the Child Protection Unit and in consultation with team members. The pilot enhances the Link Nurse role, developing skills in Child Protection and supporting the Named Nurse in facilitating increased group supervision sessions for Nursery Nurses. This is important given the increase in skill mix within the PCT. The pilot will be evaluated and, should the need be identified, form the basis of a proposal for an increase in Named Nurse hours.

4.1.4 Screening for Post Natal Depression
Further work is being undertaken by Dr Peter Marks, Director of Public Health, Karen Groves, Lead Clinician and Sue Cowlishaw, Team Leader to address the inequality in service provision for minority ethnic groups and to identify key areas for further development, e.g.

- A culturally sensitive tool;
- Training to include cultural issues*;
- Clearer referral pathways;
- Liaison with other agencies/services, e.g. midwifery and mental health;
- Clinical supervision of staff.

The PCT has also recently appointed an *Asian Women's Counsellor who will be working closely with the teams.

4.1.5 Hearing Screening
Following a report by Dr Peter Marks and Karen Groves, further work was undertaken to review the operational arrangements of this service. We have established enhanced roles for Nursery Nurses to provide a peripatetic service across the PCT. A continuous programme of training will also be provided for all Nursery Nurse and support posts to ensure continuity and consistent standards of delivery. The service will be subject to ongoing evaluation. This is an interim arrangement until neonatal screening is universally introduced to minimise the risk, and to allow more effective use of Health Visitor skills to focus on the Public Health agenda.

4.1.6 Information for Patients and the Public (IPP)
Team Leaders and teams continue to work closely with the PALS Coordinator and IPP to ensure accurate up-to-date information is available on the Internet in addition to the development of Child Information Packs.

4.1.7 Communication Strategy
A Communication Strategy has been developed for liaison between General Practices and the teams. Link Health Visitor roles have been identified for each Practice and a single point of referral is to be introduced.

4.1.8 Geographical Teams
Work continues within the PCT and Sure Start Teams to establish the geographical boundaries for each team and to develop those services identified as required by the practitioners’ health needs assessments. One example of this is a Women’s Health Clinic that can be accessed by any woman but that also specifically caters for those from minority ethnic groups. Since this chapter was written, the PCT was able to confirm that the new teams became operational in January 2003.
4.1.9 Locality Budgets
A simple bidding process has been adopted by the PCT to enable practitioners to access funds to support local initiatives. Many of those introduced as pilots have been sustained. This year’s allocation has been matched by funding from the HIMP budget.

4.1.10 Fitness for Purpose
Additional ongoing evaluation has been commissioned by Central Derby PCT externally facilitated by Debbie Lee, Head of Professional Services and Clinical Governance, Mansfield PCT and Di Roffe, Public Health Strategy Manager, Trent Workforce Development Confederation.

4.1.11 Nurse Triage
Following completion of the triage course by a Health Visitor this has initiated plans to work innovatively with a Practice to introduce Nurse Triage sessions – one of which will have a Child and Family focus and management of minor ailments.

4.1.12 School Nursing
School nurses are linking into the geographical teams in each area, and looking forward to increased partnership working.

Pupil Health Questionnaire
A pupil health questionnaire in the form of an attractive, coloured booklet, has been developed with the help of pupils at Merrill Secondary School, Alvaston, Derby and has been piloted with all Year 8 and Year 10 students. The information from these will be used to inform individual and school health plans, as well as contributing towards the community health profile.

Baby Think It Over Dolls
These are being used as part of the Child Care GCSE course at Merrill School, and in babysitting courses at Merrill and at the Pupil Referral Unit at Peartree House. A basic First Aid course has also been run at Step Forward, another branch of the Pupil Referral Unit, and several students have gained their Level 1 certificate.

Pupil Referral Unit
The Unit provides education for pupils who are excluded from main-stream education. There are now named nurses for these units whom visit regularly, and provide a school health service for pupils with complex needs.

A multi agency steering group, which includes a school nurse representative, is being formed to consider implementing a scheme designed by the National Pyramid Trust. This scheme, which would be school based, aims to identify emotional difficulties at an early stage, and to provide effective intervention to improve outcomes for those children at risk.
Chapter Five: Conclusions – Key factors for achieving sustainable change

5.1 Introduction
As indicated in the preceding chapters, a number of lessons have been learned through the development, implementation and evaluation of the PHAAR programme. These are summarised here as an aid to others embarking on a similar programme of change and modernisation of health visitor and school nurse services.

5.2 The Change Process
The following elements were found to be especially helpful:

- **A whole systems approach** to planning and implementing change which anticipates both the potential risks and benefits of the change at a range of levels (e.g. organisational, managerial, professional and personal) simultaneously;
- **A programme which uses evidence-based and theoretically sound change management techniques** including a thorough environmental assessment, visioning, creation of a desire for change and comprehensive and pro-active action planning;
- **Active senior organisational support** for the change programme, which includes the chief executive and other members of the executive and non executive team;
- **A dedicated programme facilitator** with positional power and professional credibility to ensure the programme is operationalised effectively and sustainably;
- **High levels of fieldworker involvement** to ensure engagement and commitment to planned changes;
- **Diagnostic analysis** of the enabling and resisting forces to change at the outset of the programme;
- **Early and sensitive involvement of key stakeholders** (e.g. GPs and practice managers) but take care that their views do not override those of the fieldworkers;
- **Regular formal and informal learning and reflection opportunities** for fieldstaff and managers throughout the period of change;
- **Early wins** to provide encouragement and support for further change;
- **Ongoing formative and summative evaluation**, of sufficient objectivity, to assess progress against expectations and to provide an honest account of how things might be improved;
- **An appropriate balance of challenge and support** to ensure continued enthusiasm and willingness to change, even when things become difficult;
- **A willingness to ‘have a go’** and do things differently, even if the way forward is not always as clear as people might prefer.

Be prepared for:

- A tendency for the status quo to predominate, meaning that large injections of energy may be required to prevent a natural reversion to this position;
- Challenges to become major dramas which then lead to a lowering of morale and fear of ‘grasping the nettle’;
- Opposing views from practitioners about the need for change. Do not assume that there is professional consensus, especially on major issues relating to policy and practice;
5.3 Professional Issues
The following elements were found to be especially helpful:

• **Community Health Needs Assessment** including work with local people;
• **Agreeing to stop as well as start**, in order to expand work in new areas, some existing work will need to be undertaken more efficiently, reduced, stopped or delegated to others;
• **The debate and identification of**:
  – custom and practice: evidence based practice, which things are being done because they always have been and which have been shown to be effective?
  – universal services: services targeted to need how much of the service will be delivered equally to all and how much targeted to ensure equity?
• **Work with others**, other agencies, new initiatives such as Sure Start or healthy schools and local people;
• **Shared workloads**, either working together in teams or working with corporate (shared) caseloads.

5.4 Organisational Issues
The following elements were found to be especially helpful:

• **Creation of appropriate organisational structures** to enable fieldworkers to respond flexibly to local needs within agreed local priorities and to ensure team accountability for practice;
• **Changing the distribution of staff** to ensure those with greater needs have higher resource levels;
• **Creation of multi-skilled teams** to create greater flexibility and cost efficiency;
• **Effective communication** to all involved and affected by the proposed changes;
• **Collective management of risks of change**, equally shared between different levels of the organisation;

5.5 A Final Word
PHAAR was developed in response to major policy changes associated with public health practice in primary care in England, which were announced in 1999. Health visitors and school nurses were singled out as key players in improving health and reducing health inequalities at a local level. It is now two years since the project began and six months since it formally ceased to operate as a pilot. From the evidence presented in this report it is clear that operationalising complex policy initiatives locally requires vision, tenacity and endless patience, as well as excellent change management skills.

We hope, in sharing our experiences, both good and not so good, we have given others encouragement either to begin the process or to continue in the face of the inevitable difficulties. Our view is that despite the obstacles and challenges, the potential benefits in terms of job satisfaction, health improvement and greater equity in service provision are compelling reasons for making change.

As is the nature of pilot projects, we have been able to show only one particular approach to implementing sustainable change and modernization to health visiting and school nursing practice. However, our experience of working on and hearing about similar programmes elsewhere suggests
that the challenges facing PCTs as well as the solutions required are remarkably similar.

We close this report with couple of the positive comments received from staff at the close of the programme:

‘Most helpful has been ‘permission’ to do things differently’ (SN 51)
‘PHAAR has given me the confidence to move away from being just “0-5” focused but to look at the wider public health agenda. PHAAR has also helped to look at the research evidence to back up the findings in health inequalities and has given me the confidence to be instrumental in facilitating the team to work corporately and share work more easily’ (HV 60)

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