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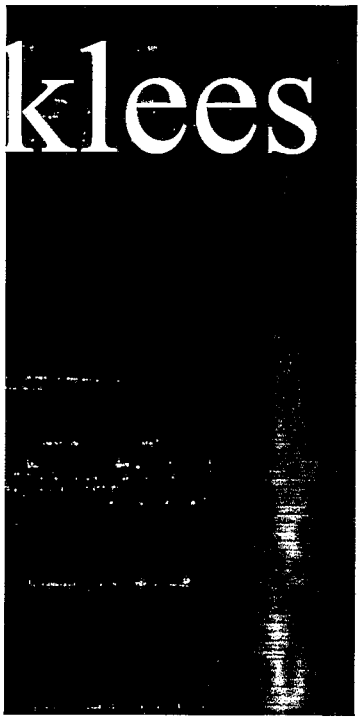
A Review of Community Nursing in North Kirklees

The agenda, the current position, resource allocation and involving the public

Malcolm Whitfield, Kate Gerrish

A compilation of research based reports
to inform the modernisation of community nursing services



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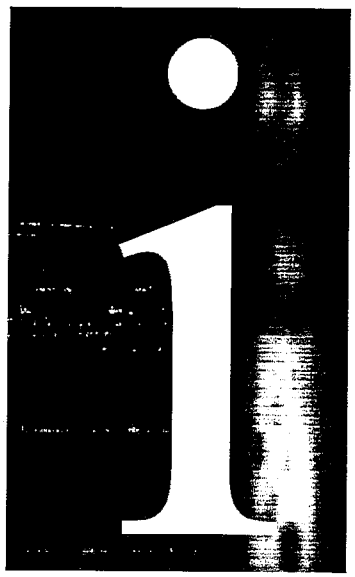

Introduction

The aim of this compilation of four reports is to generate research based information to support a review group tasked with the modernisation of community nursing services within North Kirklees PCT.

The key objectives of the reports, leading up to the development of a strategy are to:

- Describe, through critical appraisal, the local and national drivers that will shape the nursing strategy with a particular emphasis on current health policy and evidence supporting different models of service delivery. (Report 1)
- Review and assimilate the opinions of the main stakeholders in the North Kirklees Health Community on the baseline position and current strategic direction of community nursing services and their beliefs / ideas on the way forward. (Report 2)
- Examine options for the allocation of community nursing resources as a proportion of the overall budget and between general practices. (Report 3)
- Describe the methodologies available to elicit consumer views on developments within the PCT (Report 4)

The structure of the reports reflect the objectives set, although we have mirrored, where possible the structure of the nursing strategy document "Making a Difference" to enable a smooth assimilation with existing strategic initiatives.

Current health and related social policy seeks to measure the performance of the health and social care systems by observing their impact upon the health status of the populations they serve. Although this may seem to be an obvious measure of the success of a health system, it has in fact never been done before either in the UK or elsewhere in the world. Health care per se has a relatively small impact on health status when compared to issues such as socio-economic status, employment, diet, lifestyle, education, the environment etc. A successful policy therefore requires a major shift in the way health and social care professionals work. Establishing an integrated approach between different professional groups across the many agencies involved either directly or indirectly in the health and social care industry will be challenging in the extreme. It is clear that even if Community Nursing operates at an optimum level in its current role its ability to impact upon health at a population level will remain limited.

Throughout the review, therefore, we have sought to view Community Nursing in the wider context of the health and social care community. Community Nurses, like other primary care professionals, will play a vital role in the modernisation of clinical practice in the NHS at all levels.

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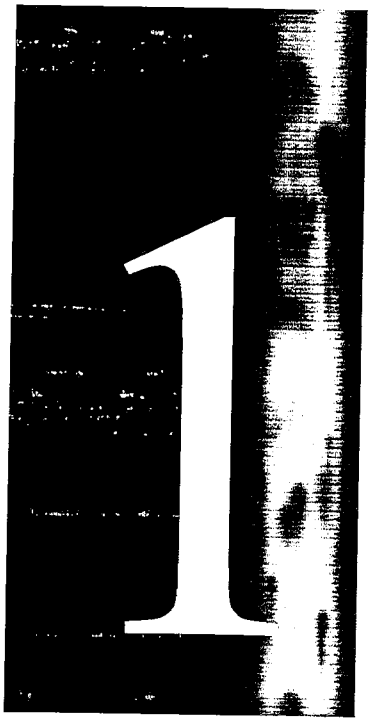
Modernising Community Nursing in North Kirklees

(The national policy objectives and their evidence base)

A compilation of research based reports
to inform the modernisation of community nursing services



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chapter one

public health targets

health inequalities

Current health policy in the UK is underpinned by an objective to improve the health status of the population and in particular to reduce inequalities in health status between different groups within society. *Reducing Health Inequalities: An Action Report (Our Healthier Nation)*, (July, 1999)[1] set out a series of objectives and a strategy for Nurses, Midwives, Health Visitors, Health Authorities (HAs), Primary Care Trusts (PCTs) and Primary Care Groups (PCGs). This seems to be an ideal starting point from which to build a community nursing strategy.

The aim of this policy document, as set out in (para. 1.1) is to improve the health of the worst off in society and narrow the health gap. This is to be done by the development of an integrated health strategy, which tackles social, economic and environmental causes of ill health as well as its consequences (para. 1.4, 2.4, 10.1)[1], see also *Saving Lives: Our Healthier Nation*, (July 1999).

a fairer society

A key theme of the initiative is to promote social inclusion (para 2.3)[2] and equity of access to services for all members of society (para. 2.3)[1]. It prioritises health inequalities in women of childbearing age, expectant mothers and young children and the promotion of well being, mobility, independence and social contacts of older people, ensuring access to health services, which are distributed according to need (para. 2.2). These themes will form a major priority for Community Nurses generally and Health Visiting in particular.

Similarly, priority is given to the enhancement of preventative services, which reduce admissions to hospital and provide optimal support for recuperation and rehabilitation. It is envisaged that this will form a key theme in the intermediate care agenda and is the basis of the *National Service Framework for the Elderly* (para. 2.13)[1].

building healthy co

The *Reducing Health Inequalities* action report targets policy towards reducing health inequalities and assessing the impact of policy. It specifically considers the needs of minority ethnic groups and the implementation of policies to reduce social inequality and raises awareness of specific health risks.

[1] Department of Health, *Reducing Health Inequalities: An Action Report, (Our Healthier Nation)*, (July 1999).
[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).

The Report recommends that work within the targeted health action zones is used to improve the relationship between health and local authorities and to provide better co-ordinated and more seamless services. PCGs and PCTs are required to set a framework for local service delivery, the promotion of health improvement and the development of wider roles for professional staff (para. 3.2)[1]. This again will impact upon community nursing as set out in Chapter 3.

Targets are to be established in four public health priority areas; coronary heart disease and strokes, cancer, injury prevention and suicide (para. 3.6)[2]. An assessment of local health inequalities is to be undertaken to set targets and specify outcomes, within three-year health improvement programmes. The implementation of this work will be monitored through the NHS Performance Assessment Framework (para. 3.7)[1]. Previous community nursing profile work will contribute greatly to this exercise.

education and early

These programmes will affect school nurses in particular and include Sure Start (para.4.1)[1] (para.2.1)[2]The Healthy Schools Programme (para.4.4)[1], Social and Health Education in Primary and Secondary Schools (para.4.5)[1], and nutritional initiatives (see below, para. 9.10)[1]. Any strategic development of school nursing in particular will need to build from these priorities.

employment

Programmes that require liaison between health services and employers/employment agencies include the Healthy Workplace Initiative and the Occupational Health Strategy (para. 5.5)[1]. The aims of these programmes are to ameliorate the health consequences of unemployment, improve job quality and reduce physical and psychosocial work hazards.

Health services will be affected by the Family Friendly policy (para. 5.6)[1]. These will enable people to balance their working and family lives more easily, by improving childcare, introducing parental leave and adopting Working Time Regulations (para. 5.6)[1] to reduce stress (see Chapter 2).

housing

Policies that may require liaison between health services and other agencies include the implementation of space and amenity standards (para. 6.3)[1], the active encouragement of fitting smoke alarm systems (para 6.3)[1], the tackling of fuel poverty (para. 6.5), the promotion of home energy efficiency (para. 6.5)[1], the Homeless Action Programme (para. 6.6)[1] and the Homeless Mentally Ill Initiative (para. 6.7)[1]. These initiatives will probably require the assessment of these factors to be incorporated into the clinical assessment protocols of community nurses.

reducing crime

Initiatives that will require liaison between health services and other agencies include the impact of crime of the health of victims (para. 7.1)[1], community crime prevention (para 7.2)[1], drug prevention work (targeted in health action zones, see para. 3.2) and strategies to avoid drug misuse (para. 7.3)[1].

transport and mobil

The National Road Safety Strategy will involve health services in its policy to reduce ill health induced through vehicle emissions, road accident fatalities and serious injuries (para. 8.3)[1] by reducing general motor vehicle use. Health services may be involved in the review of Road Speed Policy (para. 8.3)[1] and the School Travel Advisory Group (para. 8.3)[1]. Policy will encourage walking and cycling as healthy alternatives, through their safe separation from other traffic (para. 8.3)[1].

[1] Department of Health, *Reducing Health Inequalities: An Action Report, (Our Healthier Nation)*, (July 1999).
[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).

other public health i

Further initiatives impacting upon the workload of community nurses are discussed throughout the report. They include the promotion of active and healthier lifestyles.

example 1

An integrated range of maternity services in Manchester has been targeted at women with mental health needs, problems of substance misuse and refugees who do not speak English (para. 2.23)[2].

Similarly, initiatives are in place to modernise A&E departments and to provide alternative forms of health advice (i.e NHS Direct help line, walk-in centres etc.). There is a drive to disseminate good practice through health improvement beacons in this area (para. 9.1)[1].

The focus on health encourages nurses to address nutritional concerns by: promoting breastfeeding, healthier school meals, dietary education, reduction of salt in the diet. In addition, nurses are encouraged to advise on preventative measures against obesity and heart disease (para 9.2)[1]. This includes promoting healthy lifestyle choices, encouraging independent self-management and maximising mental and physical well being (para. 10.6)[2]. The policies include targeted health plans to address local needs (e.g. immunization/vaccination programs and teenage contraception in schools, back-pain initiatives in the workplace, and the control of infectious disease in primary care settings), (para. 10.8)[2].

example 2

Approaching health issues hand-in-hand with housing problems provided an integrated plan for improving the quality of life for East London residents (para. 10.8)[2].

By focusing on health at key stages in life it is anticipated that long term benefits will accrue. For example, a broadening of the educational contribution of midwives, in informing young people of contraceptive options, sexual health and relationship issues and the responsibilities involved in pregnancy and childcare (para. 10.27)[2] and in providing lifestyle advice, antenatal and parenting classes at times and in places which will reach people most effectively, with continuous follow-up care in the postnatal period (para. 10.29, 10.30)[2] will potentially have two effects. Firstly it will impact upon the health of the women and secondly it will impact upon the health and quality of life of the child.

[1] Department of Health, *Reducing Health Inequalities: An Action Report, (Our Healthier Nation)*, (July 1999).
[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).

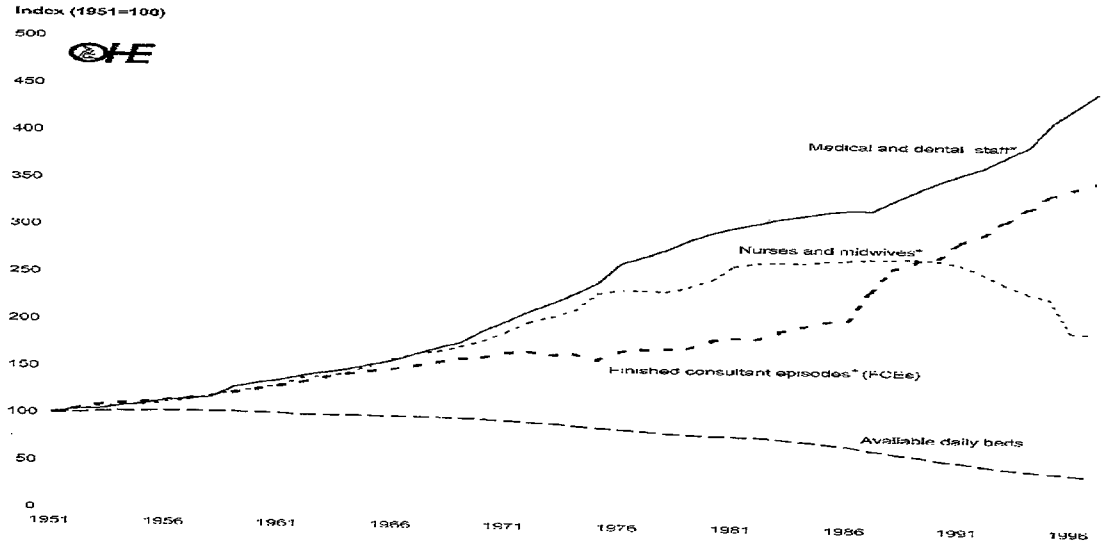
chapter two

the nursing workforce

recruitment and retention

The current manpower shortage in nursing is a major obstacle to the modernisation of the NHS. Following the introduction of the internal market in the early 1990s the number of patients treated and the numbers of medical staff treating them in hospital continued to increase in line with existing trends. The number of beds and the numbers of nurses however declined sharply. (See fig. 3.6)

Figure 3.6 Growth in NHS medical and nursing staff numbers, FCEs and available beds, UK, 1951 - 1997



Notes : *Figures relate to whole-time equivalents (see also Table 3.6).
*Prior to 1987/88, figures relate to discharges and deaths.
Sources: See Table 3.6.

This has had a twofold effect. Firstly it means that less nurses are treating more patients. Secondly the increased throughput of more patients, through less beds, has increased enormously the considerable workload associated with admitting and discharging patients.

This phenomena is being repeated across Central Europe where internal market reforms are being introduced. The reason is unclear but it is speculated that the introduction of a market into health care brings with it a strong focus on financial control (in the UK financial objectives were the drivers of Trust board performance). When financial control is slipping the easiest way to bring expenditure into line is to freeze post. As most posts are nursing posts this leads to a surreptitious reduction of the nursing workforce. Frozen posts mean that newly qualified nurses cannot get a job and become unemployed. Publicity about unemployment in nursing dissuades young people from training and so the cycle

develops. The reduction of nurses in the hospital sector combined with rapid growth in the nursing home sector has led to a significant diminishing of the pool from which nurses can be recruited.

More nurses, midwives and health visitors are needed to reduce shortages and also to provide for a flexible work force (para. 2.25)[2]. Strategies to increase the number of nurses available to the NHS are of great importance to health communities. They include ranges of initiatives from incentives to stay after retirement age to the recruitment of nurses from overseas.

enhanced recruitme

Policies need to be in place to assure equality of access to education, development and career advancement from a variety of social and academic backgrounds, and age-ranges (para. 2.26)[2]. Similarly, initiatives need to be developed to achieve a better match between the social and ethnic composition of the professions and the communities they serve, especially from black and ethnic minority groups (para. 2.34)[2].

example

A 'Job Shop' bureau located in a multi-ethnic practice in Bradford provides access to all NHS training programmes and jobs in the city, as well as careers advice and support (para. 3.7)[2].

There is currently a drive from Central Government to ensure that the ethnic composition of the nursing workforce reflects, as far as is possible, the ethnic composition of the local community. This is aimed at:

a) promoting culturally appropriate services.

b) overcoming disadvantage/discrimination regarding recruitment and promotion of health professionals from ethnic minority backgrounds (The New NHS, MaD, NHS Plan).

Iganski et al, (1998) and Gerrish et al, (1996) analysed entrants into pre and post registration nurse education and identified similar findings:

- Applicants from female black groups **to pre-reg nursing from those resident in UK** are overrepresented relative to the population as a whole. Asian applicants are consistently under-represented. Under representation of the Asian communities is a matter of concern in view of the relationship between ethnic diversity in the nursing workforce and the provision of health services sensitive to the needs of minority ethnic communities.

- **application outcome** - both black and Asian applicants when compared with white applicants were less likely to have commenced training or be holding an offer for training. Higher proportions of black and Asian applicants are rejected without interview. Recruitment and selection policies and practices adopted by nurse education institutions may have key role in accounting for these patterns.

- **targeting of minority ethnic groups** - little evidence of targeting recruitment in minority ethnic communities. Activity tended to be ad hoc, intermittent and frequently relied on initiative of particularly aware or committed individuals.

They recommended that institutional strategies be developed to target local recruitment - this would need to be informed by reliable data concerning local demography and ethnic composition of current workforce.

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[3] Iganski, P., Spong, A., Mason, D., Humphreys,A. & Watkins, M., *Recruiting Minority Ethnic Groups Into Nursing, Midwifery and Health Visiting*, Researching Professional Education Series, Report Number 7, (English National Board, London, 1998).
[4] Gerrish, K., Husband, C., & Mackenzie, J., *Nursing for a Multi-ethnic Society*, (Open University Press, Buckingham, 1996).

an ageing communi

Current community nursing vacancy factors tend to be lower than hospital vacancy factors. The NHS nursing workforce as a whole is ageing and the Audit Commission report identified this to be a particularly pertinent issue for District Nurses. Other reports indicate that it is a national problem for District Nurses, Health Visitors and Practice Nurses. If recruitment is or could be an issue in North Kirklees there is a need to consider: nursing bank, nursing agency, back to nursing programmes, overseas recruitment etc. Millar B., (2000), found that the number of nurses on the register has fallen to a seven-year low, but the long term trend, reported by UKCC, is said to be encouraging. The number of nurses on the register fell by 3,220 last year. Only 13.3% of those on the register are under 30. This figure can be contrasted with the number of nurses on the register over 50 years old: 23.3%, the highest level ever recorded. Many of the new entrants could be accounted for by overseas recruitment. The number of applicants trained outside the UK and EU has more than doubled since 94/5.

Buchan, J., (1999) demonstrated that one in five or 20% of nurses on the UK professional register were aged 50 years or older in 1999. By 2010 it is likely that 25% of nurses will be aged 50 years or older. The implications of this age shift for employers are as follows:

a) Greater numbers of nurses are reaching or will soon reach retirement age.

b) Over the next few years the profession will lose, through retirement, many of its most experienced practitioners.

c) Many nurses reaching their middle years are likely to have different requirements and attitudes to nursing work.

Data were examined from official sources, including attitudinal surveys and case studies with organisations, to assess the major effects of the ageing of the workforce. The key findings were that:

- The age profile of nurses working in the NHS appears to be younger than that of the total nurse population with the age profile of nurses working in nursing homes and as practice nurses being older than that of NHS nursing workforce.
- In respect of community nursing, data from 1996/7 indicates that 28% of practice nurses, 27% of health visitors, 25% of district nurses and approximately 31% of community nursing auxiliaries are aged 50 or older. The age profile of Health Care Assistants is younger than nursing auxiliaries.
- Overall the age profile of NHS nurses masks considerable variation between specialities and trusts.
- The 'pool' of potential returnees from which the NHS and other employers attempt to recruit is declining in numbers as it ages too. This is likely to lead to greater competition between employers to attract staff.
- 'Older' nurses have raised problems regarding balancing work with domestic commitments and to job dissatisfaction.
- The changing nature of community nursing higher patient throughput, higher patient dependency in community are seen to contribute to increased stress and workload.

issues to consider

The organisational cost of losing experienced nurses and the additional costs of replacing them in a tightening nursing labour market is likely to have major implications for PCG / PCTs. Strategies need to be in place to deal with this key challenge. Initiatives could include:

[5] Millar, B., "Decline and Fall", *Health Service Journal*, (2000).
[6] Buchan, J., "The 'Greying' of the United Kingdom Nursing Workforce: implications for employment policy and practice" *Journal of Advanced Nursing*, 30 (4), (1999), pp. 818-826.

- The provision of appropriate flexible hours for older nurses who have caring responsibilities
- Improving access to continuing professional development
- Reducing pension inflexibility and phased retirement benefits
- Reviews of skill mix and the work force profile
- Greater consideration to career development opportunities
- An investigation in to how career ladders and pay systems can best remunerate older nurses who have continued to acquire skills and competencies long after they have hit top increment of current salary.

education and training

pre-education traini

Training and Enterprise Councils (TECs) should give PCG/PCTs access to vocational training systems (para. 4.10)[2]. Similarly there is a perceived need to create stronger and more effective working relationships between the NHS and the universities (DoH, QAA, UKCC) (para. 4.17)[2]. These partnerships will strengthen the capacity for the delivery of a full range of educational and training initiatives to health communities.

Recruitment should take place through high profile and multi-media public campaigns, building awareness through educational institutions such as schools (para. 3.6, 3.7)[2]. Systems need to be developed to credit prior learning and provide a flexible system for incremental progression for people to access nurse training (para. 2.35)[2]. These types of initiatives, combined with a strengthening of the links between vocational training and pre-registration education, will allow a widening of access to people who wish take up a career as a qualified nurse later in life after a period working as a health care assistant. More part-time education and training opportunities: 'stepping on' and 'stepping off' points (para. 4.8, 4.9)[2] need to be developed.

These recruitment initiatives, combined with systems to ensure that newly qualified nurses and midwives are equipped with full range of skills, through practice-based teaching and clinical placements (para. 4.11, 4.12)[2] will have an impact on Community Nurse recruitment in the medium to long term but are likely to have a significant impact on the clinical supervision and teaching of student nurses in the interim. Careful thought needs to be given to how this initial pressure upon the system can be handled.

continuing professi

Nurses, midwives and heath visitors must undertake continuing professional development to renew their registration every three years (para. 1.6)[2]. NHS organizations are required to provide Continuing Professional Development (CPD) (para. 4.18)[2]. This again has significant implications for the availability of nursing resource in the immediate future. The Continuing Professional Development framework needs to include:

- A relationship to staff appraisal systems.
- A life-long learning ethos.
- Inter-professional learning.

There needs to be in place a Continuing Professional Development program for health care assistants in the form of Individual Learning Accounts. This will form part of a career progression

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*

Program from Health Care Assistant to Nurse Consultant. Buchan J[6] demonstrated that NHS nurses aged 50+ are less likely to apply for CPD than younger cohorts. The extent to which this problem may be attributed to factors such as a lack of commitment from nurses, lack of provision, practical difficulties of attending due to the need to balance professional and non-work commitments, or age discrimination on the part of the employer is not clear. Further findings included the following:

- That PREP requirements for mandatory professional update require a commitment to CPD for all nurses. Also there is a need to retrain staff, update skills and provide for 'life long learning'.
- That career structures for nurses are flatter and less hierarchical than previously, with fewer promotional opportunities. Older nurses in particular require viable and relevant career development opportunities if they are to be retained and motivated.
- That it is anticipated that the demand for CPD from older nurses will increase.
- That back to nursing initiatives are required. For example the running of open days, the provision of clinical updating for returnees, the allocation of a workplace mentor and the creation of personal development plans for each returnee.

The Audit Commission report '*Hidden Talents*' demonstrated that:

- Continuing Professional Development (CPD) was key to meeting patients' needs, improving quality of care, supporting clinical governance, and modernising the NHS.
- Staff training needs were often not identified and planned for. 50% of Trust staff surveyed did not have a Personal Development Plan (PDP).
- Training needs across organisations are often not identified systematically.
- HImP's have not yet influenced the training planned for and provided by Trusts.
- There are wide discrepancies across Trusts regarding the opportunities for nurses to pursue higher education.
- Nursing auxiliaries and part-time staff experience poorer access to training.
- 20% of Trusts had used less that 75% of the post-registered nurse training available.
- Training needs to be made more accessible for those who cannot be released from their jobs.
- Individuals need to take responsibility for their own personal development
- Managers need to agree PDPs with staff and create opportunities for on-the-job development
- Trust Boards need to have an overview of resource use and performance manage training and development issues.
- As PCTs establish increased interagency working these new service providers need to ensure that experience and good practice is not dissipated build on strengths.

The Department of Health report '*Investment and Reform for NHS Staff* set out that:

- The NHS Plan acknowledges that the need to invest in skills and potential of staff who do not have a professional qualifications has been neglected for too long.
- Over the next 3 years all unqualified staff are to have access to an Individual Learning Account of £150 or dedicated training to NVQ level 2 or 3.

[6] Buchan, J., "The 'Greying' of the United Kingdom Nursing Workforce: implications for employment policy and practice" *Journal of Advanced Nursing*, 30 (4), (1999), pp. 818-826.
[7] The Audit Commission, *Hidden Talents: Education, Training and Development for Healthcare Staff in NHS Trusts, (London, 2001).*
[8] Department of Health, *Investment and Reform for NHS Staff Taking forward the NHS Plan, (2001).*

- National frameworks for implementation need to be in place from April 2001
- 'Improve your study skills' programmes need to be established and designed to help staff with NVQ levels 2 & 3 develop skills to equip them for participation in professional training courses.
- There is a need to establish PDPs for non-professionally qualified staff

The Royal College of General Practitioners, in their report '*The Primary Health Care Team*' (1998) outlined the following issues:

- There is a need for information sheets providing an overview of the role and structure of the primary health care team.
- Increased teamwork in primary health care has led to a recognition of the need for a multi-disciplinary approach to education and training of members of the PHCT. Whereas GPs can address their educational needs through the postgraduate education allowance, educational opportunities are less obvious for other members of the team. A further complication is that the amount of money available for team-based education is limited.
- With the fall in the number of GP registrars and the shortage in nurse recruitment there may be a greater need for PHCTs to share their workload in the future. Some GPs may be hesitant about transferring work to other professionals such as nurse practitioners because of perceived problems in areas such as the levels of appropriate training, personal liability and cost effectiveness. One way to overcome professional differences is for doctors and nurses to receive joint education at undergraduate level in order to build a greater understanding of each other's work and improve inter-professional communication. RCGP sees joint professional education as potentially holding the key to remove misunderstanding of the roles of other team members and in helping to remove attitudes that block the development of effective teamwork.

improving working lives

modern career fram

Health organizations are required to promote career structures for nurses with a clear trajectory (from cadet to nurse, midwife or health visitor consultant, and from Health Care Assistant to Registered Practitioner, Senior Registered Practitioner and Consultant Practitioner) (para. 5.7)[2]. This will need to be done by developing competency frameworks and identifying key thresholds for each stage at local NHS level, within standardized, national guidelines (para. 4.18)[2].

flexible working - f

Trusts and Health Authorities need to modernize their employment relations along with the development of human rights and family friendly policies(see *Fairness at Work*). Employers need also to monitor the effect of such policies and promote examples of good practice. Examples of the types of initiatives contemplated are the provision of management and IT support for self-rostering schemes, the development of effective childcare arrangements, study leave, career breaks and secondements. (para. 6.5)[2]

There is a requirement for the employment of anti-harassment procedures to deal with conflicts arising in primary care. Violence and intimidation (against staff or patients) is to be reduced by 20% in 2001 and 30% in 2003, through increased security, effective complaints procedures and investigations, and public campaigns (para. 6.15, 6.16, 7.6)[2]. (Audits need to be in place to assess the current baseline).

All employers should aim to reduce sick absence and accidents at work by 20% in 2001 and 30% in 2003 through e.g. appropriate lifting and handling training, and fast-track physiotherapy services, to

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[9] Royal College of General Practitioners (RCGP), *The Primary Health Care Team, RCGP Briefing Paper No 21, (RCGP, London, 1998).*

reduce work accidents and sick absence.

Flexible working and family friendly policies have been highlighted as key policy concerns (MaD, NHS Plan). This is not just about childcare but also carer responsibilities for older dependents.

Buchan J[6] stated that flexibility is often portrayed as an employer's response directed towards helping nurses accommodate work-life and domestic commitments. Implicitly or explicitly this flexibility is usually related to childcare responsibilities but for many nurses in the ageing workforce flexibility will be required to enable the provision of care to adult dependents or to facilitate access to educational programmes. Similarly many are seeking support to enable a 'phased' approach to retirement.

One third of nurses in 50+ age group report carer responsibilities for elderly or dependant adults. Research into employment patterns highlights that caregivers are less likely to be in full-time employment than those without caring responsibilities.

Given the current demographic profile of largely female nursing profession it is likely that there will be a marked increase in the proportion of nurses with caring responsibilities for elderly relatives and partners over the next decade. The provision of flexible employment for nurses will need to take account of this demographic shift[6].

There has been a trend in recent years in the UK economy to support early retirement. However, it is now recognised that this approach is no longer sustainable because of the cost, the ageing population and tightening job market. Survey evidence suggests that there is an increasing tendency for people in their 40s and 50s to be more positive about retiring early and to be more open to a phased transition from permanent employment to full retirement. Nurses' decisions on retirement will be linked to their financial status, caring responsibilities, the nature of their employment and the effect of a retirement decision of a spouse/partner[6].

There is a high incidence of career breaks and part-time or occasional working in nursing which is likely to be major factor limiting the adequacy of many nurses' pension provision. The need to enhance pension provision and maintain financial stability is likely to be a main reason why many nurses work beyond the age of 55.

[6] Buchan, J., "The 'Greying' of the United Kingdom Nursing Workforce: implications for employment policy and practice" *Journal of Advanced Nursing, 30 (4), (1999), pp. 818-826.*

[illegible]

developing nursing services

enhancing the quality of care

clinical governance

Systems must be in place to ensure that nurses, midwives and health visitors fully understand clinical governance implementation plans and important milestones that need to be achieved (para. 7.6)[2]. There needs to be improved access to and employment of clinical guidelines and information. This in turn will require enhanced research appraisal skills to carry out and audit best evidence-based practice (para. 7.6)[2]. Trusts must agree the training needs of Community Nurses and participate in regular appraisals and Personal Development Programs. They must also develop systems clinical and statutory midwife supervision.

All staff must fully understand and implement local risk management policies and be aware of complaints procedures. They must know how to report clinical incidents and poor/unsatisfactory colleague practice and support their reporting with open investigation. They must be able to reflect on and learn from adverse events (para. 7.6)[2].

evidence based prac

All Trusts must implement national quality standards through the National Service Frameworks and National Institute for Clinical Excellence (para. 7.1)[2]. They must develop a research base and promote career development through a cadre of nursing, midwifery and health visiting researchers (para. 7.12)[2].

They should also provide a rigorous and systematic assessment of practice, and support its public dissemination via the NHS Net and National Electronic Library for Health, to facilitate the application of research findings (para. 7.13)[2].

Initiatives should be in place to strengthen evidence-based practice, improve effectiveness/quality and to minimise variations in standards of care (para. 7.14)[2].

clinical benchmarki

Initiatives must be in place to make standards explicit including dynamic benchmarking within PCTs, along with the monitoring and improvement of practice (para. 7.10)[2].

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).

example

North-West Paediatric nurses have successfully benchmarked clinical practice in children's nursing. Expert external evaluation ensures consensus between PCTs and provides a relative measure of their performance (para. 7.10)[2].

enhanced professional development

professional self-reg

Trusts must ensure local delivery via mechanisms of professional self-regulation and clinical governance, underpinned by supervision, annual appraisal, personal development planning, lifelong learning and mandatory periodic re-registration (para. 7.5, 7.6)[2]. Professional Self Regulation should be promoted (in accordance with United Kingdom Central Council for Nursing, Midwifery and Health Visiting Code of Professional Conduct and related guidance) and systems provided for the identification and referral of poor performance (para. 9.1)[2]. Nurses, midwives and health visitors must fully understand the obligations associated with professional registration, exercise autonomy and accountability within the context of the profession's regulatory framework (para.9.4)[2] and maintain and improve their knowledge and competence. They must flag-up personal limitations in practice or difficulties in undertaking expanded responsibilities (para. 9.2)[2]

strengthening leade

Trusts must improve accountability through the provision of strong leadership, standardized reporting arrangements, open investigation, reflection and application. (para. 7.6)[2]. They must develop clinical governance, strategic leadership and management skills through schemes such as those run by the Royal College of Nursing, or UNISON's work with NHS organizations. In addition they should facilitate informal development through mentoring, shadowing, job swaps, secondements and participation in learning sets (para. 8.4, 8.6, 8.8)[2].

Sisters, Charge Nurses and their equivalents should be targeted in both hospital and community settings, to develop leadership skills in PCTs and PCGs (para. 8.4, 8.5, 8.6, 8.8)[2]. Trusts should ensure effective contribution to planning and commissioning services from nurses, midwives and health visitors, through a special Focus Group (para. 8.7)[2].

Investment should be made in professional development plans and review systems for all nurses, midwives and health visitors, ensuring equal access and provision for black and ethnic minority groups and part-time staff. Supervision should be used to identify and establish effective support and coaching of potential leaders (through mentoring, shadowing, job swaps, secondements and participation in learning sets) (para. 8.9)[2].

Alimo-Metcalfe, B., (1999) set out the qualities and competencies for good leaders in the NHS. The author differentiated between transactional and transformational leadership.

Transactional management emphasises organising and planning the use of resources, 'fixing' problems that emerge and monitoring the progress of activities directed at achieving predictable outcomes and predetermined objectives.

Transformational leadership goes beyond management and involves creating new scenarios and visions, challenging the status quo, initiating new approaches and exciting the creative emotional drive in individuals to strive beyond the ordinary to deliver the exceptional.

The case for new leadership in the NHS is linked to a need to deal with greater uncertainty and increased complexity. Also the constant need to be able to adapt to change, in the context of limited resources being available. The validity of transformational leadership model has been supported by growing evidence from studies that have investigated it efficacy. Research has demonstrated that

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).
[10] Alimo-Metcalfe, B., "Leadership in the NHS: what are the competencies and qualities needed and how can they be developed", in Mark, A. & Dopson, S., *Organisational Behaviour in Health Care, (Macmillan Business, London, 1999).*

transformational leadership correlates strongly with a variety of objective outcome measures including:

- Commitment, effort, performance and job satisfaction of followers.
- Employee innovation, harmony and good citizenship.
- Financial performance of organisations.
- Performance in the public health sector.

Transformational leadership should not be understood as a replacement for transactional leadership but rather as an augmentation of this approach, since both are important in complex organisations.

Three variables consistently emerge as contributing to dysfunctional stress in staff[10]. These are the:

- Degree of performance pressure which will not decrease in organisations in the foreseeable future.
- Degree to which an individual experiences the freedom and autonomy to control their work and use their discretion greater degree of autonomy the lower the experience of dysfunctional stress.
- Extent to which work roles and objectives are clarified - greater degree of clarity of objectives the lower the experience of dysfunctional stress.

The style of leadership can impact upon the level of work stress experienced by all staff. Studies comparing stress levels in groups that experience similarly high levels of performance pressure found lower levels of perceived stress in groups in which individuals experience a high degree of autonomy and discretion. Also greater job satisfaction experienced by those in situations that permitted high job control.

Consistent research findings that show that staff who perceive their managers as predominately transformational have significantly higher levels of job satisfaction, motivation, commitment and performance.

Alimo-Metcalfe et al found that most managers seem relatively unaware of the role that they can play in either reducing or exacerbating stress. Apart from very real costs to individuals in terms of physical and mental stress, there are considerable organisational costs, including those arising from lower performance and low job commitment.

Traditional approaches to reducing stress have placed the responsibility for stress management on the employee. It is clear from the literature that organisations could realise more benefit from interventions designed to change the system in order to prevent the occurrence of work stress. Despite Alimo-Metcalf's finding that most managers are unaware of the role they play on the impact of work stress on employees, leader behaviour is amenable to change and thus a prime targets for efforts to alleviate unhealthy levels of work stress within the PCT.

Transformational leadership is most likely to alleviate stress as it is more empowering and allows staff greater autonomy and discretion. However, it needs to be combined with functional transactional behaviours. The characteristics of this style of leadership are:

- Openness to new ideas.
- Honesty/tolerance regarding mistakes.
- Being visionary promoter of organisational achievements.
- Intellectual flexibility.
- Entrepreneurial risk taking.

[10] Alimo-Metcalfe, B., "Leadership in the NHS: what are the competencies and qualities needed and how can they be developed", in Mark, A. & Dopson, S., *Organisational Behaviour in Health Care, (Macmillan Business, London, 1999).*

- Political skills.
- Tenacity to achieve organisational goals.
- Integrity.
- Genuinely interested in concerns and aspirations of staff as individuals.
- Empowering and creating opportunities for staff to develop.

Commitment to transformational leadership raises issues for the development and selection of staff who have responsibility for recruiting others.

Sofarelli et al (1998)[11] argued that the development of an appropriate model of transformational leadership will ensure that nurses can play a pivotal role in process of change. 'It will assist nursing develop into an empowered profession with the potential to be a dominant voice in reshaping health care system for the future'.

Managers (transactional leaders) work in hierarchical organisations and in positions which have legitimate sources of power with the authority to delegate. The emphasis of their work is on control, decision-making, decision analysis and results. Concerned with short-term view and bottom line. Leaders (transformational leaders) receive power through other means. The main focus is on group process, influencing, inspiring trust, challenging the status quo, and empowering others. In contemporary health care the move from bureaucratic management style to effective leadership is imperative.

Lindholm et al (2000)[12] undertook a study of nurse managers' leadership styles in Sweden using open-ended tape recorded interviews. They found that the nurse managers who had a clear leadership style (related mainly to a transformational or transactional leadership model), experienced fewer management problems than nurse managers with a composite leadership style.

clinical supervision

Systems must be in place to monitor the delivery of quality standards, and to provide feedback to teams and individuals against the frameworks used by national bodies such as the Commission for Health Improvement, the National Performance Framework, and the patient and user survey (para. 7.11)[2].

The DoH report *Making a Difference: Clinical Supervision in Primary Care (2000)*[13] *summarises the lessons learnt about implementing and developing clinical supervision in primary care. It highlights the importance of clinical supervision for Nurses and Health Visitors and the need for it to be developed, strengthened and integrated into the wider clinical governance development programme and linked to annual appraisal and personal development planning (page 46, para 7.5).*

A key commitment of the Making a Difference document was the re-launch of clinical supervision in primary care.

Clinical supervision was defined as 'a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations'.

Different models have been developed. The most common entail one-to-one sessions or small group meetings involving a trained supervisor or peers who may be chosen by the supervisees or allocated to them. Whichever model chosen clinical supervision usually involves meeting regularly to reflect on practice with the intention of learning, developing practice and providing high quality care to patients.

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[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[11] Sofarelli, D., & Brown, D., "The Need for Nursing Leadership in Uncertain Times", *Journal of Nursing Management, 6, (1998), pp. 201-207.*
[12] Lindholm, M., Sivberg, B., & Uden, G., "Leadership Styles Among Nurse Managers in Changing Organisations" *,Journal of Nursing Management, 8, (2000),* pp. 327-335.
[13] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*

Some organisations have been slow to develop clinical supervision. The 1999 Audit Commission 'First Assessment' found only half of District Nurses had access to clinical supervision.

Factors militating against the successful implementation of clinical supervision include:

- Inconsistent support for clinical supervision e.g. exclusion from the mainstream agenda by items such as clinical governance or human resource management, or good support from the Board but not supported by middle managers.
- Rural issues problems of travelling time for practitioners working over large areas or those professionally isolated from colleagues.
- A need for evidence on positive outcomes from clinical supervision on patients.
- Resistance from some practitioners.
- Lack of a champion no one to steer or lead process of implementation at team and organisational level.
- Difficulty in finding time.

Keys to success include:

- A need to be seen as part of clinical governance.
- Locally developed and supported implementation plans.
- Leadership at organisation and team level ideally with protected time for implementation and champions at each level.
- Adoption of philosophy of clinical supervision rather than imposing a particular model on staff.
- Use of evidence of positive outcomes.
- Links with systems of appraisal and CPD.
- Preparation of managers, supervisors and supervisees to ensue common understanding.

PCG/ PCTs need to endorse the principle of clinical supervision as part of clinical governance at Board level.

They need to find a clinical supervision 'champion' amongst their staff and allocate some protected time to audit current provision of clinical supervision and set targets for future involvement in clinical supervision.

They need to find out from staff e.g. through a 'nurses forum' what models of clinical supervision would be most practical and beneficial in each area of the organisation and for each staff group.

They need to develop systems of clinical supervision linked to Clinical Governance and Continuing Professional Development where they do not already exist. Consideration may be given to using the Manchester clinical supervision scale to evaluate the effectiveness of clinical supervision in the organisation

extended roles

Trusts should encourage and extend the roles of nurses, midwives and health visitors as public health promoters. This will include the provision of information, early assessment, screening and disease control, facilitating access to services, and acting as advocates for vulnerable and socially excluded groups (see *Saving Lives: Our Healthier Nation*).

Healy, P., (1999) described some of the advanced practice roles developing in nursing, in particular situations where nurses take on tasks from doctors. *Making a Difference*[2] describes four responsibilities of nurse consultants: expert practice, professional leadership and consultancy, education and development, practice and services development linked to research and evaluation. Nurse consultants form part of DoH human resource framework and pay.

Manley, K., (1997), (2000), (2000), has written three articles describing a 3 year action research project (1992-1995) investigating the development of a consultant nurse post and to consider whether it contributed to a new organisational culture. The author became a consultant nurse and action researcher to a ITU NDU for 4 days per week. The role primarily involved leadership and facilitation. Outcomes focused on the development and empowerment of staff, the development of nursing practice and a transformational culture.

The role of the consultant nurse appears to be that of a clinical leader as exemplified in the literature on NDUs. Changes in culture similar to those reported in the wider NDU literature were also identified.

Notes from **NHSE Trent Regional Nurse Forum** Oct 2000 outline recent approval of applications from community trusts for nurse consultant posts in relation to community nursing. They cover the following areas of interest:

- Intermediate care.
- Public health.
- Domestic violence.
- Primary care.
- TB.
- Sexual health.
- Haemoglobinopathies.
- Child protection and children in need.

nurse practitioner rc

Hicks et al (1999) described how considerable confusion exists relating to the definition and occupational boundaries of nurse practitioners. The clinical practice and training of nurse practitioners remains unregulated, unstandardised and heavily dependent on local forces.

The study entailed a survey of nurses in acute and primary care to identify the essential characteristics of Nurse Practitioners. Barton, T. et al (1999) describe the Nurse Practitioner role in the two settings. Both acute and primary care perceived the nurse practitioner's role as including examination and diagnosis and a range of research activities. Primary care regarded business and management activities as essential, whereas the acute sector highlighted issues such as high levels of communication skills, autonomy and risk management as being of greater importance.

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[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[14] Healy, P., "Unknown quantity", *Health Service Journal*, 22 , (July, 1999), pp. 9-10.
[15] Manley, K., "A Conceptual Framework for Advanced Practice: an action research project operationalising an advanced practitioner / consultant nurse role", *Journal of Clinical Nursing*, 6, (1997), pp. 179-190.
[16] Manley, K., "Organisational Culture and Consultant Nurse Outcomes: part 1 organisational culture", *Nursing Standard*, 14 (36), (2000), pp. 34-38.
[17] Manley, K., "Organisational culture and consultant nurse outcomes: part 2 nurse outcomes", *Nursing Standard, 14(37), (2000), pp. 34-39.*
[18] It should be noted that the study was undertaken before recent government policy on nurse consultant posts. Therefore, this study should not be seen as an evaluation of Nurse Consultant posts.
[19] See for example Gerrish, K., "A Pluralistic Evaluation of Nursing/Practice Development Units", *Journal of Clinical Nursing*, 10 (1), (2001), pp. 109-118.
[20] Hicks, C., & Hennessy, D., "A Task-Based Approach to Defining the role of the Nurse Practitioner: the Views of UK Acute and Primary Sector Nurses", *Journal of Advanced Nursing, 29 (3), (1999), pp. 666-673.*
[21] Barton, T., Thome, R. & Hoptroff, M., "The Nurse Practitioner: Redefining Occupational Boundaries", *International Journal of Nursing Studies, 36; (1999), pp. 57-63.*

The authors also looked at the occupational boundaries of nurse practitioners and undertook a literature review debating the development of the nursing practitioner role within the UK. The study raised issues of negotiating new boundaries between nursing and medicine.

They found that there was no agreed definition of the role of nurse practitioners. However the literature has shown that advanced education for nurses facilitates skills in the following areas: differential diagnosis; the ability to autonomously initiate and manage treatment or refer, if judgement dictates; screening patients for disease; developing preventative care management and the referral or discharge of patients.

Support for Nurse Practitioners within medical profession rests largely on an expected contribution to reduced workload by shedding unwanted tasks. There is ongoing confusion in differentiating between clinical nurse specialists and the nurse practitioners and between specialists and generalists. There is currently no national professional recognition of the term. The UKCC has not resolved the issue when considering high levels of practice.

The educational requirements of Nurse Practitioners remain unclear. Initially training was at degree level but now there is a proliferation at master's level.

Little research has been undertaken on the Nurse Practitioner role. There is a problem of increasing demand for Nurse Practitioners but a perpetuating lack a clarity regarding their roles. Employers want Nurse Practitioners now, yet educationalists propose lengthy education programmes.

The service demand for Nurse Practitioner is driven by economic rather than professional motivation. The nature of the role undertaken is ambiguous since different players have different views and because the role is evolving. The future development of Nurse Practitioner roles raises issues regarding advanced multi-professional education. Professional collaboration is seen as the key to the development and endorsement from existing professionals. It should give rise to appropriate support, regulation and where necessary, controlling legislation.

Read et al[22] carried out a DoH funded project 'Exploring New Roles in Practice' (ENRiP). This was a three stage study. A mapping exercise of a 20% sample of acute trusts in England was undertaken to identify the emerging range and purpose of new roles for nurses and PAMs. This resulted in a database, which provided a sampling frame for 32 case studies to clarify the range of issues relating to the introduction of new roles. The database in its entirety also provided the population for a survey designed to establish the generalisability of conclusions emerging from earlier stages of research.

The study found that the clarity of lines of accountability and levels of support available to post holders varied considerably. Overall there was a lack of evaluation of the new roles. Factors which promoted or compromised the effectiveness of the roles related to the ways in which the job was organised, the characteristics of post holder, the support or opposition from key players, multi-disciplinary team working, reluctance of inability to relinquish non-specialist aspects of work, inadequate resources, volume work. The full costs of innovative roles (both set-up and on-going) were often not identified initially, or if identified they could not then be met. Education and training needs were identified but not always met due to lack of time, cover or funding. There was often inadequate resources specifically lack of staff, insufficient funding, lack of secretarial support, lack of IT equipment, limited accommodation

The implications of the study were that integrated mechanisms will be required for workforce planning and these will need to include not just nurses and doctors but all other professionals who are playing an increasingly important role in health care delivery. Each profession will also need to rethink its traditional recruitment processes, educational strategies, continuing professional development and career patterns so that joint working is facilitated. A more integrated approach to the accreditation and regulation of individual practitioners will be required if quality assurance is to be maintained and the relationship between the professions changes.

In a second study Read, S., (1999)[23] examined Nurse-led care and the importance of management support. It was shown that Nurse led services often fail to research their full potential because of inadequate management. A strategic approach to the introduction of new roles was recommended.

The approach must include multi-disciplinary discussion and planning, human resources, financial, educational and research expertise must be considered at all stages of the discussion.

[22] Read et al

[23] Read, S.,"Nurse-led Care: the importance of management support", *NT Research, 4(6), (1999),pp. 408-421.*

Chambers, N., (2000)[24] reported a study examining the development of Nurse Practitioner roles in 3 GP practices in Derbyshire. Nurse Practitioners offered primary health care consultations on undifferentiated health problems as an alternative first point of contact to seeing GP. The broad aim of the project was to enable nursing skills to be utilised more appropriately, enable GPs to practise medical skills more extensively and provide greater choice for patients.

The evaluation of the project sought to ascertain the impact of the new role on patient satisfaction and on the primary health care team. It involved a survey of patients and focus groups discussions with health care professionals including a survey of patients in 3 Nurse Practitioner practices and 3 matched control practices.

Nurse Practitioners were found to have had a reasonable depth of penetration into the practice population, with 20% of patients having consulted with Nurse Practitioner on at least one occasion. Patients consulting with the Nurse Practitioner gave statistically significant higher satisfaction scores for the Nurse Practitioner in comparison with GP.

The introduction of Nurse Practitioners did not have a significant effect on reducing the workload of GPs. Some blurring of the boundaries between Practice Nurses and Nurse Practitioners was found in relation to triage and minor illness clinics.

On the job training of Nurse Practitioners by GPs was time consuming. The UKCC unwillingness to recognise the role of the Nurse Practitioner is seen as a major impediment to the further development of the role despite a proliferation of academic courses designed for Nurse Practitioners.

working in new ways

The NHSE (2001) *Primary care, General Practice and the NHS Plan: information for GPs, nurses, other health professionals and staff working in primary care in England* states the following:

The NHS Plan will mean:

- Primary care will provide a greater range of services.
- Resources will be directed at improving professional working lives, increasing job satisfaction and supporting GPs and other primary care staff in improving patient care.
- Successful, flexible multidisciplinary working with respect for individual professionals will be developed further to deliver better patient services.
- The practice will remain the basic unit of primary care within a system in which standards are improved and a wider range of more accessible services is offered.
- Practices will be offered greater freedoms and incentives as modernisation proceeds.

Targets of importance to nursing:

- 500 one-stop primary care centres by 2004.
- 50% of PCTs to have electronic personal medical records by 2004.
- A major expansion of PMS.
- NHS Direct to triage all out of hours calls by 2004.
- Nurses undertaking more roles.

Measures to reduce GP workload:

- Better use of receptionist and Practice Nurses to deal with coughs, colds and minor ailments.

[24] Chambers, N., "A UK Nurse Practitioner Study" in M. Gott (ed.), *Nursing Practice, Policy and Change, (Radcliffe Medical Press, Oxford, 2000).*

- Using NHS Direct for triage of out of hours calls.
- Using nurses and practice therapists for certification and administration for other organisations.
- Developing the role of practice nurses and IT in maintaining registers, developing care plans and creating recall systems.

Other issues:

- Nurses and Health Visitors will undertake a wider range of roles determined by patient and community need. They will be trained to take on more of the routine and minor ailment workload, enabling GPs to spend more time with patients and concentrate on those who need their expertise.
- Rapid expansion of the number of nurses in the NHS will mean a significant number of extra practice nurses whose role will be expanded.
- A review of the primary care workforce is looking at how the skills of staff can be better used and further expansion can be achieved after 2004.

Williams et al (1999)[25] examined the changing roles in primary care. This ethnographic study examined the relevant literature and involved 15 in-depth interviews with range of health professionals and consumer representatives. They identified a culture of uncertainty that might impair the potential for innovation in primary care. This included:

- A breaking down of professional identity through boundary changes, with a tension between allegiance to the profession on the one hand and place of work on the other hand.
- Working within a risk environment, especially uncertainty in relation to the changing status of patients and clients.
- Uncertainty in relation to the operation of new nursing roles, including training and leadership strategies for new roles.

They recommended that policy makers and managers should be informed that the further erosion of professional boundaries could lead to greater uncertainty and low staff morale.

The report suggests that attention should be paid to the legal infrastructure, which enables nurses to undertake tasks formerly undertaken by GPs. Considerable thought has been given to nurse prescribing. This needs to be extended into liability and negligence. Practices supporting workforce changes require clearer distinctions between professional roles to enable more efficient exploitation of current opportunities.

It would appear appropriate for individual contracts to be used where nurses assume new roles. These will provide clarity regarding boundaries with other health care professionals, combined with security to avoid exploitation and overlap. There is a general need for further training and support for nurses who are undertaking new roles and for affected colleagues.

integrated working

Making a Difference[2] supports development of integrated ways of working. It considers that the term 'integrated nursing teams' could be restrictive. 'Integrated working' accommodates other professionals and agencies.

Omitting the word 'team' keeps the focus on the recipient of care rather than membership of the 'team'. 'Integrated working' is necessary to balance the increasing complexity and specialisation of work in primary care which can sometimes fragment services. There is an expectation that PCTs will support nurses in PHC develop and pool skills through integrated working to make a more flexible

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[25] Williams, A. & Sibbald, B. "Changing Roles and Identities in Primary Health Care: exploring a culture of uncertainty", *Journal of Advanced Nursing, 29(3), (1999), pp. 737-745.*

and responsive set of skills available to practice populations and local communities while maintaining the defined professional expertise.

A strong multi-professional community should be developed within each PCT, which links individual teams with the organisation as a whole so that a coherent programme of CPD, quality improvement and innovation can flourish (page 66 para 10.25).

Integrated working, further endorsed by the NHS Plan, reinforces the need to break down old demarcations between professionals and highlights new roles for nurses. It is a means of ensuring that staff work in a coherent way to address locally identified health needs and deliver health improvement programmes. Integrating core and specialist competencies needs to include practitioners based in district wide teams. For example, specialist nurses, mental health and children's nursing teams, midwives employed in acute Trusts, specialist/outreach nurses.

Integration of clinical and public health responsibilities is recommended. Health Visitors, School Nurses and Midwives have a particularly important public health contribution to make. Health Visitors have a responsibility to act as catalyst for health needs profiling. They need to work with others to ensure that local services and community initiatives correspond to the identified needs and preferences of local population and that they are targeted on equalities. School Nurses contribute knowledge of issues affecting health of school-aged population. They need to work with other disciplines and agencies in addressing these.

A number of factors have been identified which facilitate team working. These include[2]:

- High level of participation and communication.
- Clarity of vision clear objectives for team.
- Mutual understanding of roles within team.
- Sense of ownership and belonging among teams.
- Emphasis on members' skills and competencies, not traditional roles.
- Flexible working practices.
- Opportunities for shared learning.
- Support for innovations.
- Organisational barriers removed.
- Integrated working comes from team not imposed.
- Benefits of team working understood and outweigh costs.
- Takes account of personal and professional development of members.

Similarly barriers to team working have been identified. These include:

- Organisational boundaries with traditional hierarchies.
- Lack of clarity about roles.
- Separate managerial lines.
- Status and gender issues.
- A lack of commonly accessible data.

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*

- Lack of facilitation (training) for team working and people management.

Integrated working must not be associated with a cost-cutting exercise, the dilution of existing skills, promoting the generic nurse or devaluing the contribution of the specialist nurse.

Key principles of integrated working have been identified. These include:

- Professional leadership with shared strategy and vision.
- Clear accountability frameworks to underpin practice and cross boundary working.
- Team autonomy, responsibility and authority to operate.
- Care centred on health care needs of population.
- Team must be flexible, to reduce overlap, build on specialties and respond to differing situations.

There are a number of implications in these recommendations for PCTs. They need to review the way nurses and other staff are deployed in order to ensure that they gain maximum benefit from their specialist skills for patients and the community. They need to consider introducing or strengthening integrated working across nurses and other staff at practice (traditional base for ICNTs), locality (cluster of practices) or PCG level. Specialist nurses and other professionals (e.g. therapists and social workers) need to be included in thinking about integrated working. It is recommended that staff are involved from the outset in any change to ways of working.

Experience shows that efforts should be made to address concerns about the purpose of any change early in the process and that the purpose of integrated working is clear and is supported by commitment at a strategic level. Organisations need to allocate dedicated time for leaders to share this purpose with their staff.

In the implementation of integrated working key supporters need to be identified to plan health needs assessment, evaluation and dissemination strategies. Line managers need to be incorporated into the planning and implementation process, using their skills in change management and professional development. Time needs to be given for adaptation and support in particular to the shared learning process is vital.

Galvin, K. et al (1999) carried out an action research study of one general practice designed to create change. Data was collected from multiple sources including team workshops, patient focus group interviews, individual interviews with GPs, practice managers, reflective diaries and patient surveys.

The aims of the study were to:

a) gain user perspective of service and identify particular patient needs.

b) examine role and types of work required of a nursing team to develop user-led service.

c) clarify core and specialist skills to meet patient needs.

d) identify key areas for change.

e) define new roles and responsibilities.

f) analyse current practice in order to propose new models of team working.

Overall there was high satisfaction with the services and the care expressed by the patient survey and interviews. Data from patients helped shape new roles and responsibilities for team members. Team workshops identified a range of issues related to integrated working.

These included: working across professional boundaries; identification of core skills that could be shared; clarification of specialist skills; responding to user needs; identification of organisational changes and support required. The ideal model from a GP perspective was a flexible nursing

[26] Galvin, K. et al., "Investigating and Implementing Change Within the Primary Health Care Nursing Team", *Journal of Advanced Nursing, 30 (1), (1999)*, pp. 238-247.

practitioner able to work in both practice and community settings and to reduce duplication. The main areas of collaborative working that were developed were: child health, leg ulcer management, cardiovascular health. There were proposals for E grade generic primary health care nurses and support workers.

Ross et al (2000)[27] evaluated seven nursing teams in primary care across two health authorities/trusts. Their findings indicated that this type of organisational change is concerned predominantly with structural, professional and organisational issues rather than patient care. In the teams studied the opportunity for integration led to a pragmatic coalition that encouraged its members to plan, execute and manage change themselves, according to a vague definition rather than a patient focused agenda.

nurse prescribing

Systems must be established to promote nurse prescribing to aid primary care service development and provide support for GPs (para 2.20 & 10.18)[2]. Certain limited prescribing rights have been granted to District Nurses and Health Visitors. They can prescribe from a limited nursing formulary. Practice Nurses can only prescribe if they have either a District Nurse or Health Visitor qualification. A proposal to extend prescribing rights to other health professionals have recently been put forward in the Review of Prescribing, Supply and Administration of Medicines, DoH 1999 (Crown II report).

Baird, A. (2000)[28], in a small scale qualitative study to ascertain the implications of nurse prescribing for practice nurses, found that practice nurses exert considerable influence over prescribing in diverse therapeutic areas within general practice, for example through agreed treatment protocols.

As generalists with a broad scope of practice, it may be difficult to accommodate their prescribing requirements inherent in such a broad scope of practice within the framework of the Crown II proposals. Both Practice Nurses and GPs were in favour of extending prescribing rights to Practice Nurses. Extending nurse prescribing raised important issues regarding accountability and patient safety. The training implications of broadening nurse prescribing will be considerable. Currently District Nurses and Health Visitors have to complete a short course approved by the ENB in order to be authorised to prescribe.

A consultation document was issued by DoH in October 2000[29] following the Government's announcement that it had accepted and would take forward the main recommendations of the Review of Prescribing, Supply and Administration of Medicines (Crown II report). Similarly, the NHS Plan reinforced the Government's commitment to extend nurse prescribing to a wider range of nurses from an expanded Nurse Prescriber's Formulary. The Closing date for consultation process was the 10th of January 2001

In April 2000 the Secretary of State announced that £10 million would be available from 2001-2004 to support a training programme to extend nurse prescribing. By March 2001 approximately 23,000 District Nurses and Health Visitors should have qualified to prescribe from the current Nurse Prescriber's Formulary.

A number of principles underpin the extension of nurse prescribing. These include:

- Patient safety should be paramount.
- Better and more convenient care for patients.
- Extension of nurse prescribing will reflect what is needed to manage patients' medical conditions, and convenient access to treatment. This will help to define: a) the range of interventions suitable, b) which medicines might be added to the Nurse Prescriber's Formulary, c) what kind of training and support nurses will need, d) which nurses will need prescribing training.

[27] Ross, F., Rink, E.. & Furne,A., "Integration or pragmatic coalition? An evaluation of nursing teams in primary care", *Journal of Interprofessional Care, 14 (3), (2000), pp. 257-267.*
[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[28] Baird, A., "Crown II: the implications of nurse prescribing for practice nurses", British Journal of Community Nursing., 5 (9), (2000), pp. 454-461.
[29] Department of Health, *Consultation on Proposals to Extend Nurse Prescribing, (2000).*

- Decisions will be driven by patient and local service need.
- Nurses will take full clinical responsibility for their decisions.
- Pharmacists and the PPA need to be able to identify easily those nurses entitled to prescribe and what they can prescribe.

The main areas addressed in consultation document include an extension of the Nurse Prescriber's Formulary to include treatment for minor injuries and ailments, health maintenance, chronic disease management and palliative care. Several different proposals were put forward for extending the current Formulary including enabling nurses to prescribe all medicines with exception of controlled drugs, i.e. the same as dentists.

It is proposed that there should be an expansion of the range of nurses who are trained to prescribe. It is recognised that it is not cost effective for all nurses to be trained but there is evidently a need to extend prescribing to GP practices, nurse-led clinics and some aspects of secondary care.

In the first instances the extension of prescribing may include: nurse, midwife and health visitor consultants, specialist practitioners, nurse practitioners, others who manage wards/clinics and other nurses in primary care with relevant qualifications. A new programme of training is to be approved by ENB by September 2001. From September 2001 nurse prescribing will be an integral part of specialist practitioner courses (i.e. training for District Nurses, Health Visitors, Practice Nurses, School Nurses etc.)

A Royal College of General Practitioners (RCGP) report (2001)[30] stated that:

- The RCGP is in favour of extension of nurse prescribing and calls for proper training and support for nurses who wish to develop these skills.
- It is important for continuity of care that there is some form of shared medical record so that both doctors and nurses aware of what has been prescribed for each patient, especially in relation to chronic disease management. Ideally practice protocols should be in place so that a single person, whether it is the GP or the nurse, takes responsibility especially if nurses are to undertake prescribing for chronic disease management such as asthma and diabetes.
- If nurse prescribing it extended the RCGP would expect systems to be put in place that provide the same safeguards and assurances in respect of nurses that revalidation will provide for doctors.
- The RCGP disappointed that proposals ignore recommendations from the Crown II report on the approach to education and training for 'new prescribers' that supported a period of supervised practice in prescribing and that the drugs 'new prescribers' have access to should be subject to expert clinical pharmacological and drug safety vetting. The concept of nurse prescribing now envisaged is so vastly different from the Crown II review that the RCGP are of the opinion that a completely different level of education and training is needed.
- The RCGP feel that there should be no change in the regime for prescribing controlled drugs or those used for palliative care until the recommendations of the Shipman Inquiry have been made.
- The RCGP support a wide expansion of the Nurse Prescribing Formulary.

workload management

skill mix

Ebeid, A., (1999)[31] provides an account of how one Trust adopted a human resource management approach to developing staff and community nursing services.

[30] Royal College of General Practitioners, *Summary of RCGP Response to DH Proposals for the Extension of Nurse Prescribing, Press release issued on 16/01/01.*
[31] Ebeid, A., "Managing Change Within Community Nursing", *Community Practitioner, 72 (9), (1999), pp. 296-298.*

This aimed to achieve a 'modernised, innovative needs-led evidence-based' health visiting service. A locality manager undertook an equity exercise to ascertain and redistribute workload responsibilities among 18 health visitors employed in the locality. The exercise identified unacceptable workload variation (120-300 families per WTE Health Visitor) with no link to need. In addition it found that there was an unequal deployment of support staff- i.e. trained nurses and assistants. This led to a reallocation of Health Visitor resource on a formula of 50 families per day of Health Visitor time, which was adjusted for CPT responsibilities.

Skills deficits were identified in immunisation, management and leadership skills. An updating exercise was introduced. Similarly it was found that the skills mix had not been well developed. Health Care Assistants were developed to take on routine family visiting work and assist with hearing tests. Nursery nurses were involved in a practical parenting initiative. Qualified nurses were trained in home visits and immunisation. Health Visitors adopted a more supervisory role.

In a follow up article on the above project, beneficial outcomes were identified including saving of £10,000 in 97/98 through skill mix while at the same time increasing activity both in group contact and home visits. G grades were reduced by 1.5wte, E grades by 1.7 WTE. Two years into the project most Health Visitors viewed the skill mix more positively and it is seen to have been beneficial.

Hicks et al (2000)[32] described an alternative approach to skill mix review. Clinical skill mix has been acknowledged to be one solution to the problem of providing high quality health care within framework of restricted resources in NHS. Methodological difficulties in taking accurate measurements of clinical outcomes, following a set of treatment inputs, have contributed to inconclusive results from many skill mix reviews. Rather than look at clinical and fiscal outcomes as primary indices of successful skill mix, this study focuses on the relevance of task inputs within a given clinical domain. Members of a large PHCT evaluated the importance of a range of job tasks to the provision of quality care within their primary care role and their perceived performance on them. Any perceived skill deficits could inform commissioning of further training to improve performance levels or future selection of staff.

Humphries et al (2000)[33] reported an open forum on the future of School Nursing held at the University of Central Lancashire. It was identified that school nurses spend the majority of their time on screening and surveillance of healthy people aged 5-16 years, although there is no national programme that details who is screened for what, when and by whom. There is variation between the type of core screening and surveillance programmes, which suggests that many School Nurses spend time and resources on unnecessary work.

Skill mix initiatives introducing different grades of nurses, nursery nurses and Health Care Assistants could allow qualified School Nurses to concentrate on public health functions such as health promotion, developing services and strategies, working as part of multi-disciplinary groups that concentrate in individuals, families, and communities.

The CPHVA suggests that School Nurses at G grade should be first-line managers with a specialist role in, for example, sexual health or mental health.

Jenkins-Clarke et al (1998)[34] carried out an observational and interview study of 10 general practices (GPs and attached Community Nurses, District Nurses, Health Visitors, Practice Nurses). The objectives of the study were to:

a) Document workload in terms of current patterns of activities and interactions between GP and other members of PHCT.

b) Assess potential for some GP activities to be performed by other members of PHCT.

c) Examine attitudes of GPs towards delegation, and nurses attitudes to taking on other responsibilities.

They found that 39% of all GP consultations had a delegatable element and 17% were deemed to be

[32] Hicks, C., & Hennessy D., "An Alternative Methodology for Clinical Skill-Mix Review: a pilot case study with a primary health care team", *Journal of Interprofessional Care* 14: 1, (2000), pp. 59-74.
[33] Humphries, J., & Tonge, J., "Looking Ahead: a forum on the future of school nursing", *Community Practitioner*, 73, (12), (2000), pp. 881-883.
[34] Jenkins-Clarke, S. & Carr-Hill, R., "Teams and Seams: skill mix in primary care", *Journal of Advanced Nursing*, 28 (5), (1998), pp. 1120-1126.

delegatable in their entirety. GPs referred any delegation to Practice Nurses in their current team and Nurse Practitioners in an enhanced team rather than District Nurses or Health Visitors.

Activities deemed most amenable to delegation included skin complaints, screening, contraception, prescribing, advice and reassurance. Doctors and nurses expressed some reservations about delegation. Some Practice Nurses did not feel equipped to take on enhanced roles.

McIntosh et al (2000)[35] found that arguments for grade mix reviews include: cost effectiveness in the use of scarce resources, matching skills to patients' needs, flexibility in meeting increased demand for nursing care and the release of the specialist district nursing sister for care planning and team management. Grade mix changes in the UK (including a decrease in the number of G grades and an increase in the number of CNs and Health Care Assistants) have occurred incrementally and unevenly across the UK without policy guidelines, without an apparent basis upon which to judge the appropriateness of any specific mix of grades and largely without evidence-based debate about possible consequences for patient care. The relationship between grade mix and skill mix is elusive although recent policy states that skill mix should be related to patients' needs and nursing roles and responsibilities should be flexible.

Current policy supports role development among nurse consultants, role sharing between nurse consultants and the blurring of boundaries between nurses and doctors.

Delegation practice was found to vary both within and between areas. In an ethnographic study of the way in which grade and skill mix are taken into account in the delegation of nursing care. 76 members of 21 District Nursing teams were observed and interviewed[33]. Considerable differences were uncovered in the responsibilities allocated to more junior and unqualified team members. Where there were increases in E grade RGNs there was a reduction in the scope of development for D grade Enrolled Nurses and Health Care Assistants. Where fewer RGNs, and Enrolled Nurses were available Health Care Assistants had more scope for development.

The local Health Board policy allowed some flexibility in delegation of practice but it was driven more by a mixture of work force planning and workload management and it occurred in an ad-hoc, uneven manner, which resulted in inconsistent use of skills across District Nursing teams. Key issues, which were linked to increasing delegation, included:

a) The direct involvement of District Nursing in the training and supervision of Health Care Assistants.

b) A balancing act was required to make appropriate delegation decisions based on the level of experience within the team and complexity of patient needs.

c) There was a need for G grades to balance the provision of staff development for members of team with their requirement to act as an accountable practitioner.

The report concluded that there is need for greater recognition of the centrality of the leadership and supervision roles provided by G grade.

Rapport et al (1997)[36] carried out an interview study of a district nursing service in one health district. Forty three staff participated. They included District Nurses, other community nurses, managers, GPs, social workers/managers, patients and nursing home directors. The aims of the study were to:

a) Describe the organisation and provision of community nursing services.

b) Explore how primary care professionals have responded to a process of change within the community.

c) Consider district nurses' understanding of complete care.

d) Explore views of patients and informal carers regarding health and social care provision.

[35] McIntosh, J., Moriarty, D., Lugton, J. & Carney, O., "Evolutionary Change in the Use of Skills Within the District Nursing Team: a study in two Health Board areas in Scotland", *Journal of Advanced Nursing, 32 (4), (2000), pp. 783-790.*

[33] Humphries, J., & Tonge, J., "Looking Ahead: a forum on the future of school nursing", *Community Practitioner, 73, (12), (2000), pp. 881-883.*

[36] Rapport, F., Maggs, C., "Measuring Care: the case of district nursing", *Journal of Advanced Nursing, 25, (1997), pp. 673-680.*

The study found that there was variation in workload but in general nurses felt pressurised. This was enhanced by heavy administrative responsibilities, difficulties obtaining equipment and other resources and difficulties accessing training. Patients perceived District Nurses to be more amenable than GPs for discussing medical problems and other related concerns. District Nurses were concerned about the level and standard of social care provision and found contact with social workers difficult. There was little shared understanding between the District Nurse team members and managers of each other's responsibilities.

The Royal College of Nursing report on Practice Nursing and Skill Mix (1997)[37] summarises the research into practice nursing undertaken by Aitkin and others. Practice Nurses are seen to provide a flexible resource that is accessible to patients and central to the practice, of being able to fulfil its obligations to provide general medical services. In 1983 there were 3,284 Practice Nurses in the UK but since 1990 new GP contract numbers have risen steadily. Aitkin identified that there were approximately 18,000 Practice Nurses employed in the UK (1993). The responsibilities of Practice Nurses include:

- Well woman and family planning.
- Child and adult immunisation.
- Chronic disease management, e.g. hypertension, asthma, diabetes.
- Counselling.
- Primary and secondary prevention of heart disease.
- Health promotion banding requirements.
- Clinical audit.
- Participating in professional education, e.g. GP trainees, medical students.

It is recognised that skill mix in respect of practice nursing is important to the development of primary health care. However, for skill mix to be successful in improving services to patients, more appropriate use of skills, not reduction of costs, should be the deciding factor. Practice Nurses should be involved in decisions to employ Health Care Assistants and must be willing to accept responsibility for work that they delegate to Health Care Assistants. It is recommended that the criteria for applying skill mix exercises in general practice setting should be as follows:

- The process should be a local one i.e. practice led.
- All members of the team should be consulted and be aware of the implications of any proposed changes to their role before agreement is reached.
- The exercise should be focused on identifying the needs of the practice population, the skills that are available within the PHCT, the skills that need to be developed, and the training that will be required.
- The public receive high quality health care.

The Royal College of General Practitioners position statement on the general practitioner workforce (2001)[38] stated that proposals in the NHS Plan to increase the number of GPs are insufficient in view of the proposed developments in primary care. Many new GPs are needed just to make good current shortfalls and to start to address the imminent retirement of large numbers of GPs. The skill-mix review is not seen to provide an adequate answer. The RCGP consider that an increase of the GP workforce in the order of 30% is required. The NHS Plan presents an opportunity to develop an explicit primary care agenda where workforce planning is truly integrated to include skill-mix issues between GP's and non-medical staff. Specific skills can often be taught to personnel who have previously not undertaken these skills. But it is the ability of professionals to apply skills and knowledge from a broad base to meet the needs of an individual patient that is valuable, as opposed

[37] Royal College of Nursing, "Practice Nursing and Skill Mix" in *Issues in Nursing and Health No 42, (RCN, London, 1997).*
[38] Royal College of General Practitioners, *Position Statement on the General Practitioner Workforce, (RCGP, London, 2001).*

to a mechanistic ability to carry out specified tasks.

Flexibility in roles and careers must be introduced across the whole primary care workforce, including GPs. This will require an examination of systems for role refinement, personal development and career changes. There is a need for a review of Gp's key skills and development patterns of working that use and develop those skills. This may require a redefinition and reallocation of some traditional areas of GPs work, for example new roles in intermediate care. Similarly there needs to be an urgent review of tasks undertaken in primary care and the potential to delegate appropriate tasks to trained support staff.

For example, much of the work regarding implementation of the NSF coronary heart disease involves the regular collection and manipulation of data. Doctors and nurses cannot be trained and put in place overnight, but a cadre of data collection clerks, employed by PCTs could be deployed in a relatively short time if sufficient funds were made available. More thought should be given to use of personnel such as Health Care Assistants and phlebotomists. Clinicians should be supported to do the tasks that only they can undertake, with greater use made of less highly trained personnel in non-clinical and support roles.

caseload manageme

Nash, C., & Williams, C., (1997)[39], in a county wide survey of Health Visitors in Cornwall, revealed low morale and a need for more effective caseload management. 98% of Health Visitor time was spent with children under 5. It was felt that this did not allow for service development or innovative practice. Subsequently steps were taken to strengthen leadership and to introduce a priority index system and protocols for treatment. Link groups were established to look at child protection and the promotion of innovative practice/evidence-based practice. The priority index system was developed in response to a requirement for measurable Health Visitor outcomes and is a system of prioritising client need and standardising workload management across the trust. It drew upon Milton Keynes' priority index system developed from the Nottingham risk index.

Clients are ranked in high, medium and low intervention categories. The use of this tool demonstrated that in areas of high deprivation clients required short-term intensive Health Visitor interventions. Clients from areas with pockets of deprivation were usually prioritised into the 'medium' category. 75% Health Visitors found the tool useful.

referral criteria

The NHS Executive (1998)[40] in its examination of Electronic Patient Records (EPR) demonstrated that electronic multidisciplinary assessment and discharge summaries led to an improved scheduling of district nursing staff. 87% of the discharges analysed indicated that District Nurse visits were not required for two or more days even though patients were visited within 24 hours. Savings from the analysis were calculated to be around 1.05 hours per patient. District Nurses reduced the time spent on the first assessment because the quality of clinical information contained in the multidisciplinary summary was more comprehensive and accurate. The project improved the prioritising of visits and reduced wasted trips. Ultimately electronic records led to an ability to undertake increased caseload with the same resource.

Worth, A. (1996)[41] examined the impact of a more proactive approach by practitioners to the development of referral criteria. They used selected findings from a Scottish study concerned with examining the effectiveness of current methods of assessment of need for district nursing. The study involved 2 GP attached District Nurse teams. Asample of 20 District Nurses and GP's/social workers from the same districts were identified as potential referrers to the service. The data collection included an examination of all referrals to District Nurses over a 4 month period in order to identify the characteristics of those referred and the District Nurses view of the appropriateness. There was no clear consensus concerning the nature of the need for district nursing was identified either from District Nurses or the other professionals interviewed. Individual needs for district nursing were

[39] Nash, C. & Williams, C., "Beating the Blues", *Health Service Journal, (January, 1997), pp. 30-31.*
[40] NHS Executive, *EPR Documented Uutcomes, (1998).*
[41] Worth, A., "Identifying Need for District Nursing: towards a more proactive approach by practitioners" *NT Research, 4 (4), (1996), pp. 260-268.*

primarily identified by Gps (55%) and hospital staff (33%). 91% of referrals were deemed by the District Nurses to be appropriate.

The predominant view amongst District Nurses was that unmet need relates mainly to insufficiently early referral of need by GPs. Social workers have a poor understanding of the District Nurses role and make few referrals to the service. The District Nurses' concept of need can be viewed as inconsistent but their role flexibility is valued by GPs as an effective contribution to meeting needs in primary health care. District Nurses have limited involvement in the identification of need for their care at a community level. They are reluctant to increase client access to their service. Community health profiles provide a means of making district nursing assessment more needs-led and of giving the District Nurses an influence in the policy making process.

resource allocation

Gerrish, K., (1999)[42] presented selected findings from a large ethnographic study of the provision of district nursing care to patients from different ethnic backgrounds. An analysis of the allocation of District Nurse resource to different GP practices identified marked inequalities in the district nursing provision, which impacted upon service delivery to ethnic minority patients. Single-handed, inner city, GP practices with a large ethnic minority population received a much smaller allocation of nursing staff that single group practices servicing a predominantly white practice population. Observation of caseload management indicated that despite differences in the size of the practice populations served by different District Nurses teams all patients referred for district nursing care received it. However, a number of covert processes appeared to limit the size of those teams serving a number of single-handed practices and thereby a large practice population, so that it remained manageable within the limited nursing resources available. Processes included the following:

- Referral patterns from GPs had developed to accommodate the limited nursing resource. GPs were apparently not referring patients because they did not appreciate the District Nurses' contribution.
- The large number of single-handed practices served made communication between District Nurses and GPs difficult so marketing of District Nurse services was limited.
- A fear of uncovering needs, which could not be met within available resources, provided nurses with the justification for not identifying the health needs of their practice populations.
- The limited time available severely constrained the opportunities for District Nurses to develop and expand services to patients registered with inner city practices.

[42] Gerrish, K., "Inequalities in Service Provision: an examination of institutional influences on the provision of district nursing care to minority ethnic communities", *Journal of Advanced Nursing, 30 (6), (1999), pp. 1263-127.*

chapter four

service organisation and delivery

new model of service delivery

planning / commisi

Community nurses, midwives and health visitors should be encouraged to become planners and commissioners of care in PCGs (also at Executive and Board level) to aid collaborative practice and information sharing (para. 10.22)[2]. This should be part of a program to integrate knowledge, skills and abilities at primary health care team level, in order to plan effective local health strategies (para. 10.23)[2]. Policy directives (MaD, NHS Plan etc.) leading to various initiatives including:

- PMS pilots nurse-led services.
- NHS Direct, Walk-in Centres.
- Nurse triage in GP practices.
- Self-managed integrated nursing teams.
- Intermediate care hospital at home.
- One stop shops.
- Twilight and night services.
- Out of hours nurse triage.
- Specialist services e.g. Macmillan CNO briefing funding available to support palliative care training for District Nurses.
- Health-social care innovation e.g. joint Health Care Assistants Bristol.
- Health Visitor, School Nurse focus on public health.
- Practice Nurse developments linked to 'Primary care, general practice and the NHS Plan'.

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care*, (London, 2000).

McDonald et al, (1997)[43] reported on a survey of 22 trusts covering District Nurse, Health Visitor and School Nurse services.

District Nurse Services
There was considerable variation in the number of general staff employed in District Nurse service, the grades of nurses and the number of specialist nurses. All trusts covered day and twilight times and half covered night-time. Some night-time services were either completely or partially covered by Marie Curie and Macmillan nurses. Where District Nurse services were GP practice-based some trusts had a separate management system or a joint GP and locality based management system.

Health Visitor Services
There was little evidence of skill mix in Health visiting services. Services varied in terms of client groups served. Half of the trusts allocated 75%+ of Health Visitor time to under 5s. The remainder were allocated to different age groups from school children to elderly. Most were attached to GP practices. The timing and number of contacts varied considerably. Some trusts had structured visiting (5-6 routine visits before age of 5), others more ad-hoc in mutual agreement with parents. There were a wide range of services screening, developmental monitoring, information/advice, parenting skills, responsibilities in area of child protection, detection and prevention of child abuse. Some were involved in immunization/vaccination programmes and sleep clinics. Similarly there was little involvement with older people. Where present it focused on over 75 screening, health promotion, bereavement counselling and home visits after hospital stay.

School Nurse Services
School nursing was provided at much lower costs. They tended to employ relatively few general nursing staff. Most school nurses were at F grade or lower (i.e. lower than District Nurses and Health Visitors who were employed at G grade) Some School Nurses focused on large screening programmes, others focused primarily on health promotion. They were generally attached to clinics or localities with responsibility for one or more secondary schools and their feeder primary schools.

All community nursing services face common issues although they are occasionally presented as different problems. The following sets out the main issues:

District nursing

- Shift from secondary to primary care, early discharge and increased day surgery.
- Changing demands of population. Served increasing numbers of elderly, chronically disabled patients, dependant patients with acute conditions or degenerative diseases, terminally ill patients requiring round the clock care.
- Complexity of medical/clinical need increasing with specialist treatments such as tracheotomy, chemotherapy, Hickman lines.
- Increased hospital at home services.
- Anticipated greater involvement with practice nurses to prevent duplication of services. Shared protocols.
- Poor communication between different providers of care such as community, acute and social services.
- Skill mix. Lack of appropriate skill mix.
- Training requirements for nurses increasing because of changes in primary care.
- Specialist equipment difficult to obtain.

[43] McDonald, A.L., Langford, I. & Boldero, N., "The Future of Community Nursing in the United Kingdom: district nursing, health visiting and school nursing", *Journal of Advanced Nursing, 26, (1997), pp. 257-265.*

School nursing:

- Shift from illness to health promotion model occurring.
- Decline in universal school medical examination and increase use of health interview, expansion into health education, counselling and support especially in relation to drugs, sex and other lifestyle issues. Increasing involvement in immunisation programmes and improved asthma support.
- Shift required a reduction in other tasks such as routine screening and some immunisations (to be undertaken in general practice).
- Increase in number of nursing assistants to undertake some tasks.
- Identified need for research into skill mix issues.

Health visitors:

- Concern that the way being squeezed out by nurse practitioners and expansion of practice nurse's role in health promotion.
- GPs may prefer to employ Practice Nurses and Nurse Practitioners in preference to Health Visitors.
- Health Visitors and School Nurses were concerned about being marginalized in the move towards integrated primary health care teams. As emphasis changes from treating illness to health promotion, concern was expressed about how performance could be measured on the less quantifiable outcomes of preventative care.
- Problem of the how role of Health Visitors is being defined in relation to needs being met by social services. Due to resource constraints social services are only interested in formal referrals. Problems may have to be left unattended until they become serious enough for referral to be considered whereas prompt intervention at an early stage by community nursing and social services might defuse problem before it develops.

Other issues:

- Wide variety of information systems in place. Most effective systems for auditing are often claimed to be manual. Information systems generally did not include any measure of outcomes although this was now being addressed.
- Poor quality of information systems resulted in only rough estimate of the time each nursing service spent on a variety of tasks. Estimates considered unreliable.
- Estimated time spent on client and related activities varied considerably between trusts for both district nurses and health visitors.

Tinsley, R et al 1998)[44], in a study into the organisation of community nursing, undertook an evaluation of 6 innovative pilot projects of the organisation of community nursing services, some GP based and some PHCT focused.

They found that there were some advantages to focusing primary care around GP practices. Basing nurses in the practice was found to be particularly advantageous. There were some clear indications that the adoption by GPs of multiple, and sometimes conflicting roles manager, provider and purchaser-of community nursing inhibits the development of fully integrated primary health care teams and can be detrimental to the nursing function.

Ashburner et al, (1999)[45] considered the relationship between doctors and other health professionals over contested professional boundaries. This was in relation to actual tasks performed and which

[44] Tinsley, R & Luck, M. "Organising Community Nursing: an exploratory study", *Health and Social Care in the Community, 6 (5), (1998), pp. 353-360.*

[45] Ashburner, L. & Birch, K., "Professional Control Issues Between Medicine and Nursing in Primary Care" , in A.. Mark & S. Dopson (eds), *Organisational Behaviour in Health Care: The Research Agenda, (Macmillan Business, London, 1999).*

profession has control over the tasks. They found that boundary issues tend to occur when duties previously carried out by GPs, whether or not they actually require a medical practitioner, are transferred to nurses. They examined the development of advanced nursing practice in primary care and the issue of their substitution for GPs in response to NHS pressures. They found that the issue of who might be the most appropriate person to deliver care in terms of patient need or health need does not seem to be within those an important factor taken into consideration by doctors. Collectively, issues of professional medical control appear to be of key importance in the maintenance of professional dominance. There was no agreed definition of the level or scope of work that nurse practitioners can or should do. Thus the development of the role has been ad-hoc and is largely the outcome of an increased workload following the new contract. The way practice nurses have developed their role relates predominantly to the particular needs and views of individual GPs rather than to patient or health needs, or within a framework of professional development.

Their research demonstrated that GPs can spend a substantial amount of their time on duties that do not require a medically qualified practitioner. Changes in GP contracts have increased pressures on GPs. Similarly, research shows that nurses can be as effective as doctors - and as acceptable to patients-in securing compliance with therapy for chronic disease, making initial assessment of patients, diagnosing and treating certain minor acute illnesses and behavioural disorders, and rehabilitating elderly patients after surgery (DoH 1996 'Neighbourhood Nursing').

With the changing nature of primary care provision, the relationship between a changing health care policy agenda and nursing practice is complex and diverse. There is a danger that the potential for primary health care services will not be realised because of outmoded methods of working and specialisation, and structures that fragment the primary care service.

Extensions of the Practice Nurse role are linked primarily to the changing workload and responsibilities of GPs. Over the last decade there has been an extraordinary growth in the number of Practice Nurses and in the services they provide. GPs are reimbursed up to 70% of a Practice Nurse salary where they can demonstrate that Practice Nurses are fulfilling GP's obligations for health promotion and screening activity.

Nurses, doctors and the government are interested in Nurse Practitioner developments for different reasons. Nurses wish to extend their role, doctors want to share their workload and enhance the practice team, and government is looking for more cost effective ways of meeting health service needs.

pms pilots-nurse le

Personal medical services (PMS) may be delivered in deprived areas or to vulnerable groups through community nurses and health visitors working with local [illegible] (para. 10.24)[2].

Chapple, et al (2000)[46] examined the patients' perceptions of changing professional boundaries. In particular they examined a nurse-led Personal Medical Services 'Primary Care Act' pilot in Salford. Nurses managed the practice as independent contractors employing a GP for 20 hours per week. The practice team also included practice managers and District Nurses, together with a Health Visitor, Practice Nurse, midwife, and receptionist. They produced a case study using questionnaires, in-depth interviews and observations. Their article was based mainly on interviews with patients who had experienced the nurse-led service.

Some patients attributed high status to the nurse by emphasising that the nurse leading the practice was highly qualified. Other patients reconstructed the [illegible] through of the nurse as a doctor - this related to the patient's descriptions of core activities such as diagnosis and treatment. In the provision of social support and continuity of care, however, patients valued the service highly. Consideration of the service in contrast to that which had previously been provided by GP's were more important than whether the service was doctor or nurse led.

The literature around nursing in primary care has diversified and expanded recently. Nurses are increasingly employed instead of doctors in some areas of work.

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[46] Chapple, A., Rogers, A., Macdonald, W. and Sergison, M., "Patients' Perceptions of Changing Professional Boundaries and the Future of Nurse-led Services", *Primary Health Care Research & Development, 1, (2000) pp. 51-59.*

This has been accelerated because of concern about cost effectiveness, shortage of GPs, pressure from non-medical professionals seeking role development and the need to provide adequate primary health care for certain population groups.

PMS initiatives promote flexible work and practice arrangements including services that are principally managed and run by nurses. Of the 85 pilots some have salaried GPs working for community trusts, others have nurses and doctors working in partnership, and 8 are nurse-led in areas where there is a shortage of GPs. (Impending retirement of Asian GPs may result in up to 25% of GPs lost in some deprived areas in next few years).

The discussion in the study points out that as the range of nurse led initiatives develops in primary care it is increasingly important that evaluations take account of the patient's perspective on this type of service development.

Thomas S (2000)[47] made reference to a nurse practitioner who runs a PMS pilot in Derby which employs a GP. When patients were given a choice as to who they would wish to see. 60% patients chose to see the nurse as the first point of contact. Most of these patients were managed entirely by the nurse without reference to the GP. Of the 40% who choose to see the GP, approximately 12% could have been managed appropriately by the nurse. A health needs assessment of the community served indicated that 15% of patient needs were non-medical and suggested that there is a need to consider marriage guidance and debt counselling services.

nhs direct, walk in c

Nurses will play a key role in the establishment of new walk-in centers (see *Modernizing Mental Health Services*) including the support of 24 hour nursed beds and outreach services (para 2.13)[2].

Walk-in Centres

Thomas S (2000)[45] estimated that there were 36 walk-in centres by end of 2000. Data from the Soho walk-in centre has shown that only 3% of people using the service need to see a GP (the rest saw a nurse). Most commonly presented problems include; bladder infections, stomach pains, skin infections, colds, flu and women's health. 64% of attendees classed themselves as workers and used the service because access was more convenient than accessing GP services. 43% were unregistered with a GP.

The walk in centre in Sheffield is reported to be targeting groups that often experience difficulty in accessing health care services, e.g. ethnic minority groups and the student population.

intermediate care

Continuous initiatives should be in place to breakdown the interface between primary and secondary care through 'Hospital at home' and rapid response teams, to minimise risks associated with acute care, support discharged patients and lower readmissions (para 2.21)[2]. Outreach work should be encouraged, including care in the home and the self-management of health through district nursing, rapid response teams, and practice nurses (para. 10.14)[2].

Thomas S (2000)[48] examined the role of community nurses in intermediate care. The King's Fund definition of intermediate care is: That range of services designed to facilitate the transition from hospital to home, and from medical dependence. Where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired. Community nurses may be involved in intermediate care in community hospitals, hospital at home schemes, community assessment and rehabilitation schemes, hospital hotels.

Making a Difference states that nurse led initiatives could be developed to target the public health priority area of coronary heart disease, by providing:

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47 Thomas, S., "The Changing Face of Community Nursing", *Primary Health Care, 10 (5), (2000), 21-24.*
2 Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
48 Thomas, S., "The Changing Face of Community Nursing", *Primary Health Care, 10 (5), (2000) pp. 21-24.*

- Nurse-led blood pressure clinics to identify/manage hypo/hypertension and medication compliance (para.14).[2]
- Smoking cessation clinics (using national smoking cessation guidelines).
- 'Healthy lifestyle' clinics (addressing diet, nutrition, exercise) in collaboration with other health professionals.
- Cholesterol clinics.
- Home-based initiative care for patients with congestive cardiac failure.
- Nurses-led chest-pain clinics or risk factor screening/reduction clinics.
- Co-ordinate and deliver cardiac rehabilitation programmes (in conjunction with other health care professionals).

out of hours service

Trusts must promote 24 hour, 365 days a year access to NHS services, through NHS Direct (telephone helpline) and NHS Primary Care Walk-in Centres (para. 10.13)[2].

pcg / pct developme

The Centre for Innovation in Primary Care (2000) reported early perceptions from a PCG in North Sheffield. This local study formed part of a Reflective Learning Programme in which the views and experiences of 4 professional groups who have a stake in the development of PCGs were gathered and then followed up with structured feedback in order to assist development and team working. Data was collected via focused interviews with 12 GPs, 4 Practice Nurses, 7 attached District Nurses/Health Visitors and 3 Health Authority managers. (There are a total of 21 GP practices in North Sheffield PCG).

The professional groups hoped that formation at the PCG would lead to more resources being secured for socially deprived areas and raise standards in struggling practices. They expected that primary care would be given more influence over the primary-secondary care interface. It was felt that the PCG was an opportunity for Practice Nurses to break down professional isolation and to increase collaborative working practices.

The Health Authority envisaged that new blood and the right combination of clinical and management input would enable the Board to make real changes to patient care. There were some concerns regarding formation of the PCG, which included a lack of authority to achieve real change, the size of PCG's agenda and the increasing workload. It was felt that primary care was taking the weight of social deprivation.

There were concerns about the capacity of clinicians struggling as part-time, untrained managers with intractable strategic issues. District Nurses/Health Visitors were concerned that if the PCT became their employer, GPs might seek to limit their professional autonomy. They were also concerned that GPs would control the agenda and seek to limit the new emphasis on social health issues.

Practice Nurses were concerned that changes may have a negative effect on their workload and morale, with the potential for innovation stifled by excessive workload and conservative employers. Personal contact with board members, via open meetings, visits to practices and professional forums, were widely valued. A wider constituency of health professionals saw the PCG as having little impact on their work.

In Board member's practices, there was a perception that Board activities had a knock-on effect with

[2] Department of Health, *Making a Difference: Clinical Supervision in Primary Care, (London, 2000).*
[49] Centre for Innovation in Primary Care *"PCG Development: early perceptions from North Sheffield Primary Care Group, (CIPC, Sheffield, 2000).*

other practice members and reduced Board member's contribution to practice business.

Concern was expressed to nurture those practices that were seen as innovators, and also team workers and net workers, who may then help to draw in less enthusiastic practices.

Clinical governance was seen to be a major impetus for change, although interviewees were not clear on what this would mean in practice. In order to develop and sustain confidence in the PCG there was a perceived need to achieve some early positive results. These included, for example: small successes, which demonstrate action and progress in patient care; to establish transparency and consultation over new resources; to respect diversity in dealing with practices; to show readiness to listen to people on the ground, and finally, to be seen to bridge the gap between managers and practitioners.

Some professional groups showed a degree of desire to insulate themselves from yet more change.

innovations in healt

Many nurses, midwives and health visitors working in primary care can be described as public health workers, in that they focus on whole communities as well as individuals. Examples of public health functions include: community profiling, health needs assessment, communicable disease control and community development. The role of the health visitor is largely family centred in that they:

- Deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs.
- Run parenting groups and provide home visits to help improve support, advice and information to parents, especially vulnerable children and their families, supporting initiatives such as Sure Start.
- Work through PCTs to identify health needs of neighbourhoods and special groups such as the homeless and agree local health plans.
- Work with local communities to help them identify and tackle their own health needs such as measures to combat the social isolation of elderly people or the development of local accident prevention schemes.
- Provide health promotion programmes to target accidents, cancer, mental illness, coronary heart disease and stroke.

Saving Lives Our Healthier Nation encourages health visitors to develop family centred public health role working with individuals, families and communities to improve health and tackle health inequalities. To achieve this collaborative work with other agencies, rather than solely with the PHCT, is crucial.

To achieve these objectives a number of Health Visitor/School Nurse Development Programmes have been established. These include the:

- *Health Visitor / School Nurse Innovation Fund* - Announced by Tessa Jowell, Minister for Public Health in Oct 1998, the main part of the Fund is for the creation of 31 new leadership posts over the period 1999-2002.
- *The Initiative Projects* - Commenced with some 30 projects funded in 1998/99 and begun in 1999/2000, with a range of deliverable timescales.
- *The Network for Innovation in Health Visiting and School Nursing* - Led by the Centre for Innovation in Primary Care in Sheffield, this is a staff support network and IT data base linked to the NHS Learning Network and the Our Healthier Nation website.
- *The Toolkits* - Two practice development tool kits, one for Health Visitors and one for School Nurses aimed for launch early 2001 with annual supplements drawing on the output from a range of projects.

- *Workforce Planning* - To ensure the right numbers of Health Visitors and School Nurses are available to meet the needs of the new roles.
- *Education and Training* - To ensure that education programmes meet the training needs of the new roles.
- *Communications* - A strategy for effectively communicating key messages and developments to the professions and the public and for facilitating communications and learning within the professions between leading edge and innovative practitioners.
- *Research and Evaluation*: To develop evaluation and research tools from and for the overall programme and evaluate the effectiveness of the programme.

health visitor / scho

The aim of this fund is to make significant and demonstrable progress over 3 years, (to be completed by April 2002), towards a family centred public health role for Health Visitors and a child-centred public health roles for School Nurses. It recognises that emphasis needs to be placed on establishing new ways of working in relation to:

- Identifying and targeting needs, establishing plans.
- Encouraging participation.
- Working in partnership with other agencies.
- Addressing inequalities.
- Leading teams with varied skill mixes.
- Focusing on communities rather than just individuals.

Health Visitors already aim to provide social and emotional support to parents and are acceptable to mothers in disadvantaged settings. It is considered that an enhancement of their role and capacity to provide social and emotional support to disadvantaged parents is needed as part of the range of neighbourhood services to support parents.

The National Health Inequalities Targets[51] set out a number of improvements in health status required by the end of the next decade.

Starting with children under the age of one year, the first target is to reduce by at least 10% the gap in mortality between manual groups and the population as a whole by 2010. The rationale for this is that this indicator measures indirectly the effects of prevention in terms of parent support, health promotion & access to services including ante-natal care and neonatal intensive care etc. Improvement in infant mortality can best be achieved through interventions aimed at the pregnant mother including smoking control, breast feeding, parent support by both the Health Visitor and community, reduced poverty & improved maternal mental health etc. Similarly better access to health care though NHS Direct, primary care, A&E and hospitals should improve the health status of the unborn child. The target is formulated in terms of socio-economic groups and thereby compliments the area-based life expectancy target. It is anticipated that these targets will be monitored annually through the NHS performance framework.

Starting with the Health Authorities, there is an expectation that the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole will be reduced by at least 10% by 2010. The rationale for this again is that it measures the wider determinants of health status and the impact of health prevention programmes, improved access to care, resource allocation and treatment.

[50] Acheson, S. D., *Independent Inquiry into Inequalities and Health (The Acheson Report), (The Stationery Office, London, 1998).*
[51] Department of Health, *The National Health Inequalities Targets, (February 2001).*

An overall measure of the reduction on health inequalities with targets being adopted in other countries and proposed by the World Health Organisation (WHO).

delivery mechanism

The main levers for the reduction in health inequalities are seen as equitable, needs based resource allocation and good performance management. Commitments that reduce inequalities will be a key criterion for resource allocation. Achieving proposed targets does not necessarily require extra resources. Existing resources may need to be targeted more effectively on particular groups.

Cowley, S (1999)[52] examined the issues relating to population based interventions. It was found that it is important for Health Visitor / School Nurse to emphasise effective and collaborative action across disciplines and agencies, notably health, education and voluntary sectors. Public health work is not just required in deprived areas and with vulnerable groups, it needs to underpin the whole of the health visiting and school nursing approach. School nursing interventions were often focused on individuals to achieve a depth of care but they need to be based in a deep understanding of the context of the whole school population and the area in which it is situated.

Allen D (2000)[53] reported on a CPHVA initiated 2 day meeting: 'Leading the future of health visiting'. The Office for Public Management (OPM) facilitated the meeting, which involved health visitors, managers and policy makers. The meeting identified the forces operating at the national level that will bring about change in Health Visiting as follows:

- Focus on Primary Care.
- Public health agenda.
- Emphasis on interagency working.
- Focus on quality and clinical effectiveness and outcomes.
- New information strategy for NHS.
- Professional self-regulation and accreditation system.
- Workforce planning and training agenda.
- Pressure on resources.
- Changes in demand.

They felt that the key issues for the health visiting profession to emerge were:

- The need to shape a clear vision.
- The opportunities presented by current policy.
- No other profession contributes to the primary prevention of ill-health for whole populations.
- The uniqueness of the profession's contribution is potential rather than actual.
- Clarity is needed as to where the profession can make the greatest contribution.
- At present the Health Visitor is seen as having most leverage at the individual and family levels. The emphasis needs to shift to a community and population-based public health role. This should build on the principles of health visiting, focus on addressing the health impact of poverty and social exclusion, draw on community development.

[52] Cowley, S., "From Population to People: public health in practice", *Community Practitioner, 72, (4), (1999), pp.* 88-90.
[53] Allen, D., "The Vision Thing", *Community Practitioner, 73 (2), (2000), pp. 4[illegible]-453.*

- Demographic and policy factors mean that Health Visitors will need to lead teams of other workers.
- Barriers to effective delegation need to be addressed.
- Work needed to define the populations with whom health visitors will work.
- If families are chosen as the key entry route, this concept must be defined in an inclusive way.

The challenges were seen as:

- The need for strong leadership of the Health Visitor profession.
- Improved partnership and interagency working.
- Enhanced support regarding information exchange between Health Visitors and other community practitioners and support workers.
- The need for clarification as to where the profession can make the greatest contribution and the consequent changes in role, relationships and skills, ... will result.
- The present role has most legitimacy at the level of the individual and to slightly less extent the family, but is this where Health Visitors add the greatest value. There is a feeling that Health Visiting should develop a more community and population based role.
- Demographic and workforce trends in Health Visiting will make it difficult for them to develop a community focus.

Saving Lives: Our Healthier Nation implies that Health Visitors should be leading teams including nurses, nursery nurses, and other community workers. Currently the majority of Health Visitors are not leading teams. This poses the question as to what barriers might be preventing Health Visitors delegating their work with individuals to others. It is widely felt that Health Visiting needs to seize this opportunity to maximise its contribution to health improvement and sustain its long-term viability though working together with other agencies and the voluntary sector.

Cowley, S. et al (1999)[54] carried out an action research project based on a single fundholding practice. The aim was to use the GP contracting system to enable the delivery of a participative, needs-based health visiting service.

Additionally, it was intended that the process should be observed during the implementation of the proposed changes to identify any organisational constraints to the process. Their paper outlines the complexities involved in the implementation of changes to health visiting services and the multiple processes involved in structuring decisions about 'health needs'.

During the initial phase of interviewing, 50 families with resident children, registered with practice, were seen to elicit their views of health and health needs. The views were analysed and integrated into the practice profile to identify which health needs were prioritised in order to identify how they might best be met. The original intention was to establish new approaches to practice among existing staff, however, workload pressures led to the development of 2 new posts: a home visiting service for families with school aged children and a community development project.

The project initially encountered hostility from Health Visitors and School Nurses as they were seen to encroach on traditional professional territories. Reactions were seen to be linked to poor communication strategies across the trust, arising mainly from uncertain changes, job insecurity and the vulnerability of senior personnel.

Elkan et al (2000)[55] and Robinson, J., (1999)[56] have carried out systematic reviews to identify key areas where home visiting has been demonstrated to be effective.

[54] Cowley, S. & Billings, J., "Implementing New Health Visiting Services Through Action Research: an analysis of process. *Journal of Advanced Nursing, 30 (4), (1999), pp. 965-974.*

[55] Elkan et al, "The Effectiveness of Domiciliary Health Visiting: a systematic review of international studies and a selective review of the British literature", *Health Technology Assessment, 4 (13), (2000).*

[56] Robinson, J., "Domiciliary Health Visiting: a systematic review", *Community Practitioner, 72 (2), (1999), pp. 15-18.*

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Cotton, L. et al (2000)[57] reviewed the literature, and showed that variation in school nursing resources across the UK has no relationship to deprivation and also that there was controversy about the changing role of school nursing services. They found that the routine school entry medical examination has disappeared and has largely been replaced by screening for vision and hearing defects and growth disorder, coupled with health care interviews. These are carried out by School Nurses to identify health problems, initiate appropriate referrals and offer health education.

There is little evidence of effectiveness for the school medical examination or the health care interview. Education policy guidance highlights the potential for school health services to contribute to support for pupils with poor health, learning and behavioural problems and other special needs. The level of investment in school nursing services varies widely between districts due more to historical factors or local financial pressures than to any explicit purchasing or commissioning policy.

The project, which was undertaken from 95-97, gave a detailed examination of the costs and structure of community child health services including school nursing in 4 study areas. This was done through a postal survey of trusts recruited to the study throughout England to measure variations in resources and service provision. Interviews were carried out with providers to identify trends in service provision and with education staff about the school health service to determine their priorities and areas of dissatisfaction.

Although there was a wide variation in the cost of school nursing service, in contrast to previous reports 24% of the variance could be explained by deprivation. There appeared to be a modest correlation between deprivation and expenditure, both in School Nurse services and community child health services as whole. Schools in the most deprived areas may spend up to twice as much on school nursing than schools in more affluent locations. School health profiles might therefore be used to inform resource allocation.

There were no clear associations with any other social or functional variables such as the number of children with statements of special educational need, the number of the children on the protection register, or the number of teenage pregnancies. The greatest allocation of time was in routine screening and surveillance tasks. Doubts are increasingly being expressed as to whether this work should have such a high priority when considered alongside other challenges facing schools. Relatively little time was allocated to other activities such as health promotion, support of special needs, social difficulties or unwell children, or teenage clinics where there is evidence that School Nurses could make a valuable contribution.

Equity is complex and contentious issues. The NHS is based on principles of horizontal equity (that 2 populations with equal health needs should receive the same access to health care) and vertical equity (that populations with greater health needs should receive higher levels of access). Also it is argued that the NHS as an employer has a responsibility to ensure that individual staff should be called upon to undertake similar workloads. Thus staff working with challenging clients in deprived neighbourhoods might expect to have smaller caseloads.

Wainwright, et al (2000)[58] examined the role of school nurses in health promotion. They found that school nurses identified with the promotion of health and health care and the development of the school as an environment conducive to health. There was little evidence from a systematic review of the effectiveness of school nursing interventions. Current school nursing practice was found to concentrate on screening primary, secondary and tertiary prevention and health education. It was felt that a move towards a primary care led NHS can be problematic for School Nurses in that it centralises the role of the GP.

It was felt that there might be tensions between practice in primary care and school nursing given the problems of conflicting boundaries, communication difficulties and confidentiality.

School nurses do not provide direct services to GPs so have little to offer the current funding structure of primary care. Difficulties experienced by School Nurses can be confounded by the administrative separation of education and health care. It was felt that there would need to be closer integration

[57] Cotton, L., Brazier, J., Hall, D., Lindsay, G., Marsh, P., Polnay, L. & Williams, T., "School Nursing: costs and potential benefits", *Journal of Advanced Nursing, 31(5), (2000), pp. 1063-1071.*

[58] Wainwright, P., Thomas, J. & Jones, M., "Health Promotion and the Role of School Nurses: a systematic review", *Journal of Advanced Nursing, 32(5), (2000), pp. 1083-1091.*

between school nursing and the education system.

A study by SPRU (Lightfoot & Bines 1996) identified the key elements of the School Nurse role as: safeguarding the health and welfare of children, family support, being a confidante for the child and health promotion. The literature suggests a lack of a coherent strategy for school nursing and an absence of good quality research to inform such a strategy.

Humphries, J. and Tonge, J., (2000)[59] reported on an open forum on the future of School Nursing held at the University of Central Lancashire. It was felt by the forum that school nurses spend the majority of their time on the screening and surveillance of healthy people aged between 5-16 years although there is no national programme that details who is screened for what, when and by whom. The core programme for school age children tends to be determined by managers or school medical officers with school nurses having little input. There is a variation between the types of core screening and surveillance programmes, which suggests that many School Nurses are spending time and resources on unnecessary work.

It was felt that skill mixing between different grades of nurses, nursery nurses and Health Care Assistants would allow qualified School Nurses to concentrate on public health functions such as health promotion, developing services and working as part of multi-disciplinary groups that concentrate in individuals, families, and communities. It was believed that parents, children, doctors and other community nurses may have an erroneous perception of what a School Nurse does. The CPHVA suggested that School Nurses at G grade should specialise in, for example, sexual health or mental health. They caution that School Nurses moving into PCTs face danger that their professional identify could be lost and services marginalised[60].

A joint report from the Community Practitioner and Health Visitor Association, The Queen's Nursing Institute, and The Royal College of Nursing on the future of School Nursing proposed that the UK's 2,500 School Nurses should take a more proactive role in preventing teenage pregnancies and addressing the drugs, smoking and alcohol problems amongst school children.

They called for the introduction of a set standard for School Nurses across the country to replace the present ad-hoc policy where cover on schools can vary enormously. However, it recommended universal access to school nursing services for every school aged child with the focus on specific areas of health concern as opposed to current routine screening programmes. Services should be available for the whole school age population and available both within and outside school hours.

It was recommended that a benchmark be developed for every primary school. The proposal was for a 3-person team of a School Nurse, community nurse and support worker with a caseload of 5,000-6,000 children although this could vary according to the demands of each area. In order to implement recommendations it is estimated that 500 more School Nurses are required. This represents a 20% increase in present numbers, at a cost of £9 million per annum.

practice nursing issues

The Centre for Innovation in Primary Care (2000)[61] produced a report of 2 studies into practice nursing. The first study surveyed the roles and responsibilities of Practice Nurses in Sheffield, the second study examined consultation patterns with GPs and Practice Nurses.

Practice nurses were found to undertake a wide variety of clinical responsibilities, including chronic disease management (diabetes, asthma hypertension, coronary heart disease management), health promotion (baby clinics, well women, over 75 checks), immunisation and vaccination (especially 'flu), treatments, and domiciliary visits. Role and responsibilities vary considerably across practices and the levels of decision-making and autonomous clinical responsibility varied greatly. The range of work that practice nurses perform is shifting, broader as more take on the systematic care of chronic diseases and triaging of minor illnesses. They tend to only put in one practice, most have only ever have worked in one practice. As a consequence Practice Nurses can suffer significant professional isolation. Most Practice Nurses are paid on G or H grade. Given the wide variation of role it is likely that some practice nurses are being paid inappropriately

[59] Humphries, J., & Tonge, J., "Looking Ahead: a forum on the future of school nursing", *Community Practitioner, 73, (12), (2000), pp. 481*.
[60] CPHVA, QNI, RCN, *School Nursing Within the Public Health Agenda: A Way Forward for Practice*, (CPHVA, London, 2000).
[61] Centre for Innovation in Primary Care, *What do Practice Nurses Do? A study of practice nurses, their skills and patterns of work*, (CIPC, Sheffield, 2000).

grade.

Some tasks currently undertaken by Practice Nurses, e.g. some treatment room activities, could be undertaken by RGNs or Health Care Assistants. Practice Nurses are increasingly responsible for the care of chronic diseases. The role is most well developed with diabetic care, where nearly 80% of all consultations with diabetes now take place with a Practice Nurse. The role is less advanced in the care of chronic mental health problems.

Thomas, S., (2000)[62] showed that the number of Practice Nurses has grown considerably from the mid 1980s in response to the needs of general practice.

Between 1982 and 1992 number of Practice Nurses rose from 1,515 to 9640. By 1995 there were 18,000 Practice Nurses in England, equivalent to 10,000 WTE. By 1998 the figure had risen to 10,198 WTE.

Eve, R., Gerrish, K., and Waller, J., (2001)[63] report on selected findings from work undertaken by the Centre for Innovation in Primary Care in the roles and responsibilities of Practice Nurses. They found that Practice Nurses were actively involved in chronic disease management in relation to diabetes, hypertension, asthma and COAD. Variability of involvement was identified, but clearly for some diseases some practice nurses act as fully independent practitioners diagnosing, investigating, initiating and changing treatment . The NHS Plan calls upon employers to empower appropriately qualified nurses to undertake a wider range of clinical tasks including managing patient caseloads for chronic diseases such as diabetes and running more nurse led clinics. Practice Nurses are ideally positioned to take forward such developments working within agreed protocols. They will need to consider questions about specialisation. Within the context of some PCTs it may be appropriate for some Practice Nurses to become specialists as opposed to generalists.

[52] Thomas S., "The Changing Face of Community Nursing", *Primary Health Care, 10 (5), (2000), 21-24.*
[63] Eve, R., Gerrish, K. and Waller, J. "Chronic Disease Management: current involvement and future opportunities for practice nursing", to be published in *Practice Nurse, (May 23rd, 2001).*

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The Review of Community Nursing Services across North Kirklees

A Report on the Consultation with Key Stakeholders

A compilation of research based reports
to inform the modernisation of community nursing services

report 2

Introduction

This report is one of a series of three produced as part of a consultancy project to generate research based information to support a review of the community nursing services provided by Dewsbury Health Care NHS Trust across North Kirklees PCG and to advise senior managers in both the Trust and the PCG on issues of effectiveness, efficiency and compliance with the modernisation agenda. The project has been undertaken by the School of Health and Related Research and the School of Nursing and Midwifery at the University of Sheffield during the period May to October 2001.

The key objectives of the project are to:

i. Describe the objectives and role of the current Community Nursing Service and compare this with current policy requirements and established best practice.

ii. Examine the allocative efficiency of the current Community Nursing Service in relation to skill mix, workload management and organisation of service provision.

iii. Review the technical efficiency of the Community Nursing Service in relation to skill mix, workload management and organisation of service provision.

iv. Develop options for the systematic collection and analysis of data reflecting the views of patients, carers and other staff.

This report focuses specifically on presenting information collected from key stakeholders in the North Kirklees health community on their perceptions of the objectives of the current community nursing service in relation to the various policy objectives and their opinions on the future strategic direction for the service to take.

In accordance with the project specification, community nursing has been interpreted to include district nursing, health visiting, school nursing and practice nursing. It should be noted that a detailed review of practice nursing in North Kirklees was completed in November 2000 and the Executive Summary of that work is included in Appendix 1.

chapter one

method

The consultation process comprised a series of interviews and focus group discussions with key stakeholders. Focus group discussions were undertaken with separate groups of district nurses, health visitors, school nurses, community nursing team leaders, and primary care managers from Dewsbury Health Care NHS Trust, practice nurses from North Kirklees PCG and representatives from social services. In addition, individual interviews were undertaken with the Nurse Adviser, Community Nursing, the Information Manager, the Accountant, the Director of Primary Care and hospital managers from the Trust.

The interview agenda explored respondents' perceptions of the key priorities impacting upon primary health care as a result of the government's modernisation agenda, the current capability of the nursing workforce to respond to these demands, the constraints hindering community nursing's ability to engage in the modernisation agenda, ideas for how such barriers might be overcome, the strengths of the current service and opinions as to the future direction of community nursing. Due to the diverse backgrounds of those interviewed, the specific topics explored during the interviews varied between respondents.

With the participant's permission the interviews/focus groups were tape-recorded and detailed notes were subsequently made of the points raised. All participants were assured that the information they provided would be treated confidentially and their anonymity would be preserved in the report of the consultation process.

Documentation relating to the provision of community nursing services provided by the Trust was also reviewed. (See Appendix 2)

In order to provide some coherence to the report, the main issues to arise from the consultation process have been grouped together to reflect the broad topic areas identified through the analysis of external policy drivers and research presented in the related report entitled 'Report 1, A Review of Community Nursing in North Kirklees: The national policy objectives and their evidence-base'. The reader is referred to this related report in order to gain an understanding of the external policy drivers that are impacting upon the development of community nursing services in North Kirklees.

This report begins by providing an overview of the organisation of community nursing services in North Kirklees and considers a number of contextual issues that were deemed by the various stakeholders to impact upon the modernisation of community nursing. It then moves on to consider the key issues that stakeholders identified as being important to the future development of community nursing services. It concludes by summarising the main issues identified from the consultation process that need to be considered in taking forward community nursing services.

Chapter two

the organisation of community nursing services

At the time that the consultation took place district nurses, health visitors and school nurses were employed by Dewsbury Health Care NHS Trust whereas practice nurses were employed by individual GP practices in the North Kirklees PCG. The organisation of the community nursing services was co-terminus with PCG boundaries. District nurses and health visitors were 'attached' to one or more general practices with responsibility for providing a service to the respective practice populations. School nurses were attached to specific schools within North Kirklees. Local authority social services covered both North and South Kirklees but were divided into two sections that were co-terminus with the health services.

Community nursing services within the Trust were organised into three localities, each of which was led by a Primary Care Manager. Within each locality community nursing staff were managed within a team structure led by a team leader. Team leaders were responsible for the day-to-day management of the team and service delivery; they carried a devolved budget that enabled them to make decisions about skill mix when opportunities arose. The size and composition of the teams varied between different localities and within each locality. Some teams comprised combined teams of district nurses, health visitors and school nurses whereas others were uni-professional.

The Trust was seeking to appoint Practice Development Nurses in district nursing and health visiting who would assume responsibility for supporting the development of clinical practice and facilitating the dissemination and uptake of innovative practice. In addition, each locality was in the process of appointing a health visitor with a part-time responsibility for co-ordinating public health initiatives in health visiting across the localities.

At the time of undertaking the stakeholder interviews the public consultation process regarding the move from PCG to PCT status was underway and formal approval was awaited regarding the formation of the PCTs in April 2002. It was anticipated that from April 2002, the employment of district nurses, health visitors and school nurses would transfer from DHCT to the North Kirklees PCT. It was not clear whether practice nurses would continue to be employed by General Practitioners (GPs) following the creation of the PCT.

At the time of undertaking this review (summer 2001) dialogue between Trust staff and the PCG had been primarily at senior management level. However, it was anticipated that in the lead up to the formation of the PCT there would be more active engagement of staff at all levels of the organisation. There was, at this stage, little clarity about the future organisation of community nursing. It was thought that the service may be delivered in four localities from April 2002. It is not clear, however, if this will simply result in the division of the Dewsbury locality into two or if all localities will have new boundaries.

chapter three

the current context of community nursing in north kirklees

Community nurses in North Kirklees were perceived by all the stakeholders to be working in a complex and changing primary and community care environment. The current Labour government's policy agenda to modernise health and social care was considered to be enormous and carried major implications for the development of primary health care services in general, and community nursing services in particular.

Many stakeholders stressed that it would be essential to ensure that a modernised community nursing workforce reflected the modernised health and social care services that were required to be delivered in North Kirklees. To this end, the review of community nursing needed to be part of an overall strategic response to wider policy directives on improving health and health care in North Kirklees.

A number of contextual issues were identified that had a bearing on the modernisation of community nursing in North Kirklees.

- The unit of general practice was perceived to be a significant strength in the provision of primary health care in the UK through providing a clear focus for service delivery to a defined practice population although it was acknowledged that integrated multi-professional working was not necessarily easy to achieve in the Primary Health Care Team. Some stakeholders questioned whether different configurations, for example a neighbourhood or patch focus might be more effective and economical in meeting health improvement targets. Although the current arrangement carries many advantages (both actual and potential), for example, in terms of collaborative team working and continuity of care, tensions can arise when community nurses see their role including responsibilities beyond the general practice, for example in respect of public health and community development. Quite how these tensions might be resolved by the future PCT is unclear. In the meantime, community nursing must take forward the modernisation agenda whilst at the same time recognising that the boundaries of primary care may shift in the future and that health care may need to be delivered in new ways in new venues.

- With the impending move to PCT status in April 2002 the employment contracts for district nurses, health visitors and school nurses will transfer to the PCT and it may be that practice nurse contracts also transfer. The uncertainty arising from a change of employer will inevitably lead to anxiety amongst community nurses that will need to be carefully managed throughout the transition process.

- Although the various stakeholders cited examples of innovative practice in district nursing, health visiting and school nursing which are cited in subsequent sections of this report such innovation was not necessarily widespread. Where innovation did occur it was often seen to be as a result of the motivation and enthusiasm of individual practitioners. Some stakeholders expressed concern that community nursing in North Kirklees was 'lagging behind' community nursing services in neighbouring districts. Key national developments in community nursing such as the introduction of integrated nursing teams and clinical supervision were not clearly in evidence. However, a Steering Group had recently been established and was making

considerable progress in taking forward the public health agenda for health visitors and school nurses.

- The staffing establishment in relation to population for district nursing, health visiting and school nursing was reported by staff to be below the national average. In the main, stakeholders attributed this shortfall to an historical division of resources by the then Health Authority between North and South Kirklees, with North Kirklees perceived to have been disadvantaged. Although the Trust had begun to remedy the situation, community nursing was still considered to be under-resourced and this was seen to carry implications for the capacity of community nursing to respond to the additional demands of the modernisation agenda. Although no data on the practice nursing establishment were considered, practice nurses themselves perceived that there was currently a shortfall in the practice nurse establishment in relation to workload. Again, this will affect the extent to which practice nursing may be able to respond to the modernisation agenda.

- Although the locality structure was seen to be beneficial in terms of addressing local need, several stakeholders expressed concern that the localities tended to operate as semi-autonomous 'organisations' and that there had been a competitive element rather than collaboration in the relationships between localities. Front line practitioners considered that communication between the localities had been not been encouraged by some managers.

- As stated earlier, communication between the Trust and the PCG had been restricted to the level of senior management until recently. Two community nurses from the Trust had been appointed to the PCG Board. Although these nurses had reported back to senior managers, they had not engaged in open dialogue with community nursing colleagues until recently.

- The PCG nurses had been actively involved in leading the development of a community nursing strategy for the PCG/T. There had been limited involvement of other Trust staff in the development of this strategy although it had been sent on completion to all community nurses. It was anticipated that working groups, involving a range of front line staff as well as mangers, would be established to take the strategy forward.

- Practice nurses had established a Practice Nurse Forum that met on a regular base to discuss issues affecting practice nursing and to provide 'a voice for practice nurses'. The PCG had consulted with the Forum over a number of matters and it was anticipated that the Forum would play a key role in the lead up to PCT status. In addition, practice nurses were involved in a number of PCG working groups.

- Working relationships between health and social care front line practitioners was reported to be good. However, social services were currently in the process of reconfiguring their services and it was recognised that these changes, alongside the move to PCT status and the proposed reconfiguration of the acute services involving Dewsbury, Wakefield and Pontefract, raised particular challenges in terms of 'keeping the show on the road' whilst at the same time planning to develop services in response to the modernisation agenda. Several stakeholders stressed the importance of not underestimating the time required to gain ownership for new service development, allowing people the opportunity to network and to build up new relationships.

Chapter four

the public health agenda

Many community nurses, by virtue of the particular role they occupy, engage in public health activities. Health visitors, for example, attend to the health and well-being of families with young children; school nurses play an active part in promoting the health of school aged children; district nurses frequently support the carers and practice nurses, through involvement in women's health, travel clinics and chronic disease management, play an important role in promoting the health of practice populations. Rather than merely confirm the public health 'givens' in respect of the roles and responsibilities of different community nurses, the interviews with stakeholders focused on the current public health challenges identified in key policy documents highlighted in Report 1, 'The national policy objectives and their evidence-base'. These challenges are expressed in terms of the responsibilities of health authorities, community trusts and PCGs collectively and in collaboration with other agencies, to address health inequalities, and a call for community nurses in general, and health visitors and school nurses in particular, to engage more actively in public health work.

The key public health issues identified by stakeholders that related to the modernisation of community nursing are summarised below.

- The Trust had recently established a multi-agency Steering Group to take forward a Public Health Innovation Project with the specific aim of establishing a clear framework for developing the public health role of health visitors and school nurses. In addition to clarifying the public health roles of these two professional groups, the project was designed to enable their participation in local planning for public health, particularly the health improvement programme, and to develop educational programmes to support such developments. It was intended that health visitors and school nurses would become more actively involved in health needs assessment of the communities with which they were involved.

- The focus of school nursing was seen to be changing with a greater emphasis placed on health promotion activities in schools linked to the Healthy School Standard. School nurses were engaged in a range of public health initiatives in local schools. For example, a multi-agency school nurse led initiative entitled, 'Danger Ranger' brought together other community nurses with the emergency and environmental services and the police to deliver a collaborative health education programme. A multi-agency Steering Group had been established to support the implementation of a school health profiling exercise. At the time of the focus group with school nurses, the profiling exercise had been completed and work was underway to consider how the data obtained could be used to inform the future direction of school nursing. It was recognised that this was likely to require a refocusing of the school nurse role away from routine surveillance to a more proactive approach to responding to identified health needs. School nurses readily welcomed the opportunity to refocus their role.

- Although consideration was being given to developing the broader public health role of health visitors beyond their main focus on families with young children, many health visitors felt that the current heavy workload relating to the under 5s, together with child protection responsibilities, prevented them from extending their role. Health visitors acknowledged the irony of the situation in which they had been trained to assume a broader public health but found themselves in a

position where they made limited use of such skills. Tensions were also expressed between the health visiting core values to provide a universal service, and the need to target the health visiting resource to areas on greatest need. It was also questioned whether current health visitors possessed the full range of skills to work across all age groups and to engage in community development work. Each locality was in the process of making a part-time appointment of a health visitor to take a lead on public health initiatives linked to a health needs assessment of the local community. Specialisation, for example in relation to the NSFs, was proposed as a possible way forward although this carried the disadvantage of separating the public health function from main-stream health visiting practice.

- Most practice nurses were involved in smoking cessation activities in response to the NSF for Coronary Heart Disease. Amuch smaller proportion of health visitors, school nurses and district nurses were involved in formal activities associated with reducing smoking although a number indicated that they incorporated general health educational advice on the harmful effects of smoking into everyday practice. The PCG had appointed a former practice nurse to take a lead role in the implementation of the NSF for CHD and this nurse worked closely with practice nurses throughout North Kirklees in taking forward the NSF requirements, including the public health dimensions. Such an appointment presents considerable potential for collaborative working with other community nurses in addressing the NSF.

- Examples were provided of various public health initiatives in which community nurses were taking a lead or actively participating. Whereas many of these activities related to the Government's priorities, for example in respect of sexual health, teenage pregnancies and Sure Start initiatives, other developments were in response to local needs identified by community nurses themselves. For example, one health visitor had been instrumental in establishing a multi-agency working group to tackle issues of social exclusion in a deprived area, and another had provided a drop in MOT health clinic. At the time of undertaking the consultation, there was no comprehensive picture of the range and extent of public health initiatives being undertaken by community nurses, although as mentioned above, the Public Health Innovation Project had been established to address this issue.

- The public health role of community nurses was seen by many stakeholders to receive low priority because of the pressures to deliver existing services. Capacity to extend this role was seen to be limited due to resource constraints. However, the demands placed on community nurses are set to increase with the implementation of the broader modernisation agenda for health and social care. In order for community nurses to extend their public health role within the constraints of the existing workforce, stakeholders identified the need for all the different groups of community nurses to clarify the nature of the particular service they provide and refocus as deemed appropriate.

- Delivering on the public health agenda was seen to require multi-agency working with community nurses establishing new partners, for example, with housing, employment and education. Although there were some examples where community nurses had already established such links, these are not the agencies that community nurses have worked with traditionally. In rolling out the public health agenda the skills and confidence of community nurses in interagency working will need developing. This is an issue that the Project Group identified above, was seeking to address.

- Taking forward the public health agenda was seen to carry implications for the development of IM & T. In particular, the need was identified for community nurses to be able to access accurate data on the populations with whom they worked. The existing IT infra-structure was seen to be inadequate for this purpose.

chapter five

the nursing workforce

recruitment and retention

Reference has been made in Report 1 The national policy objectives and their evidence-base, to national concerns regarding the recruitment and retention of nurses. Community nursing services in North Kirklees have until recently encountered little difficulty in recruiting staff, however, the position appears to be changing. Stakeholders identified a number of concerns regarding recruitment and retention.

- Applications for community staff nurse and nursing auxiliary vacancies were good. However, the appointment of G grade district nurses and health visitors and senior practice development posts was becoming more difficult with vacancies not always being filled following an initial advertisement. There were very few health visitor students on placement within the Trust. This was attributed primarily to a shortfall in appointed Community Practice Teachers (CPTs) to supervise student health visitors which was linked to the issue of grading PCTs at G and not H. This represents a missed opportunity for potential recruitment.

- The Trust had previously recruited primarily from locally trained nurses. The pattern of recruitment was now changing with a greater proportion of staff recruited from outside the Dewsbury area. Retention of these staff was becoming problematic. Some front line practitioners were reported to have left because they 'felt disempowered' and 'were frustrated because they were getting blocked'.

- The proportion of the community nursing workforce who would be approaching retirement age in the next 5-10 years was a cause for concern with up to one third of community nurses, including practice nurses, reported to be approaching retirement. Bearing in mind the current difficulties in recruiting to senior posts it was recognised that the situation was likely to get worse. The need to develop effective strategies for workforce planning and succession planning across North Kirklees was highlighted.

- It was reported that many of those approaching retirement were seeking to leave employment at the earliest opportunity. The loss of so many experienced practitioners over the next 5-10 years was seen to carry major implications for the development of community nursing services unless appropriately qualified replacement staff are appointed. It was proposed that the Trust should consider introducing more incentives for staff to stay, for example, opportunities for phased retirement.

- Difficulties were reported in recruiting practice nurses of a suitable calibre and with appropriate experience. This was seen to be related to the idiosyncratic nature of practice nursing, the lack of a clear career framework and inconsistencies in the terms of employment of practice nurses. Retention of practice nurses in some single-handed practices was problematic. It was proposed that where difficulties were encountered in recruiting to single-handed practices because of the

Limited number of nursing hours, an integrated model of practice nursing with a pooled resource might be a way forward. It was also suggested that the introduction of a practice nurse induction programme and an expansion of nurse practitioner posts would help to make practice nursing a more attractive career option.

- The recruitment of nurses from minority ethnic backgrounds, in order that the ethnic composition of the community nursing workforce reflected that of the local population, remained a challenge. Very few nurses were from minority ethnic backgrounds and stakeholders were not aware of any specific initiatives currently being undertaken by the Trust to promote recruitment from minority ethnic communities.

- Whilst the Trust as a whole had undertaken considerable work in relation to recruitment and retention this was seen to focus primarily on hospital services and there was a need to develop a recruitment and retention strategy that addressed the particular needs of primary care.

education and training

Investment in the education and training of the community nursing workforce was identified as an important consideration in terms of equipping practitioners with the knowledge and skills to respond to the modernisation agenda. A number of issues were identified relating to the further education and training of the community nursing workforce.

- The community nursing services were reported to benefit from a highly experienced and qualified district nursing and health visiting workforce in that many practitioners had obtained or were pursuing degree level qualifications. Additionally, many community nurses had undertaken short professional clinical courses. However, although the workforce was seen to be highly qualified, there was a perception amongst some community nurses that the knowledge and skills gained through continuing professional education were not necessarily utilised to best effect.

- All Trust staff were expected to have an annual appraisal and personal development plan, and the majority of practitioners interviewed reported this to be the case. They also expressed general satisfaction with the training opportunities available to them. However, it was not clear how the individual education needs identified in the PDPs were integrated into an overall education and training strategy for community nursing.

- School nurses expressed concern at the lack of structured education opportunities as much of the provision that was available locally was perceived not to be of direct relevance to the particular field of school nursing practice. Moreover, there was no standardised training in key areas of school nursing development, for example, in respect of sexual health. Unlike district nurses and health visitors, there was no national requirement for school nurses to have undertaken specialist practitioner training.

- The educational development of practice nurses was not as well established as other community nurses. Very few practices nurses reported that they participated in an annual appraisal and none had a personal development plan linked to the needs of the general practice. Although many practice nurses had undertaken short clinical courses relevant to their role, for example cervical cytology, asthma management and diabetes care, very few had gained a specialist practitioner qualification or were undertaking relevant degree programmes. This was attributed largely to difficulties in practice nurses securing funding and study leave to support continuing professional development. Those practice nurses pursuing degree programmes generally did so at their own expense and in their own time. Elsewhere in the country, for example Leeds, a relief team of practice nurses has been established to backfill for study leave etc. in order to support the continuing professional development of practice nurses as well as helping in the recruitment to new posts and this may be something for the PCT to consider in the future. An experienced practice nurse had been appointed as Primary Care Development Nurse to support the development of practice nurses employed by single-handed practices in one area. Whilst this was perceived to have been beneficial it was felt that the full potential of the post had not been realised because of problems of practice nurse retention in the practices concerned and the need for the Primary Care Development Nurse to back-fill for staff vacancies. Nevertheless, this type of post has considerable potential to support the future development of practice nursing across the PCG/T.

- There were some examples of multi-professional and multi-agency education and training initiatives underway, however, stakeholders identified this as an important area for further development. Joint training involving health visitors, school nurses and social workers in the area of child protection was well established although it was suggested that greater attention could be paid to the identification and assessment of children at risk. Some joint training between district nurses and social workers had focused on accessing community care resources but it was felt that greater emphasis needed to be placed on services available to support intermediate care and the single assessment process required by the NSF for older people.

improving working lives

One of the greatest strengths of the current community nursing workforce was seen to be the motivation and commitment of many practitioners. However, morale amongst community nurses was reported to be variable. This was attributed to a number of factors:

- The understaffing of community nursing services had resulted in heavy workload pressures.
- The uncertainty associated with the impending creation of the PCT and the redeployment of community nurses.
- A perception that the traditional approach adopted by some managers had stifled innovation and that the contribution of experienced community nurses was not always valued by managers.
- The facilities in some health centres where staff were based were seen to be poor and to have an adverse effect on staff morale.

A number of issues were raised in respect of improving the working lives of community nurses:

- Flexibility in working hours was seen as an important means of enhancing the working lives of staff. Although as a general policy staff were able to work flexibly in the event of a family crisis and to vary their start and finishing time by 30 minutes each day, the degree of flexibility was perceived to vary across the three localities. The need for greater flexibility associated with childcare responsibilities, especially upon return from maternity leave was identified with greater opportunities for job share or reduced hours proposed.
- There was considerable diversity reported in the terms and conditions of employment of practice nurses, for example in respect of salary/grading, annual leave, uniform provision. Practice nurses stressed the need for standardisation in their employment contracts and consistency in their terms and conditions of employment with other community nurses.
- The ageing community nursing workforce in North Kirklees was seen to present particular challenges in respect of maximising the contribution of these experienced nurses, for example, through providing new opportunities to challenge and stimulate them or for phased retirement. Additionally, it was recognised that an older workforce was more likely to have carer responsibilities for adult dependents and their support needs would be different from younger nurses with children.

chapter six

developing nursing services

enhancing the quality of care

There were a number of issues identified that impacted upon progress made with addressing the clinical governance agenda in respect of community nursing.

- An audit of district nursing services in the Trust had been undertaken in 1999. The issues raised in the report reflected many of those identified in the National Audit Commission's report 'First Assessment' [1]. In line with many other Trusts nationally, the key challenges arising from the local audit related to:

  i. Clarifying the objectives of the district nursing service and defining the boundaries of the service through clear referral criteria;

  ii. Increasing the efficiency of the district nursing service by matching community nursing staffing levels more closely to need and workload;

  iii. Making progress with the clinical governance agenda by addressing: management information systems, workforce planning, clinical supervision, and seeking the views of users and carers.

  Work was now underway to clarify more clearly the role of the district nursing service and to develop referral criteria. Moreover, this current review had been commissioned to assist in taking forward the recommendations of the local audit.

- A programme of clinical supervision in relation to child protection had been implemented for health visitors and school nurses and was well received by these professional groups. However, clinical supervision in general was not widespread amongst practitioners in the Trust with just one locality reporting that a system was in place. Some practitioners in other localities indicated that in previous employment outside the Trust they had benefited from clinical supervision and were disappointed that this support was no longer available to them. There was no evidence of clinical supervision in practice nursing although the Practice Nurse Forum provided an informal mechanism for peer support. The lack of a clear policy on clinical supervision was seen to be a deficit and several stakeholders highlighted the importance of clinical supervision to underpin the forthcoming expansion of nurse prescribing.

- Audit activity within the different community nursing specialties was reported to be variable. The Trust agreed the annual audit priorities with the Health Authority, however, these were not always seen to have direct relevance to community nursing. District nurses were reported to audit leg ulcer and pressure sore prevalence. Practice nurses were actively engaged in collating information required for standard audits in general practice but there was little evidence of audit in respect of specific clinical nursing activities in general practice. It was suggested that further

consideration needed to be given to developing a more comprehensive approach to clinical audit.

- An Associate Chief Nurse within the Trust was taking forward the implementation of clinical benchmarking criteria identified in the recently published Department of Health 'Essence of Care' [2]. At the time of the consultation, all staff had been invited to presentations on the initiative and the benchmarking on record keeping had been completed.

- The Trust had established separate Quality and Practice Development Groups for district nursing, health visiting and school nursing with membership drawn from each team across the three localities. The groups provided a forum for reviewing local policy in the light of national directives and for developing policy guidelines and protocols. Whilst practitioners welcomed the overall intention of the groups, they questioned the extent to which the groups were able to achieve their objectives. Most notably, the additional workload placed on individual members when leading the development of a guideline/protocol alongside their normal responsibilities was problematic.

- Whereas disseminating good practice was seen to be an important aspect of enhancing the quality of care, opportunities for practitioners to meet to share developments across the three localities were reported to have been limited. However, Nursing Forums were in the process of being established by the Practice Development Nurses in order to facilitate networking and dissemination across the localities.

- Separate Programmes of Care for district nursing, health visiting and school nursing had been developed which provided clear guidance on the range of interventions undertaken by the different branches of community nursing.

- The annual appraisal process provided an important means for reviewing the standard of care provided by individual practitioners and teams. Although team leaders monitored the work of front-line staff within their teams on an on-going basis, the team leader with responsibility for the out of hours district nursing service commented on the variability in standards across district nursing teams and highlighted the potential benefits of a wider programme of clinical supervision for monitoring standards of care

- Practice nurses were actively involved in developing clinical guidelines and pathways in their individual practices but with the exception of PCG initiated work in relation to the NSF for coronary heart disease, guidelines were not shared across practices. This inevitably led to duplication of effort and potential variation in standards across practices. It was suggested that the PCT, once formed, should take an active lead in ensuring consistency in standards by promoting the development of common guidelines although it was recognised that this would require the full support of Gps.

- It was acknowledged that the clinical governance implications for practice nursing were considerable. Wide diversity in the roles and responsibilities of practice nurses arising from the idiosyncratic demands and expectations of different GPs, a lack of investment in the continuing professional development of practice nurses, the professional isolation of many practice nurses, and the lack of a framework for clinical supervision all needed to be considered. The extension of the concept of the Primary Care Development Nurse providing support to practice nurses employed by a number of practices could provide a means of taking forward the clinical governance agenda for practice nursing.

- Some district nurses were reported to participate in multi-professional and multi-agency quality circles that operated in the acute sector of the Trust with the intention of reviewing discharge processes. There appears to be considerable scope for further developing multi-agency approaches to reviewing the quality of services.

strengthening nursing leadership

Strengthening leadership in community nursing was seen by all stakeholders to be an important consideration in order to ensure that community nurses were able to contribute effectively to the modernisation agenda.

- The responsibility for leading community nursing in the Trust resided with the Nurse Advisor for

community nursing. Additionally, the community nurses appointed to the PCG Boards had been influential in developing the PCG's strategy for community nursing. Several stakeholders proposed that an Executive Nurse appointment should be made to the PCT in order to provide strong leadership and to ensure that the nursing contribution could be maximised and appropriate resources secured to enable the further development of community nursing.

- Many stakeholders commented that the traditional management approach adopted by the Trust (which appeared to be based on a transactional model) had affected the speed with which innovation in community nursing occurred. In its place, stakeholders envisaged a transformational model of leadership in which nurses were empowered to work more creatively, flexibly and collaboratively in taking forward the modernisation agenda.

- Many stakeholders commented that the full potential of community nursing was not being realised. Investment in clinical leadership at the level of nursing teams was seen to be essential to underpin the implementation of the modernisation agenda. Although some G grade nurses had recently completed the LEO programme, the extent to which these practitioners had been able to put their learning into practice was not clear. The intention to appoint Practice Development Nurses in district nursing and health visiting was seen as an important step in fostering clinical leadership and developing an empowered clinical workforce. School nurses expressed concern that no such appointment was planned for school nursing, and argued that such a post was important to facilitate the necessary changes to school nursing. This concern was exacerbated by a perception that school nursing was further disadvantaged by not having a manager with expertise and responsibilities in this area of community nursing.

- It was acknowledged that practice nurses have a central role to play in taking forward the modernisation agenda but concern was expressed that this contribution would not be realised without appropriate leadership. Practice nurses stressed the need for leadership provision at PCG level in order to provide direction for the development of practice nursing, empower practice nurses to move practice nursing forward and to address professional development needs.

chapter seven

working in new ways

the scope of professional practice

Reference has already been made to the need for community nurses to expand their role in public health within the context of the modernisation agenda. Other issues relating to the scope of professional practice were raised.

- Many district nurses commented that there was a lack of clarity regarding the scope of district nursing practice especially at the interface with practice nursing. Although district nurses were primarily involved in undertaking domiciliary visits some district nurses ran clinics at health centres or general practices. Others felt that they were undertaking time consuming domiciliary visits to patients who could be seen more efficiently in a clinic. The decision as to whether to provide district nursing clinics was largely historical and based on GP preferences rather than client need and there appeared to be no consistency in determining whether a district nurse or a practice nurse would run a particular clinic.

- The implementation of the NSF for older people appeared to be driven primarily by social services and although district nursing was represented in relevant working groups, the full implications of this NSF did not, as yet, appear to be fully realised by front line district nurses. The move towards a single assessment process with district nurses assuming responsibility for undertaking the assessment of some patients on their caseloads will have major implications for G grade district nurses and highlights the need for training and support, especially in areas where district nurses have not traditionally been concerned, for example in respect of means testing and financial assessments.

- The scope of health visiting practice was seen to lie primarily with the under 5s and child protection work with relatively few health visitors having involvement with older people. The demands of this workload, coupled with a perceived under-resourcing of the service, were seen by many stakeholders to constrain health visitors further extending their role. Although the forthcoming Hall report reviewing health visiting was likely to propose that health visitors relinquish much of the routine screening activities in order to pursue a more active public health agenda, concern was expressed by health visitors and social service representatives that a reduction in the routine contact with families might affect the opportunity to identify children in need.

- Some health visitors expressed frustration that their focus on general practice populations was detrimental to pursuing the wider community based public health opportunities and reaching those clients who could benefit from health visiting intervention but who might not access traditional health care services. At the same time, several stakeholders (including some health visitors) suggested that health visiting lacked clarity regarding the nature of the services provided and its future direction.

- School nursing was reported to be making progress in undertaking a health profiling exercise of local schools which it was anticipated would identify local health needs. It was anticipated that the findings of the school health profiles would then be used by school nurses to refocus their activities by reducing the current health surveillance programme in order to target the service on client groups 'in need' and develop a more proactive approach to health promotion and partnership working with parents and schools.

- Practice nursing had developed considerably in recent years in response to new demands placed on general practice with practice nurses taking on increased responsibility for chronic disease management, health promotion, minor illnesses and triage. Practice nurses anticipated that their role would continue to develop, especially in response to the proposed expansion of nurse prescribing. However, such expansion could only occur if practice nurses were able to delegate some responsibilities, for example, clerical duties.

workload management

It was recognised that the allocation of the district nursing and health visiting resource to general practices was based on a historical basis rather than a systematic formula that took account of the health needs of local communities. As a result there were perceived to be significant inequalities in the allocation of community nurses to general practices. Much of the work to date on workforce management had drawn upon data relating to the number of nursing contacts, however, this was seen to provide an incomplete picture of community nursing activity.

skill mix

The demands on community nursing to extend the scope of professional practice in order to address the modernisation agenda contrasted with the historical under funding of the service and highlighted the need to consider skill mix throughout community nursing in order to ensure a cost-effective service. Although skill mix was established in district nursing and school nursing teams, it was less evident in health visiting and practice nursing.

A number of issues were raised in respect of skill mix.

- Concern was expressed that skill mix should be viewed in terms of providing a cost effective high quality service and not as a cost-cutting exercise to reduce the number of G grade practitioners.

- Although skill mix was well established in district nursing concern was expressed that the skills of different grades of staff were not necessarily being used to best effect. G grade nurses were often tied up with routine care delivery that prevented them from fulfilling key aspects of the G grade role.

- It was proposed that increasing the number of nursery nurses and community staff nurses could enhance skill mix in health visiting. Delegation of some tasks currently undertaken by health visitors could free up health visiting time to further develop the service, especially in the area of public health. For example, immunisation might be undertaken by a registered general nurse or a registered children's nurse.

- Whereas health care assistants had recently been introduced into the school nursing service, inconsistencies were reported in the tasks they undertook with their role determined by their individual expertise, interests and aptitude rather than a clear understanding of skill mix.

- Opportunities for skill mix review arose when a vacancy occurred within a particular team. Decisions about skill mix were based on professional judgement and experience of the caseload characteristics although it was recognised that systematic workforce planning data were also needed to inform this process.

- It was suggested that providing administrative support to community nursing teams and practice nurses would free up nurses for care delivery. However, securing additional funding for administrative support was extremely difficult and where administrative appointments had been made it was often as a result of savings through skill mix review within a nursing team rather than

new funding.

- It was recognised that there was a need to adopt a more strategic approach to reviewing the workforce as a whole in order to determine whether there were the right staff in the right places doing the right things. Core and specialist community nursing skills needed to be identified and linked to a comprehensive health needs analysis of the North Kirklees community, local Health Improvement Programmes and agreement over local targets for health gain.

referral criteria

A number of issues were identified in respect of referral processes for district nursing.

- The local audit of district nursing undertaken in 1999 had identified that a significant proportion of the referrals to the district nursing service were deemed inappropriate although there was no formal mechanism for screening referrals for appropriateness. Stakeholders confirmed the need for clearer referral criteria and indicated that they should take account of cross referral between district nurses and practice nurses. In response to the local audit, work had commenced to clarify more clearly the role of the district nursing service and to draw up referral criteria.

- In practice, referrals for district nursing services were frequently received via a verbal message left on a telephone answering machine in the offices used by district nursing teams. The referral information obtained in this way was often inaccurate and incomplete. Considerable time was then spent by the district nurse tracking down the required information, however, first assessment visits were often undertaken with incomplete information on the patient. It was a suggested that more structured referral documentation and a central referral system with information then faxed to different teams would facilitate the collation of more accurate referral information.

- District nurses considered that both hospital staff and GPs, the two sources for the majority of district nursing referrals, did not fully understand the role of the district nursing service. Some referrals to the district nursing service were perceived to be made because there was no other easily identifiable health or social care professional to whom the patient could be referred. These concerns were to be addressed through the recently established working group examining discharge planning and the development of referral criteria.

caseload manageme

The national Audit Commission's report on district nursing [1] highlighted the benefits of regular profiling of caseloads in order to help district nurses improve their efficiency by ensuring that resources are targeted at those with greatest need. In addition, the results of caseload reviews could be used to inform and influence the allocation of resources and skill mix across practices and within district nursing teams.

- G grade community nurses were responsible for caseload management within their particular specialism. The findings from the local audit of district nursing reflected those of the national audit in that there was a need for a more proactive approach to managing community nursing caseloads. There was no systematic approach to caseload profiling across district nursing teams within a locality that could then be used to inform workforce planning. Concern was expressed that current data collected on caseload activity concentrated on basic contact details and did not capture the complexity of district nursing interventions with patients/carers and therefore did not provide an accurate account of district nursing activity.

- A framework for allocating dependency levels to patients on a particular caseload was in the process of being introduced in some localities. Some teams then used this information to assist in the equitable allocation of work to different team members, whereas in other teams the allocation was based on the professional judgement of the G grade nurse.

- The size of health visiting caseloads was reported to vary considerably across the Trust and was the result of an historical allocation rather than according to the needs of local communities.

There appeared to be no systematic approach to reviewing the size of caseloads, dependency and staffing levels across the Trust although work was underway to consider a framework for caseload management in district nursing. Bearing in mind the reported under-funding of the community nursing resource in general, effective caseload management and the opportunity created to link allocation of staff to caseloads should be an important consideration.

new nursing roles

The government's modernisation agenda envisages a number of opportunities for nurses to develop new roles in relation to new services [3, 4].

- Nurse consultant posts are a new development and little is known about the actual contribution such posts might make to primary care. King's College, London, is undertaking a preliminary evaluation of the first wave of nurse consultant posts but it will be some months before the findings of the evaluation are known. However, with the government's intention for 2000 nurse consultants to be in post by 2004 [3] the initiative is a significant one that merits consideration in the context of the development of community nursing services in North Kirklees. Some progress had already been made in this regard although stakeholders identified considerable scope for an expansion of new nursing roles. The Trust had recently appointed a nurse consultant with responsibility for older people. However, this post appeared to be primarily based in the acute sector with the nurse carrying responsibilities for the case management of patients on an intermediate care ward. It was not clear what role the nurse consultant might have in developing intermediate care services in primary care settings.

- Whereas a specific rapid response team had been established in social services, the responsibility for providing a rapid response in district nursing was spread across the various district nursing teams with each team taking it in turn to provide the service. At the time the social services team was set up, the preferred approach amongst the district nurses was for the service to be managed within existing teams, although the Trust had tried, unsuccessfully, to recruit a separate team. However, this arrangement was now considered to be far from satisfactory in that when G grades were the designated lead for the rapid response service they also maintained responsibility for managing their caseload and working as a member of their team. Moreover, despite protocols, there were reported inconsistencies in how responsibility for rapid response work was transferred from the day team to the out of hours service. It was now generally agreed that the original idea of a designated rapid response district nursing team would be a more appropriate means of providing the service and ensuring that patients on the caseload of the team carrying rapid response responsibilities were not disadvantaged. Although it was felt that patients received a satisfactory service from the current separate rapid response teams, it was suggested that ultimately a multi-agency rapid response team could provide a more integrated service.

- Nurse practitioner appointments in general practice were a new development with two such appointments having been established through PMS funding. It was not clear if the PCG had developed a strategy for the further expansion of nurse practitioner posts. There appeared to be some ambiguity regarding the scope of practice of nurse practitioners. Whereas nurse practitioners were assuming responsibility for triage and minor illnesses, it was noted that some practice nurses already undertook these responsibilities.

- The Trust had appointed a number of clinical nurse specialists, for example in the area of infection control, who provide a central advisory and educational resource across the North Kirklees. As previously mentioned, each of the localities was in the process of appointing a health visitor who would have a lead responsibility for taking forward the public health agenda in the locality.

integrating community nursing

The need for community nurses to adopt more flexible, integrative and collaborative approach to providing nursing services in primary care has been emphasised in a number of recent policy documents [3, 4] and had formed the basis of specific guidance from the Department of Health [5]. Although different models of integrated working amongst community nurses such as locality or geographical working have previously been advocated, the notion of integrated community nursing

teams is currently attracting interest [1]. Such teams normally comprise district nurses, health visitors and practice nurses attached to a particular general practice who then work collaboratively in responding to the health needs of the practice population. The teams are normally self-managing and carry responsibility for budgetary management [6].

- The Trust did not have a policy to promote integrated community nursing teams. Two general practices in one locality had in the past expressed interest in becoming integrated community nursing teams. However, although some time was spent in exploring the concept with the teams, there was insufficient momentum within the practices to take the initiative forward. Although there were some practices where district nurses, health visitors and practice nurses did work collaboratively, they did not function fully as an integrated team in terms of self-managing status and budgetary control for all streams of nursing.

- It was recognised that integrated community nursing teams could be difficult to establish in areas where there were a large number of single-handed practices or where community nursing staff were based some distance from the practice. Moreover, differences in the employment status of various community nurses could pose problems. Although stakeholders were generally receptive to the idea of integrated community nursing teams, it was felt that a mixed economy approach would be most appropriate, possibly with integrated working occurring in some instances at the level of the primary health care team and in others at a 'patch' level amongst a group of practices and with a multi-agency focus. However, such an approach would require the support of general practitioners, and at the time of undertaking the interviews, discussions had not taken place with the PCG regarding the future organisation of community nursing.

- Whereas district nurses, health visitors and school nurses reported that liaison between the different professional groups was good there was less involvement in collaborative working. There was some evidence of integrative working between school nurses and health visitors in the area of sexual health; however, this was seen to be primarily to result from the interest of individuals. School nurses in particular indicated that they would welcome greater collaborative working with health visitors. Collaborative working between school nurses and practice nurses was in the early stages of development. Some cross referrals and exchange of patient information was taking place but this was limited and required development. Collaborative working between district nurses and practice nurses was variable and often depended on the motivation and commitment of the individuals concerned. Whereas there was some evidence of shared care and joint initiatives, for example in respect of leg ulcer management, the potential for collaborative working was curtailed by a short fall in the practice nurse establishment. District nurses commented on the considerable variability in the activities undertaken by practice nurses and that they found themselves undertaking tasks that they felt could be more appropriately undertaken by practice nurses. Likewise, health visitors questioned whether some immunisation might be more appropriately undertaken by practice nurses. Interestingly, practice nurses raised similar issues regarding the scope of district nursing and health visiting practice and suggested that some of their current activities could be undertaken more appropriately by district nurses and/or health visitors. Developing a strategic overview as to how the skills of different community nurses might compliment each other more effectively in providing a patient-focused service will be an important consideration in the lead-up to the formation of the PCT.

- Whilst several stakeholders expressed the need to provide greater clarity in respect of the roles and responsibilities of community nurses, including practice nurses, caution was voiced against being too prescriptive. Rather than rigidly demarcate the roles and responsibilities of different community nursing practitioners, emphasis should be placed on identifying the necessary competencies required to achieve health gain. It was suggested that a health needs assessment of the local community/practice population could be used as a basis for identifying the competencies of different practitioners needed to fulfil the health needs. Whilst not advocating a generic community nurse, there was a need to breakdown professional boundaries in order to provide a more integrated patient focused-service.

chapter eight

service organisation and delivery

Innovation in service delivery linked to the modernisation agenda was occurring across the three localities, most notably in the area of public health. It was not the purpose of the review to appraise the extent to these initiatives, but it was noted that the modernisation agenda would place additional expectations on community nursing to consider new models of service delivery.

The main issues identified for community nursing to address related to inter-agency and inter-professional working, the primary / secondary care interface and IM & T developments.

inter-agency and inter-professional working

The need to enhance and further develop inter-professional and inter-agency working was seen by many stakeholders to be an important priority.

- Interagency working at a strategic policy level between health and social services was in evidence but it was felt that this would need to be built upon in order to take forward the modernisation agenda. There were different perceptions of collaborative working at different levels of the management structure. Whereas some stakeholders perceived that collaboration was good, others felt that collaboration varied depending on an individual's willingness and belief in the benefits of working with other agencies. With the exception of child protection, collaborative working at fieldwork level was reported to be patchy and depended to a large extent on the strength of personal relationships.

- Excellent inter-agency relationships had been established at a senior and middle management level around child protection and there was a willingness to work with other agencies in the area of health needs assessment with the school health profile being one such example where commitment had been forthcoming from education, social services and the health authority.

- From a community nursing perspective, collaborative working in the field of services for older people was seen to be currently under-developed but an important priority for the future. As mentioned earlier, work on the NSF for older people appeared to be driven by social services, and although it was recognised that the NSF would impact on district nursing services, front line practitioners were only just beginning to engage with the issues.

- School nurses indicated that they generally enjoyed good working relationships with head teachers although they saw the potential to work more collaboratively in respect of some teaching provision. Some school nurses were beginning to work more closely with education social workers by undertaking joint community visits and with the police in respect of raising awareness of the problems of substance misuse. However, lack of time resulting from heavy workloads was seen to inhibit further collaborative working. School nurses indicated that they would welcome closer working relationships with general practitioners. Communication between school nurses and GPs was often mediated through health visitors which was deemed

unsatisfactory. Moreover, school nurses reported difficulty in accessing health information relating to children in their care.

- Although there were examples of good practice across North Kirklees, it was also recognised that there was a need to extend inter-agency collaboration in order to deliver a modernised health and social care service. Stakeholders emphasised the need to move beyond networking across agencies, which community nurses were seen to be relatively successful at, to actually working collaboratively to address health need. The cultures of various agencies were perceived to be quite different and it was recognised that collaborative working would take time to achieve. Extending joint training between professional groups was proposed as a useful means to break down barriers.

- Historically, there had been a tension between health and social care services, in part because the organisational cultures were very different. Both district nurses and home care perceived that they were expected to assume responsibility for managing patients with chronic long term illness and tensions had arisen between what constitutes a nursing and a social care need. District nurses perceived that social services adopted a different approach to risk management with tight protocols determining the activities that home care workers were able to undertake. They identified a number of care activities which were currently undertaken by members of the district nursing team that they considered could be delegated to home care workers provided that they were trained appropriately and supervised by the district nursing team. Social service representatives reported that they were now beginning to make progress with clarifying where responsibility for certain aspects of care could, on an individual client basis, be transferred from district nursing to home care services.

- Intermediate care services were perceived by community nurses to be primarily located on the intermediate care ward located in the acute sector of the Trust and to provide a step-down facility. However, development work was currently underway in the PCG to consider different models of community based intermediate care services linked to the development of a Strategic Outline Case for funding. It was anticipated that the further development of intermediate care facilities would present new opportunities for multi-agency collaboration.

- Relationships between health visiting and social services were perceived to be variable in part because of the pressures that social workers were perceived to be working under due to financial constraints resulting in staff shortages and heavy workloads. Attempts to set up a joint forum between health visitors and social workers and to establish a shadowing scheme had failed to materialise due to staff pressures in social services. Child protection was a shared area of concern between health visitors and social workers with joint visiting occurring. The need for more joint training between health visitors and social workers was seen to be important to developing a shared understanding of each other's roles.

- There was little evidence of primary health care team meetings that brought together a broad range of health and social care practitioners. Although some community nurses were invited to meetings of the general practice team, these tended to focus on practice related issues rather than service development or integration of services.

primary-secondary care interface

The need to enhance inter-professional collaboration between different health care sectors was also seen to be important. Although the Trust carried shared responsibilities for acute and community nursing several stakeholders perceived that the two components of the service operated relatively separately. Despite evidence of some joint initiatives between primary and secondary care opportunities for an integrated approach to nursing services had not always been taken up and there was scope for further development. A number of issues were identified that merited consideration.

- In recent years, district nurses had taken on additional responsibilities for providing technical aspects of care that previously would have necessitated a prolonged hospital admission. The shift in skilled technical nursing care is likely to continue together with an increase in the proportion of patients with complex nursing needs being cared for in the community. Such developments will place additional demands on the district nursing service in the future.

- Several stakeholders perceived that there were patients currently in hospital who could be cared for in the community with the appropriate community nursing provision. The administration of

intra-venous drugs and the management of patients with an uncomplicated deep vein thrombosis were examples where care could be undertaken by community nurses. It was suggested that a framework needed to be established to enable dialogue to take place through which more patients could be cared for in the community, either through preventing hospital admissions altogether or facilitating early discharge. Opportunities to develop specialist community nursing roles and specialist outreach services also needed to be explored.

im&t developments

The development of information management and technology systems was seen to be essential to modernising community nursing.

- The IM & T infra-structure was in the process of being rolled out across the Trust. Managers had e-mail and Internet access, and plans were underway to extend this to front line practitioners. At the time of undertaking the interviews, the majority of practitioners did not have ready access to evidence-based information via the Internet or an intranet to inform their practice.

- Some management information was collated by community nursing teams inputting computerised data. However, practitioners felt that the data collected did not necessarily provide an accurate picture of community nursing activity. Moreover, as at the time of undertaking the interviews not all front line practitioners had access to a computer to input data, the accuracy of such data for planning purposes was questioned.

- Nursing records were not held electronically although community nurses had access to electronic patient records in the general practices to which they were attached. However, a lack of consistency in software used by GPs meant that a uniform approach to electronic patient records was still to be developed.

Conclusion

In concluding, it is not the intention to reiterate the issues that have already been identified in the earlier sections of this report but rather to summarise what appear from the stakeholders' perspectives to be the key priorities to be considered in modernising community nursing services in North Kirklees.

i. The strategy for modernising community nursing needs to ensure that the community nursing workforce as a whole is equipped to deliver and further develop the modernised primary health care services that are envisaged in current health policy directives. This will necessitate an integrated approach which addresses the collective needs of district nurses, health visitors, school nurses and practice nurses.

ii. The strategy should provide a unifying focus for the development of community nursing across the North Kirklees, and although it should be responsive to local needs, it should also ensure a consistent approach to providing high quality community nursing services across the district.

iii. There are many examples of innovation and good practice in the different areas of community nursing that the Trust needs to capitalise on to further develop and modernise community nursing services. Mechanisms need to be found through which innovation can be captured and shared and individuals are enabled to flourish.

iv. Delivering on the public health agenda will require a refocusing of traditional community nursing roles and an extension of multi-agency working with community nurses establishing new partners. In rolling out the public health agenda, the skills and confidence of community nurses in interagency working will need developing.

v. Community nurses need to become more adept at working with new partners in order to maximise their contribution to health gain. Action needs to be taken to facilitate an understanding of different cultures within various agencies. Joint training initiatives could contribute to an enhanced understanding and facilitate collaboration.

vi. The apparent under-resourcing of community nursing services presents particular challenges in taking forward community nursing in North Kirklees. In addition to seeking to secure extra resource, there is scope to increase efficiency and effectiveness by matching staffing levels more closely to need and to workload, managing caseloads more effectively, and maximising skill mix opportunities. To this end, a more strategic approach needs to be taken to determining skill mix across community nursing as a whole.

vii. A clear strategy for promoting integrated working across all groups of community nurses is essential to developing primary care services which are responsive to the needs of practice populations and local communities. Moreover, there is a need to establish systems and structures to promote collaborative, integrated inter-agency working.

viii. Further investment in developing a transformational model of clinical leadership is warranted

in order to ensure that community nurses are empowered to work more creatively, flexibly and collaboratively in developing primary care services.

ix. The requirements of clinical governance make it imperative that there are systems in place to ensure a consistently high standard of patient care across community nursing services in North Kirklees. Considerable progress has been made in respect of the programmes of care, policy and protocol development, staff appraisal and personal development plans, continuing professional development, and supervision in the area of child protection for Trust employed community nurses. However, further consideration needs to be given to monitoring the performance of individuals and teams, and more general forms of clinical supervision and clinical audit. Moreover, there is an urgent need to extend such initiatives into practice nursing.

x. Ongoing investment in the continuing professional development of community nurses will ensumed that the workforce is equipped to meet the demands of the modernisation agenda. Such development will be needed to support the anticipated growth in the number of nurse consultants and nurse practitioners in general practice as well as the refocusing of traditional community nursing roles. Multi-professional education and training is needed to develop a shared understanding of different roles and support collaborative working.

xi. Difficulties in recruitment into community nursing together with the impending retirement of a significant proportion of the workforce highlights the need for a strategic approach to managing the recruitment and retention of community nurses, including those from ethnic minority backgrounds. Special consideration needs to be given to supporting newly appointed practice nurses in order to enhance retention.

xii. Dialogue between the Trust and the PCG needs to occur at all levels in order to begin to develop a cohesive organisation for the future. The anxiety amongst community nurses concerning a change of employer with the move to PCTs in April 2002 will need to be carefully managed throughout the transition process.

[illegible]

a review of practice nursing in calderdale and kirklees

g kaufman november 2000 / executive summary

Practice nursing is an exciting and vital branch of the nursing profession, and nurses working in general practice have a central role to play in the governments' modernisation agenda for primary health care. In the light of this, a review of practice nursing was undertaken in Calderdale and Kirklees to develop a local profile of practice nurses, the work they undertake, and their professional education and training. In addition, the review was carried out to explore professional development issues, terms and conditions of service for nurses working in general practice, and their managerial and leadership needs.

The review highlights the diversity of the practice nurse role, and its dynamic and challenging nature. The practice nurse is no longer an assistant to the GP, but is somebody who offers a nursing service that is therapeutic in its own right. However, the review suggests, there is sometimes a failure on the part of general practitioners and managers to recognise the value and complexity of the practice nurse role, and therefore the need for practice nurses to provide a holistic approach to care, rather than a ritualised and routine approach. It is important that a balance is achieved between getting through the work in general practice and creating an environment that permits nurses to deliver the best care in an informed way. Whilst education and training is available to underpin some of the work that practice nurses do, there is no training to address the needs of practice nurses working in extended roles. This needs to be addressed since it has implications for safe practice and the protection of patients, nurses and GPs. Furthermore, very few practice nurses have a specialist practitioner qualification in general practice nursing. More nurses need to be encouraged and supported to undertake this training, since it empowers nurses to develop and improve practice, and to contribute more effectively to the organisation and delivery of primary health care. Furthermore, practice nurses, whether they are novice or expert have little or no access to clinical supervision. This needs to be addressed since supervision is an essential developmental component for all health care professionals who have direct contact with patients. Practice nurses are highly committed professionals, who are keen to provide the best care possible for their patients. However, some nurses have difficulty in getting funding and time off for development. In addition, there are variations in clinical grading amongst nurses with similar roles and responsibilities, and there are differences in nurses' terms and conditions of service.

This situation needs to be remedied since it has a negative impact on nurse morale and the potential to adversely affect motivation and performance. There is recognition that communication and team working between practice nurses, and their community-nursing colleagues is not as good as it could be. More needs to be done to facilitate the integration of practice nurses, with community nurses, to improve working lives, and patient care in the primary care setting. Consideration also needs to be given to leadership provision for practice nurses at PCG level to address nurses' development needs and to lead the profession forward. Finally, there is a danger of a shortfall in the practice-nursing workforce in the future, since the majority of practice nurses are aged between forty and sixty years. In addition to this, there is no planning or provision for training new practice nurses. This will have implications for the recruitment of practice nurses in the long term, since the employment of nurses

from secondary care, or the independent sector, who are equipped to function in a practice nurse role, will be unlikely, given the diversity of the role, and the specialised knowledge and skills it now requires. Therefore, a strategy needs to be developed to address the recruitment and training of future practice nurses so that we have an adequate number of skilled professionals to help take forward the governments vision for primary health care.

Appendix two

trust documentation reviewed

A Review of Practice Nursing in Calderdale and Kirklees, G Kaufman, November 2000

Community Nursing Staffing Establishment by grade within age band, June 2001

Managing and Measuring Community Nursing Workload, June 2001

The public health role of health visitors and school nurses: proposal for action, March 2001

Report on School Health Profiling and data flow

Summary overheads of the audit of the public health role of health visitors and school nurses undertaken in December 2000

Primary Care Services Community Services Directorate Child Protection Supervision Plan for Health Visitors and School Nurses

Dewsbury Moor and Scout Hill Sure Start Consultation Health Aspects May/June 2001

District Nursing Programmes of Care,

Health Visiting Programmes of Care, September 2000

School Nursing Programmes of Care, January 2000

District Nursing Quality and Practice Development Group, Terms of Reference, March 2000

Health Visitor Quality and Practice Development Group, Terms of Reference, October 2000

Practice Development Nurse (District Nursing) Job description, May 2001

Practice Development Nurse (Health Visiting) Job description, May 2001

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Resource Allocation in Community Nursing across North Kirklees

A compilation of research based reports
to inform the modernisation of community nursing services

Contents

Introduction

1. This report sets out the results of a study of the District Nursing and Health Visiting resources in North Kirklees and benchmarks the results against two similar PCG/PCT populations. Specifically work has been carried out to investigate:

   - The target levels for district nursing and health visiting resources for the three PCG/PCT populations, calculated by reference to the national resource allocation formula for the NHS.

   - An estimate of the reported levels of district nursing and health visiting resource for each PCG/PCT population

   - A mechanism for the distribution of district nursing and health visiting resources locally between GP practices, or groupings of practices using localised measurements of need and other demand.

2. The project has been undertaken to enable the PCG/PCT in North Kirklees to understand how much of its resource should, in an ideal world, be targeted to Community Nursing under the national allocation formula rationale. Then to examine the allocation of Community Nursing resource at GP Practice level against a notional target allocation. (NB in practice these resources need to be taken into account over groups of GP practices for all but he very largest of practices).

3. There is currently no perfect methodology for allocating resources at GP practice level. The project uses the national formulae of weighted capitation to describe how resources are allocated to Health Authority level. It then looks at the distribution of resources to PCG/PCT level and Practice level using weighted capitation formulae. The application of a capitation formulae weighted for Townsend scores at practice level has been explored to illustrate a needs weighted distribution of these resources within each PCG/PCT.

4. In addition to North Kirklees, two other Primary Care Trust areas have been analysed to provide a context against which the North Kirklees results can be judged. The three areas are relatively deprived areas as measured by any of the public health deprivation indicators. However the areas are structured differently to deliver Community Nursing to their local populations. North Kirklees PCG is currently provided with Community Nursing services by a combined Acute Hospital and Community NHS Trust. The other two PCT's now provide community nursing services themselves having inherited the services from dedicated Community /Mental HealthTrusts.

chapter one
methodology

resource allocation formulae in the nhs

6. General taxation and national insurance contributions meet over 90% of NHS spending. The balance comes largely from the receipts of land and property sales, and a small amount from charges[1] Resources are provided for the NHS to spend through a resource allocation process. At the highest level this involves Parliamentary votes for different departmental budgets including Health, Housing, Social Security and Transport etc. Each year the Chancellor of the Exchequer issues a statement of public expenditure plans which are then formulated into Service Delivery Agreements between the Treasury and the respective Departments of Government. The overall sum allocated for Health is then allocated by the Department of Health using a resource allocation formula.

7. From 1999/2000, allocations were unified to cover the three funding streams of hospital and community health services (HCHS), discretionary general medical services (GMSCL) and prescribing. Under these current arrangements, funding is allocated to health authorities on the basis of the relative needs of their populations. A weighted capitation formula is used to determine each health authority's target fair share of available resources to enable them to commission similar levels of health services for populations in similar need. This formula will be devolved to Primary Care Trusts for the financial year 2003/04 forward.

8. Weighted capitation targets inform allocations. The formula does not determine allocations. Actual allocations reflect decisions on the speed at which health authorities are brought nearer to target through the distribution of growth. This process is described as the 'pace of change'

the national allocation formula

9. HA general allocations are the main part of HA expenditure. HAs are given allocations for their hospital and community health services (HCHS) so that they can commission health care for their resident population. It is for individual HAs to decide on the level and type of services commissioned, in partnership with local GPs and through consultation with other agencies and local people, taking account of local circumstances and national and local policies and priorities.[2]

10 The weighted capitation formula is used to determine HAs' and PCTs' fair shares of available resources to enable them to purchase similar levels of health care for populations with similar health care need. The following four elements are used to set HAs' actual allocations:[3]

- **(a) weighted capitation targets** - set according to the national weighted capitation formula which calculates HAs' fair shares of available resources based on the age distribution of the population, additional need and the unavoidable variations in the cost of providing services;

- **(b) recurrent baselines** - represent the actual current allocation that HAs received. For each allocation year the recurrent baseline is the previous year's actual allocation, plus any adjustments made within the financial year;

- **(c) distance from target (DFT)** - this is the difference between (a) and (b) above. If (a) is greater than (b), a HA is said to be under target. If (a) is smaller than (b), a HA is said to be over target;

- **(d) pace of change** - this is the speed at which HAs are moved closer to their weighted capitation targets. Ministers decide the pace of change annually for HAs and by HAs for PCGs.

special allocations

11. Not all funding is allocated according to targets set by the unified formula. Specific weighted capitation formulas are used for the special allocations such as for drug misuse and HIV prevention.

unified allocations

12. Before April 1999, HAs received revenue allocations in three main funding streams:

    - HCHS;
    - General practice infrastructure (GMSCL); and
    - Prescribing.

    From April 1999 HAs and PCGs have been funded through a single unified allocation.

13. The formula now has three components, reflecting HCHS, GMSCL and prescribing. Each component of the formula is used to produce a weighted population for each HA. These are then combined, proportional to the national expenditure on each component for the latest available year, into unified weighted populations. A single distance from target is calculated for each HA and a single pace of change policy is applied.

hospital and community health care services (hchs)

14. Since a Resource Allocation Working Party report in 1976, *Sharing Resources for Health in England*, there has been a clear objective for HCHS resource allocation. That objective is: "to secure equal opportunity of access to healthcare for people at equal risk". The Working Party recommended distributing resources on the basis of the size of population, weighted (or adjusted) according to two basic criteria:

    - **need** - adjustments were to be made to reflect perceived geographical differences in the need for healthcare;
    - **cost** - unavoidable geographical differences in the cost of providing services.

    This underlying principle of weighted capitation, in which resources are distributed between HAs on the basis of the relative need of their populations remains in place.

general medical services cash limited (gmscl)

15. Before 1999/2000, GMSCL was treated as a special allocation, with a separate formula. The GMSCL formula was used to set targets and had its own pace of change policy. In line with *The new NHS*,[5] GMSCL became part of the unified formula from 1999/2000 onwards. This means that the target for GMSCL is now combined with the HCHS and prescribing targets to create a single target.

prescribing

16. Before 1999/2000 there was a separate formula used to inform a separate allocation for prescribing. It was not used to set targets. Prescribing became part of the unified formula from 1999/2000 onwards.

allocations to pcgs

17. *The new NHS* also proposed that the national formula should be used by HAs to make allocations to Primary Care Groups (PCG) and Trusts (PCT). HAs are allowed some specific local flexibility in the application of the formula to PCGs to reflect local conditions. This is a necessary amendment where there are minor differences between PCG/T resource positions.

hospital and community health services component

18. The HCHS component is the relevant part of the National Formula for this exercise as it includes the element for Community Health Care within which sit the formulae for Health Visiting and District Nursing.

19. The Hospital and Community Health Services component is made up of the following adjustments:

    - age related need
    - additional need, over and above that accounted for by age variations in the unavoidable cost of providing healthcare (market forces factor and emergency ambulance cost adjustment). The emergency ambulance cost adjustment is not applied at PCG level.

age related need - purpose of the age weighting

20. One of the main causes of variation in the level of demand for health services is the age structure of the population. The very young and the elderly, whose populations are not evenly distributed throughout the country, tend to make more use of health services than the rest of the population. The purpose of the age weighting is to allow for varying elements of health need associated with the age structure of local populations.

21. Populations are weighted by the latest available three-year average national resource use across eight age bands, including births. The age weighting is derived using a variety of data sources. The national average HCHS expenditure per head is estimated for a range of different programmes and then aggregated up to total HCHS expenditure for each individual year. The different methods adopted for the various programmes of expenditure are explained below.

inpatient and daycases

22. To calculate the average per capita expenditure on inpatient services by age it is necessary to have activity data and cost data. Hospital Episode Statistics (HES) are used to measure the following inpatient activity:

    - completed ordinary admissions - episodes started during the year;
    - unfinished ordinary admissions - episodes started during the year;
    - daycases;
    - occupied bed days during the year.

    Activity data is translated into cost data using national average specialty cost weights.

23. Combining activity and cost data derives total expenditure on inpatient services by age. Dividing this total by a mid-year estimate of the population in each age group gives an estimate of the average per capita expenditure for each age group.

community health services

24. Costed activity for the majority of community health services is estimated. Activity data for most community programmes is available but cost weighted activity is not available. Instead, the aggregate expenditure in each programme is allocated between the age groups according to the level of activity in each age group. Total expenditure on each age group is divided by the total population in that age group to derive the average per capita expenditure by each age group.

25. The aggregate programme budgets are also calculated. This uses data collected on Health Authority Finance Return forms[8]: to calculate the weight of expenditure for each programme. This is then scaled so that the aggregate of all the programme budgets is equal to the actual expenditure on HCHS.

outpatients and daycare

26. Activity in the acute and geriatric outpatient programmes is derived from data collected in the General Household Survey (GHS). This is used to allocate the total expenditure in the programme across the age bands. As in the other cases, dividing by the population derives the average per capita expenditure. Where appropriate, activity in outpatient and daycare programmes is estimated by using activity in other programmes as a proxy. For example, activity for psychiatric outpatients and day patients is assumed to follow the same pattern as psychiatric inpatients.

other programmes

27. For programmes where no reliable activity data exists, estimates are derived using a variety of methods. These include using alternative programmes as a proxy, for instance: "administrative" is allocated pro rata to total hospital and community expenditure. In the case of the "health promotion" programme, the assumption is made that all ages use the programme equally.

deriving the age / cost curve

28. The process described above produces the age/cost curve for a given year. to avoid the possibility of distortions caused by anomalies in a single year, the age/cost curve used is an unweighted average of the most recent three years data using the specialty cost weights. the final stage, to derive the age-weighted populations, is to multiply the population of each ha in each age band by the average expenditure per head for each age band.

additional need

29. This element of the formula is intended to reflect the relative need for healthcare "over and above" (ie additional) to that accounted for by age. The need weighting takes the form of four indices for different services:

- acute;
- psychiatric;
- non-psychiatric community;
- community psychiatric.

30. The need indices are, with the exception of *standardised mortality ratios* (SMRs), based on 1991 small-area Census socio-economic variables. The relative importance of these need indices is determined by their relative share of national expenditure (three year average of the latest available figures). The table below shows the most recent estimates.

HCHS Attributed expenditure share	**%**
Acute	69.59
Psychiatric	15.14
Non-psychiatric community	11.18
Community psychiatric	4.09
Total	**100.00**

Within the Non Psychiatric Community element above the following sub components exist:

District nursing	49.70%
Health Visiting	14.51%
Community Maternity Services	10.60%
Chiropody	4.73%
Other Community	20.45%
Total	**100.00%**

31. Tables below show the various socio-economic and health status variables (with their statistically estimated *coefficients*) that are used to produce the acute and psychiatric need indices. These are based on analysis by the University of York in 1994.

Acute need index variables

Acute need variables Coefficients	**Coefficients**
Standardised Limiting Long Standing Illness Ratio under 75	0.2528
Standardised Mortality Ratio (SMR) under 75	0.1619
Proportion of economically active who are unemployed	0.0287
Proportion of pensionable age living alone	0.0765
Proportion of dependents in single carer households	0.0436

Psychiatric need index variables

Acute need variables	**Coefficients**
Proportion born in new commonwealth	0.1073
Proportion of those of pensionable age living alone	0.3609
Proportion of persons in lone parent households	0.1846
Proportion of dependants with no carer	0.1431
Proportion of adult population permanently sick	0.2616
Standardised Mortality Ratio (SMR) under 75	0.2426

32. The acute and psychiatric relative need indices are calculated by taking the product of the various socio-economic and health status need drivers weighted (exponentially) by their coefficients.

33. A research team from the Universities of Kent and Plymouth were commissioned in 1996 to develop separate need indices for various Community Health Services using a simplified method. The aim was to identify need indicators from the 1991 Census suitable for use at HA level. The utilisation data was based on a survey of selected NHS Trusts. The chosen models are summarised in the table below that shows the relevant Census variables with their coefficients

Community Health Services (CHS) need indices

	District Nursing	Health Visiting	Community Maternal	Chiropody	Other Community
Residents with no car	0.263			0.108	0.108
Households with 3 or more children	0.142				
Standardised Mortality Ratios 0-74	0.424			0.725	
Residents with no central heating		0.088			
Elderly living alone		0.172			
Single parents households		0.069			
Dependents in no carer households		0.169			
Single carer households			0.265		
Born in new commonwealth				0.139	
Educational qualifications				- 0.115	
Single, widowed, divorced					0.532

34. The indicators have clear interpretations either as health status measures or as indicators of socio-economic deprivation. Many of the Census variables are quite highly correlated with one another. This means that the estimated need indices should be looked at as a whole and too much significance should not be attached to the particular constituent variable. These separate CHS formulas are combined (in proportion to expenditure shares) into a single CHS need index.

35. There is a separate index for community psychiatric services that uses the Census variables shown below.

Community psychiatric need variables

Community psychiatric need variables	Coefficients
Residents with no car	0.128
Single, widowed or divorced	0.800
Single parent households	0.130
Standardised Mortality Ratios 0-74	0.519

overall need weighting

36. To produce an overall need index the four separate need indices (acute, psychiatric, non-psychiatric community, community psychiatric) are weighted together.

37. The next section includes details of the allocation formula and specifically how it derives a figure for community health care services that include elements for health visiting and district nursing.

district nursing and health visiting

38. District nurses deliver most of the professional nursing care provided in patients' homes and are a vital part of today's NHS. The service treats 2.75 million patients a year at a cost of £650 million. A recent report by the Audit Commission highlighted the following profile of District Nursing[4]

39. The demand for district nursing care is rising; improvements to these services are high priority for PCTs and should be considered as an important contribution to the modernisation of the NHS The Audit Commission noted that:

- the elderly population is increasing and one half of those over 85 see a district nurse,
- patients are being discharged from hospital earlier; specialist care at home is becoming more common
- more patients with acute conditions and degenerative diseases are being nursed at home

- two-thirds of trusts report a fall in the number of qualified district nurses between 1995 and 1997
- one in ten district nurses is over retirement age and the numbers entering training have shrunk by one-third since 1990
- PCTs need to review the number and mix of staff on duty to meet the needs of patients and encourage more district nurses to hold clinics for patients who are able to attend - currently 6 per cent of patient contacts take place in clinics
- PCTs should review demand for 'out-of-hours' services - one-third of trusts currently have no service after midnight
- PCTs should ensure that the right patients are getting treated and take steps to ensure district nurses are involved in profiling the needs of their local community
- 70 per cent of referrals come from GP's and hospitals but referral criteria are unclear. One in ten referrals is considered inappropriate by district nurses
- many district nurses do not review their caseloads systematically and regularly the quality of patient assessment can fall short of good practice guidelines - for example, patients with leg ulcers should be screened for arterial disease using Doppler ultrasound, but only one-half are
- Trusts and health authorities should review the district nursing service and it's organisation to ensure that it is responsive, efficient and effective in meeting the changing needs of patients and carers.

40. Health Visitors are a smaller workforce than District Nursing but together with the GPs Practice Nurses they form the main body of Community and Primary Car Nursing. Whereas District Nursing is largely historically focused on older peoples health care needs the health Visiting role is focused on care of children, although not exclusively so.

approach adopted for calculation of target allocations

40. The potential scale of this piece of work is very large. In considering which elements of the National allocation formula to include it was concluded that the main Community Health Service needs components should be utilised. Consideration about the impact of the age-sex and market forces factors on the work was given. It was concluded that for these two components their impact was in determining what share of the overall national allocation would go to each Health Authority rather than on what the allocation should be used for. This view could arguably be challenged but the impact is considered so marginal compared to the needs factors that these factors have not been included.

42. Next in determining the target shares of the allocation it was necessary to take account of those areas of health care spending which fall outside the description of health services used in the formula for hospital and community health care services (HCHS). These areas are Prescribing and Primary Care. For the purposes of this study the percentages offset for these two areas have been taken directly form the NHS Allocation Exposition book[8] and are standard percentages of 15.238% and 2.924% respectively.

43. In addition to these areas it is necessary to take account of the share of the allocation that is used to pay for management costs within Health Authorities. The figure for this differs between different Health Authority areas. It was therefore determined that for the purposes of a target formula, this figure should be standardized for each area. This was done by using the figures derived form the NHS National Accounts (1999/2000)[8] which indicates separately the management spending at national level.

44. Having adjusted each local HA allocation for the above components a net figure is derived to which can then be applied the Community Services percentage figures illustrated above. However there is a further dynamic to finalising the target spending levels. This requires the subdivision of the HA figures into PCT level figures. For the purposes of the exercise it was determined that the weighted capitation shares for each Control PCT (S)hould be applied.

establishing the actual spending

45. The next phase of the work involved analysing expenditure records to identify the local expenditure on District Nursing and Health Visiting Services. These costs are generally available at Health Authority level as part of the NHS annual accounts process. However they were not readily available at PCT level. This necessitated use of a different mechanism to derive the PCT levels. The options for this appeared to be:

    - (a) Apply a pro rated share to each PCT based on weighted capitation.
    - (b) Carry out a thorough audit to identify all cost centers and costs incurred
    - (c) Base the local expenditure on a workload measure.

46. Option 'c' was the preferred option originally. It would provide more detail than option 'a' but did not involve the volume of work associated with option 'b'. When it came to the collection of workload data from the Community Nursing Services, however the data was available but there was a widespread lack of trust in its validity. We therefore resorted to using option 'a'. In the event actual data on total expenditure became available in Control PCT (S) which was very near to the amount calculated using option 'a' (within 1%). Similarly the use of option 'a' in relation to Control PCT (D) produces a figure which seems accurate locally. In North Kirklees, however, there is a marked discrepancy in the amount estimated by the Trusts Finance department. The work would be dramatically enhanced by the production of a locally verified figure for Community Nursing split by District Nursing and Health Visiting headings but at this critically early stage in their development Primary Care Organisations cannot take on this task.

establishing resource use at gp practice level

47. The second part of the project is to examine ways in which the target resources in District Nursing and Health Visiting should be allocated at a locality level. The options for doing this were to look at individual GPs as the smallest cost centres, GP practices or fixed localities. Of these options it was considered that the detail would be too extensive at GP level, while localities are not yet clearly defined in all the PCT areas. Examining nursing levels at GP practice levels was therefore selected as the most appropriate method.

48. In order to set target levels for each GP Practice it was necessary to produce an analysis of the population of North Kirklees, CONTROL PCT (D) and CONTROL PCT (S) at electoral enumeration district level. At this level it was possible to obtain population deprivation information. The approach adopted involved using the Townsend deprivation index[10], which is sourced from Census data and identifiable down to enumeration district level.

49. The Townsend Score is a measure of levels of material deprivation that includes four variables:

    - Unemployment (lack of material resources and insecurity),
    - Overcrowding (material living conditions),
    - Lack of owner occupied accommodation (a proxy indicator of wealth) and
    - Lack or car ownership (a proxy indicator of income).

50. The Townsend Score is a summation of the standardised scores (z scores) for each variable (scores greater than zero indicate greater levels of material deprivation). This score is considered the best indicator of material deprivation currently available[9] By aggregating and then averaging the Townsend scores for each practice an overall Townsend score has been calculated. Townsend scores are absolute percentages and as a consequence they are relevant to and weighted between different population groups. Details of the Townsend deprivation system calculations at GP Practice level are shown below.

51. It would be possible to examine resource distribution using other indicators. Jarman under privileged area scores[11] are indicators of deprivation based upon GP workload. However they

are a mathematical calculation and are not relevant to absolute deprivation between different population groups. Another possible method for resource sharing would be to apply Limiting Long Term Illness indicators that are also derived from Census data.

51. It was planned that some measurement of the current utilisation of Community nursing resources at GP Practice level would be undertaken to enable a comparison with the target allocation calculation referred to above. Given that the project has already discovered that actual resource use at PCT level is difficult to establish, the prospect of obtaining the same data at GP practice level is unrealistic. There is data around that shows numbers of nursing contacts by each GP practice and this has been used to indicate current use. Although number of visits is a very limited measure of activity without some indication of the reason for visit, it is believed that it is likely that difference in case mix will be similar between localities and may be similar between practices.

52. The output for this part of the exercise will therefore be the target allocation at each GP practice level. It would not be appropriate for the project to propose a means of spending that resource that would show, for example, numbers and grades of different nurses. This must be a matter for local discretion and will be subject to he following factors:

- The existing and planned levels of Practice Nursing and the roles fulfilled by that staff group
- The availability of the required health care professional staff groups
- The local knowledge about specific patients, which can be guided by the Townsend deprivation scores but in the end, is subject to the needs of individual patients

The results of the comparison are discussed in detail in the section on findings below.

chapter two

findings

target resources - national

53. The total national resources are taken from the 2001/02 NHS Allocation Exposition Book[5]. The national resource is allocated to Health Authorities using the National Formula

target resources - ca

54. Of the total allocation to the Three Health Authorities resources should be divided as follows:

Table 1 Resources by Health Authority see Appendix A

	Weightings	Calderdale and Kirklees £ '000	Control HA (D) £ '000	Control HA (S) £ '000
Overall Allocation				367,733
Adjustment for admin				- 8,458
Adjustment for prescribing				- 56 035
Adjustment for FHS				- 10,752
Adjustment Total				292,488
Community Total				32,700
Health Visiting				4,745
District Nursing				16,252
Chiropody				1,547
Community Maternity				3,466
Other Community				6,687

Appendix A shows calculations for all England Health Authorities to derive a figure for Community Nursing applying the national formula

This table calculates a target District Nursing budget of:
£19,370,000 Calderdale & Kirklees
£10,384,000 Control HA (D)
£16,252,000 Control HA (S)

This calculates a target Health Visiting budget of
£5,655,000 Calderdale & Kirklees
£3,032,000 Control HA (D)
£4,745,000 Control HA (S)

55 It was then necessary to establish a target level for the Community Nursing at local PCT/G level. This has been approached by using the weighted capitation figures for each PCT/G as follows:

56. The Community proportion of the allocation at Health Authority level that should be committed to North Kirklees PCG, Control PCT (D) and for Control PCT (S) have been estimated using a weighted population basis as per the National Formulae. This equates to 30.14% of the total budget for North Kirklees, 36.18% for Control PCT (D) and 55.56% for Control PCT (S). The actual percentage needs to be entered when data becomes available.

Table 2 Shares of HA target figures at Primary Care Organisation Level

	Weightings	North Kirklees	Control PCT (D)	Control PCT (S)
Weighted % of HA area[7]		30.14%	36.48%	55.56%
		£'000	£'000	£'000
Community Total	0.1118	11,746	7,622	18,168
Health Visiting	0.1451	1,704	1,106	2,636
District Nursing	0.4970	5,838	3,788	9,030
Chiropody	0.0473	556	361	859
Community Maternity	0.1060	1,245	808	1,926
Other Community	0.2045	2,402	1,559	3,715

This table calculates a target District Nursing budget of:
£5,838,000 North Kirklees
£3,788,000 Control PCT (D)
£9,030,000 Control PCT (S) at the Primary Care Trust levels

This calculates a target Health Visiting budget of
£1,704,000 North Kirklees
£1,106,000 Control PCT (D)
£2,636,000 Control PCT (S) at the Primary Care Trust levels

actual resources - ca

57. To establish the actual expenditure for Health visiting and District Nursing in each of the Primary Care areas reference has been taken from the CIPFA annual accounts summary[8]. This gives audited expenditure figures at the level of Community Health Care only and at Health Authority level only. Ideally localised expenditure would be extracted for each of the sub component areas within the Community Health Care line but in the current state of organisational change and restructuring this has not been possible for his exercise. The table below shows the expenditure levels adjusted to the 2001/02 price base to enable comparison with the target expenditure shares above.

Table 3 Actual Expenditure at HA level - Community Health Services

	Calderdale and Kirklees £'000	Control HA (D) £'000	Control HA (S) £'000
Community Total	41,110	20,870	31,853
Health Visiting	5,965	3,028	4,622
District Nursing	20,435	10,375	15,834
Chiropody	1,945	987	1,507
Community Maternity	4,358	2,212	3,376
Other Community	8,407	4,268	6,514

NB figures taken from CIPFA[8]

This derives estimated actual District Nursing expenditure of:
£20,435,000 Calderdale & Kirklees
£10,375,000 Control HA (D)
£15,834,000 Control HA (S) at the Health Authority levels

This derives estimated actual Health Visiting expenditure of
£5,965,000 Calderdale & Kirklees
£3,028,000 Control PCT (D)
£4,622,000 Control PCT (S) at the Health Authority levels

58. From the above figures it is necessary to derive the actual spending levels at the individual PCT and PCG levels. In the absence of detailed expenditure figures it was determined that the actual shares should be derived using the weighted capitation figures for each PCT as for the target derivation above. This produces the following results

Table 4 Allocation of HA level Actual expenditure to Primary Care Organisation Level

	North Kirklees	Control PCT (D)	Control PCT (S)
Weighted % of HA area[7]	30.14%	36.48%	55.56%
	£'000	£'000	£'000
Community Total	12,391	7,613	17,697
Health Visiting	1,798	1,105	2,568
District Nursing	6,159	3,785	8,797
Chiropody	586	360	837
Community Maternity	1,313	807	1,876
Other Community	2,534	1,557	3,619

This derives an estimated expenditure for District Nursing of:
£6,159,000 North Kirklees
£3,785,000 Control PCT (D)
£8,797,000 Control PCT (S) at the Primary Care Trust levels

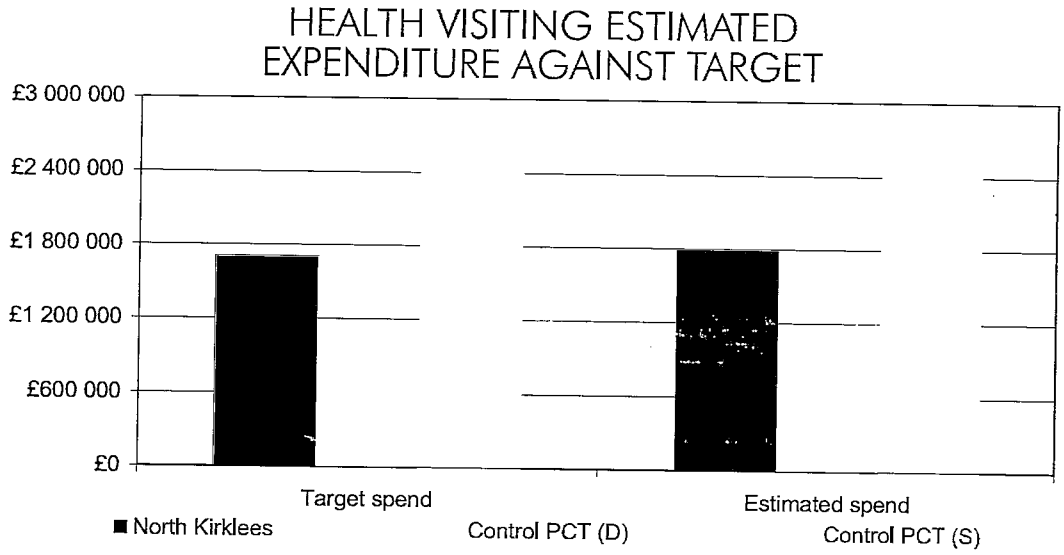
This derives an estimated expenditure for Health Visiting Nursing of:
£1,798,000 North Kirklees
£1,105,000 Control PCT (D)
£2,568,000 Control PCT (S) at the Primary Care Trust levels

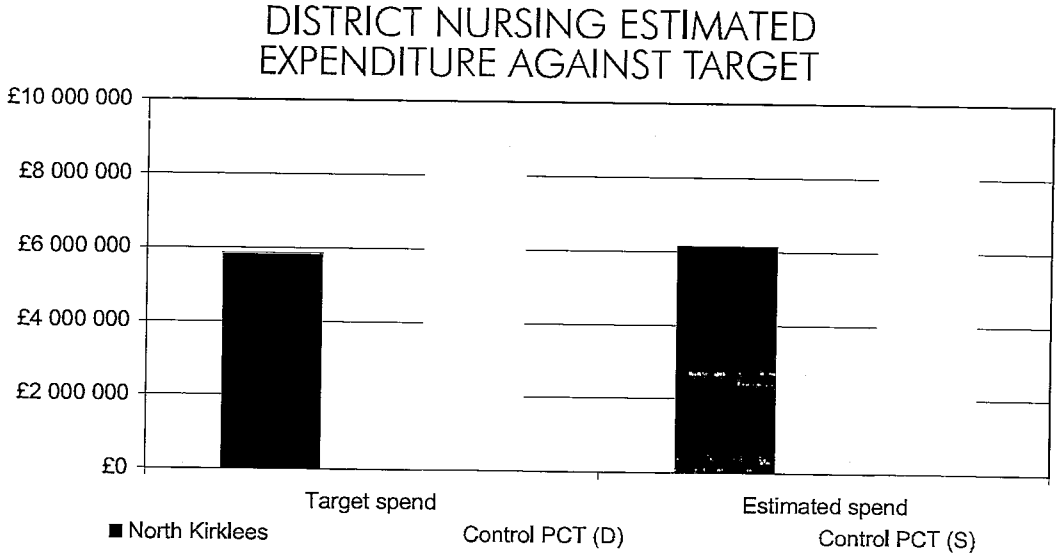
Table 5 The difference between target spend and actual spend

Budget	Target	Actual	Variance	% Variance
North Kirklees	£'000	£'000	£'000	
Community Total	11,746	12,391	645	5.49
Health Visiting	1,704	1,798	94	5.49
District Nursing	5,838	6,159	321	5.50
Chiropody	556	586	30	5.47
Community Maternity	1,245	1,313	68	5.45
Other Community	2,402	2,534	132	5.49

Budget	Target	Actual	Variance	% Variance
CONTROL PCT (D)	£'000	£'000	£'000	
Community Total	7,622	7,613	(9)	- 0.12
Health Visiting	1,106	1,105	(1)	- 0.09
District Nursing	3,788	3,785	(3)	- 0,08
Chiropody	361	360	(1)	- 0.14
Community Maternity	808	807	(1)	- 0.12
Other Community	1,559	1,557	(2)	- 0.11

Budget	Target	Actual	Variance	% Variance
CONTROL PCT (S)	£'000	£'000	£'000	
Community Total	18,168	17,697	(471)	- 2.59
Health Visiting	2,636	2,568	(68)	- 2.59
District Nursing	9,030	8,797	(233)	- 2.58
Chiropody	859	837	(22)	- 2.60
Community Maternity	1,926	1,876	(50)	- 2.59
Other Community	3,715	3,619	(96)	- 2.59





NB The calculation of actual for Community Health care 2001/02 for the Districts is based on Outturn 1999/2000 CIPFA database HAA. This shows what the Health Authority has spent on Community Services. We have uplifted the figure for inflation estimated at 4% to estimate expenditure at 2001/02 levels. We have then calculated the split of expenditure between the trusts using the 30.14% population split. We have further assumed the split of North Kirklees expenditure between District Nursing Health Visiting etc is the same as the national formulae. Although it is unlikely that the split for expenditure will exactly match the national formula shares it is necessary to use these figures in the absence of any detailed local information.

the results - part two

59. The next part of the findings shows the process used to share the target allocation at GP Practice levels. As discussed earlier there is no right or wrong answer to this question. Nor is there a gold standard for resource allocation at this level. As discussed at the beginning of this paper the Townsend deprivation measure has been selected as the most appropriate means of setting practice based targets.

60. The purpose of generating this information at practice level is not necessarily to set practice level budgets. By using GP practices as the lowest common denominator for a locality each PCT can then aggregate the results to suit what ever the locality planning arrangements are within the PCT.

61. The measurement of resources in this part of the work is by reference to finance. This is the most straightforward comparison. The options of measurement by whole time equivalent staff numbers or by numbers of community nursing contacts are less robust as the outcomes are subject to local nuances about the grading mix for the nurses and also the measurement of nursing contacts needs to be on a consistent basis. We have been unable to clearly identify staff budget allocations at or below locality level at this stage.

62. Although there are notional Whole Time Equivalent's set against each practice, it has not been possible to account for differences in grade mix etc. Nevertheless a preliminary analysis based upon WTE has been undertaken for illustrative purposes. The accuracy of this analysis would be improved with financial rather than manpower figures.

analysis by gp pract

63. The patient listings for North Kirklees are shown as Appendix A. This appendix also shows the distribution of the target allocation for the Primary Care Organisation area across the Health Visiting and the District Nursing service areas for North Kirklees.

64. It should be noted that the target budgets for each GP practice are gross costs for Community Nursing. That is they take account of any and all necessary running costs, administration and establishment overheads incurred by an organisation providing community nursing services. It is proposed that such organisations should calculate these overheads and indirect costs into the whole time equivalent nursing costs. This would help to identify efficient services by allowing comparison between different Primary care Organisation areas and would highlight those areas that incur higher overheads than others.

North Kirklees - Calculation of Gross Community Nursing Target Investment at Practice Level 2001/02 prices

	Townsend Shares %	Shares of Target Nursing Budgets		
		Health Visiting £	District Nurses £	Total £
*ABEYANCE (DR PD FREEMAN'S PATIENTS)	1.31	22,253	76,240	98,493
DR GS FOX & PARTNERS	3.57	60,877	208,569	269,446
DR SN MEDLEY & PARTNERS	2.65	45,129	154,614	199,742
DR KS LIDHAR & PARTNERS	2.71	46,171	158,183	204,354
DR AR MACKAY & PARTNERS	3.52	59,907	205,246	265,153
DR JH LEE & PARTNERS	5.04	85,854	294,142	379,997
DR K SHARMA	1.22	20,742	71,064	91,806
DR DJ YOUD & PARTNERS	5.88	100,249	343,458	443,707
DR DR BARKER & PARTNERS	5.19	88,479	303,135	391,615
DR IWR COWIE & PARTNERS	5.22	89,033	305,033	394,066
DR R PARKER & PARTNERS	8.31	141,617	485,189	626,806
DR J HICKS & PARTNERS	3.85	65,589	224,713	290,302
DR MSA KHAN & PARTNERS	4.64	79,054	270,843	349,897
DR JH CLARKE & PARTNERS	5.71	97,337	333,482	430,819
DR A GREENWOOD & PARTNERS	2.74	46,723	160,075	206,798
DR SP BULLIMORE & PARTNERS	3.04	51,732	177,238	228,970

North Kirklees - Calculation of Gross Community Nursing Target Investment at Practice Level 2001/02 prices

	Townsend Shares %	Shares of Target Nursing Budgets		
		Health Visiting £	District Nurses £	Total £
DR AI RAJPURA & PARTNERS	6.59	112,379	385,016	497,395
DR NA SALAM & PARTNERS	1.71	29,159	99,900	129,059
DR EI DADIBHAI	2.82	48,098	164,786	212,884
DR Y V S PATEL & E F O'DALY	2.48	42,235	144,698	186,933
DR H KHAN	1.39	23,653	81,035	104,688
DR B AHMAD	1.60	27,188	93,146	120,334
DR AP MEHROTRA	1.42	24,130	82,671	106,801
DR G PRASAD	1.32	22,428	76,840	99,268
DR JR WARWICK & PARTNERS	2.45	41,779	143,137	184,916
DR P SARATHY	0.92	15,593	53,422	69,014
DR TM FAROOQUI & PARTNERS	1.73	29,402	100,732	130,134
DR T UNNIKRISHNAN	1.53	26,080	89,353	115,433
DR CS HOUGHTON & PARTNERS	2.20	37,445	128,287	165,732
DR H BHAT	1.77	30,150	103,296	133,447
DR H THIMMEGOWDA	1.68	28,699	98,326	127,025
DR M AHMAD	1.20	20,418	69,954	90,372
DR WGM SUTHERLAND & PARTNERS	1.15	19,669	67,387	87,055
DR RK SOOD	1.45	24,749	84,791	109,540
Total North Kirklees		**1,704,000**	**5,838,000**	**7,542,000**

chapter three

discussion and conclusion

65. This paper has put forward a methodology for the allocation of Primary Care Organisations resources for procurement of District Nursing and Health Visiting services. These areas were selected, as they constitute a major component of PCT service provision. The methodology involved setting target allocations initially at Health Authority level and subsequently at Primary Care Trust and then at GP Practice levels. It is believed that this component of the work is reasonable robust. The targets can be traced to the National allocations formula and could easily be updated to reflect new allocations and other new data by the respective areas.

66. The part of the work that set out to measure current resource consumption has faced more difficulties. There was clear information at Health Authority level to measure expenditure and compare with the targets. At PCT level the expenditure information was less robust and at GP Practice level there are serious absences of data which would have necessitated a pro rata share of overall figures to identify any local expenditure.

67. The work should still serve the local systems with a useable allocation tool. It would be strengthened by more detailed local analysis of current practice utilisation. In particular future local work would be assisted by:

    - Inclusion of GP Practice Nursing information to compliment the Community Nursing position
    - Details of local nursing hours and grading allocated to GP practices where that is the local policy.
    - An audit of final accounts information supporting the figures submitted for programme spending in these areas to test whether consistent methodology for the allocation of overhead and indirect costs to the Community health care expenditure position is applied

68. There are also caveats about the use of the work as a solution to practice level or locality level community nursing budgets. This work addresses allocative efficiency. That is determining whether the overall health care resource is distributed to health programmes in an effective way. In this case compliance with the National formula is construed as 'effective'. There also needs to be consideration of technical efficiency. This is maximising the health care output from he given resources within a health programme.

69. The work shows that at PCT level there are the following differences between Target levels and current spending levels:

Budget	Target	Actual	Variance	% Variance
North Kirklees	£'000	£'000	£'000	
Health Visiting	1,704	1,798	94	5.49
District Nursing	5,838	6,159	321	5.50

Budget	Target	Actual	Variance	% Variance
CONTROL PCT (D)	£'000	£'000	£'000	
Health Visiting	1,106	1,105	(1)	- 0.09
District Nursing	3,788	3,785	(3)	- 0.08

Budget	Target	Actual	Variance	% Variance
CONTROL PCT (S)	£'000	£'000	£'000	
Health Visiting	2,636	2,568	(68)	- 2.59
District Nursing	9,030	8,797	(233)	- 2.58

65. This suggests that spending on Community Nursing is currently 5.5% above the target in North Kirklees, 2.6% below the target in CONTROL PCT (S) and almost exactly in line with target in CONTROL PCT (D).

66. The calculation assumes that the current budget for District Nursing and Health Visiting is around £7 million. The Finance Department figures, which came with a warning that they were incomplete, accounted for around £2 million. A great deal of work will be required of the new PCT to identify the actual expenditure on Community Nursing in North Kirklees. Although the figures for the control PCTs appear to be reasonably robust there remains a major gap between the figure reported at Health Authority level and the figures available locally in North Kirklees. This may be partially explained by the notion, expressed by staff in report two the North Kirklees receives less than its fair share of the Health Authority level budget for community nursing. It may be partially explained by the overhead costs associated with the community nursing i.e. management, accommodation, equipment, travel, energy, etc which could not be easily recognized during the transitional phase currently underway in North Kirklees.

appendix a

community health care 'targets' based on needs formula

Community Health care 'targets' based on Needs formula (£'000)

HA	Weightings Allocation	Adj for amin Exp see analysis	Adj for presc Exp see analysis	Adj for RHS Exp see analysis	Adjusted HealthCare Exp see analysis	Main Comm Weight 0.1118	Health Visiting 0.1461	District Nursing 0.487	Chiropy 0.0473	Community Maternity 0.105	Other Community 0.2045
Bradford	373007	10080	56839	10907	295181	33001	4788	16402	1551	3468	6749
Calderdale and Kirklees	438275	10080	65784	12815	348596	38973	5665	19390	1843	4131	7990
County Durham	493021	11339	75127	14416	392139	43841	6381	21789	2074	4647	8986
East Riding	427341	9829	65118	12495	339899	38001	5514	18886	1797	4028	7771
Gateshead and South Tyneside	300845	6919	45843	8797	239286	26752	3882	13296	1265	2836	5471
Leeds	569240	12863	85217	16352	444808	49730	7216	24716	2352	5271	10170
Newcastle and North Tyneside	395871	9105	60323	11575	314868	35202	5108	17486	1665	3731	7199
North Cumbria	235569	5417	35891	6887	187343	20945	3039	10410	991	2220	4283
North Yorkshire	512665	11792	78123	14991	407780	45590	6615	22658	2156	4833	9323
Northumberland	233523	5371	35584	6828	185739	20766	3013	10321	982	2201	4247
Sunderland	238153	5478	36280	6964	189422	21177	3073	10525	1002	2245	4331
Tees	440871	10140	67180	12891	350660	39204	5688	19484	1854	4156	8017
Wakefield	251077	5775	38239	7341	199701	22327	3240	11095	1056	2367	4566
Barnsley	186289	4285	28367	5447	148171	16565	2404	8233	784	1756	3388
Doncaster	294962	6784	35804	6870	186884	20894	3032	10384	988	2215	4273
Leicestershire	615919	14166	93534	18009	489890	54770	7947	27221	2591	5806	11200
Lincolnshire	469403	10795	71536	13725	373354	41741	6057	20745	1974	4425	8536
North Derbyshire	270924	6229	41291	7923	215527	24096	3496	11976	1140	2554	4928
North Nottinghamshire	283464	6519	43198	8286	225453	25206	3657	12527	1192	2672	5155
Nottingham	465499	10706	70933	13611	370249	41394	6006	20573	1958	4388	8465
Rotherham	189182	4351	28828	5532	150472	16823	2441	8361	796	1783	3440
Sheffield	432940	9958	65971	12659	344352	38499	5586	19134	1821	4081	7873
South Derbyshire	405562	9331	61952	11888	322372	36153	5246	17958	1710	3832	7393
South Humber	231702	5328	35284	6863	184277	20671	3000	10273	957	2212	4268
Bedfordshire	370744	8527	56494	10841	294882	32988	4784	16385	1559	3495	6742
Cambridgeshire	472551	10869	72007	13817	375857	42021	6097	20884	1988	4454	8593
East and North Hertfordshire	348992	8027	53179	10205	277581	31034	4503	15424	1468	3290	6346
Norfolk	551633	12688	84036	16130	438756	49053	7118	24379	2320	5200	10031
North Essex	597643	13746	91059	17475	475363	53144	7711	26413	2514	5633	10868
South Essex	502311	11553	76542	14688	399528	44667	6481	22200	2113	4735	9134
Suffolk	470284	10817	71662	13751	374055	41819	6068	20784	1978	4433	8552
West Hertfordshire	324913	8623	57129	10962	298199	33339	4837	16569	1577	3534	6818
Barking and Havering	305009	7015	46477	8918	242598	27122	3935	13480	1283	2875	5547
Barnet	248445	5714	37858	7265	197608	22093	3206	10980	1045	2342	4518
Bexley and Greenwich	345432	7945	52637	10100	274749	30717	4457	15266	1453	3255	6282
Brent and Harrow	371469	8544	56606	10862	295457	33033	4793	16417	1562	3502	6755
Bromley	278662	5029	33320	6394	173919	19444	2821	9664	920	2061	3976
Camden and Islington	396403	9117	60404	11591	315291	35250	5115	17519	1667	3736	7209
Croydon	242481	5576	36942	7089	192894	21558	3128	10714	1020	2285	4409
Ealing Hammersmith and Hounslow	581735	13380	88645	17010	462700	51730	7506	25710	2447	5483	10579
East London and the City	588866	13774	91255	17511	476336	53253	7727	26467	2519	5645	10890
Enfield and Haringey	387770	8919	59068	11338	308425	34482	5003	17137	1631	3655	7052
Hillingdon	184100	4234	28053	5383	146490	16371	2375	8136	774	1735	3348
Kensington, Chelsea and Westminster	361294	8308	55046	10562	287318	32122	4661	15965	1519	3405	6569
Kingston and Richmond	236722	5905	39119	7507	204191	22829	3312	11346	1080	2420	4668
Lambeth, Southwark and Lewisham	695407	15994	105966	20334	563113	61838	8973	30733	2925	6555	12645
Merton, Sutton and Wandsworth	488646	11469	75984	14580	396613	44341	6434	22038	2097	4700	9068
Redbridge and Waltham Forest	381329	8031	53556	10273	279440	31241	4533	15527	1478	3312	6389
Berkshire	527723	12138	80414	15431	419740	46927	6809	23323	2220	4974	9597
Buckinghamshire	443321	10196	67553	12963	352605	39422	5720	19588	1865	4179	8062
East Kent	459623	10801	71561	13732	373529	41761	6059	20755	1975	4427	8540
East Surrey	289301	6654	44084	8459	230104	25726	3733	12786	1217	2727	5261
East Sussex, Brighton and Hove	566637	13724	90925	17447	474600	53060	7699	26371	2510	5624	10851
Isle of Wight	108668	2510	16560	3178	86440	9664	1402	4803	457	1024	1976
North and Mid Hampshire	346725	7975	52804	10138	275778	30832	4474	15324	1458	3268	6305
Northamptonshire	386889	8898	58954	11313	307724	34404	4992	17099	1627	3647	7036
Oxfordshire	396445	9118	60407	11591	315309	35252	5115	17520	1667	3737	7209
Portsmouth and South East Hampshire	397591	9145	60585	11626	316236	35355	5130	17572	1672	3748	7230
Southampton and South West Hampshire	390001	8970	59428	11404	310199	34680	5032	17236	1640	3676	7092
West Kent	657819	15360	101762	19527	531170	59365	8617	29514	2809	6295	12144
West Surrey	434136	9985	66154	12694	345308	38605	5602	19187	1826	4092	7895
West Sussex	557695	12827	84992	16309	463580	48932	7105	24647	2346	5257	10142
Avon	700442	16110	106733	20481	557118	62256	9038	30955	2946	6602	12737
Cornwall and Isles of Scilly	373546	8592	56926	10923	297135	33220	4820	16510	1571	3521	6798

Community Health care 'targets' based on Needs formula (£'000)

HA	Weightings Allocation	Adj for admin Exp see analysis	Adj for presc Exp see analysis	Adj for FHS Exp see analysis	Adjusted HealthCare Exp see analysis	Main Comm Weight 0.1118	Health Visiting 0.1451	District Nursing 0.497	Chiropy 0.0473	Community Maternity 0.105	Other Community 0.2045
Dorset	56539	12107	80213	15392	418687	46809	6792	23264	2214	4912	9572
Gloucestershire	38965	9035	59988	11511	313121	35007	5080	17398	1656	3711	7159
North and East Devon	35515	8169	54123	10386	282507	31584	4583	15697	1494	3348	6459
Somerset	34479	7930	52540	10082	274242	30660	4449	15238	1450	3230	6270
South and West Devon	45270	10412	68983	13237	360072	40256	5841	20007	1904	4267	8222
Wiltshire	41000	9430	62446	11988	326106	36459	5290	18120	1724	3865	7456
Birmingham	81148	18664	123652	23727	645426	72159	10470	35883	3413	7649	14756
Coventry	24217	5570	36903	7081	192623	21535	3125	10703	1019	2283	4404
Dudley	21877	5032	33336	6397	174006	19454	2823	9669	920	2062	3978
Herefordshire	11823	2719	18016	3457	94036	10513	1526	5225	497	1114	2150
North Staffordshire	33668	8364	55416	10634	289235	32339	4692	16072	1530	3428	6613
Sandwell	24358	5602	37117	7122	193740	21660	3143	10765	1025	2296	4430
Shropshire	29523	6791	44991	8633	239388	26765	3880	13049	1242	2783	5369
Solihull	14442	3322	22007	4223	114870	12842	1863	6383	607	1361	2626
South Staffordshire	38115	8766	58074	11144	308131	34450	4997	17113	1628	3648	7038
Walsall	19461	4476	29665	5690	154791	17306	2511	8601	819	1834	3539
Warwickshire	34623	7963	52756	10123	275371	30786	4467	15301	1456	3263	6296
Wolverhampton	19082	4389	29077	5580	151776	16969	2462	8433	803	1799	3470
Worcestershire	35575	8182	54229	10402	282957	31635	4590	15722	1496	3353	6469
Bury and Rochdale	29889	6875	45546	8740	237737	26579	3857	13210	1257	2817	5435
East Lancashire	41673	9585	63502	12185	331465	37068	5377	18418	1753	3928	7578
Liverpool	41023	9435	62512	11995	326298	36480	5293	18130	1725	3867	7460
Manchester	41232	9483	62830	12056	327953	36665	5320	18223	1734	3886	7498
Morecambe Bay	24295	5588	37022	7104	193242	21604	3135	10737	1022	2290	4418
North Cheshire	23652	5440	36042	6916	188130	21033	3052	10453	995	2229	4301
North West Lancashire	38286	8806	58343	11195	304532	34047	4940	16921	1610	3609	6963
Salford and Trafford	35773	8458	56085	10763	298488	32700	4745	16252	1547	3466	6687
Sefton	23009	5291	35049	6725	182945	20453	2968	10165	967	2168	4183
South Cheshire	48595	11052	73219	14050	382184	42728	6200	21236	2021	4529	8736
South Lancashire	22342	5137	34033	6531	177642	19860	2882	9871	939	2105	4061
St Helens and Knowsley	27957	6437	42545	8163	222592	24886	3611	12368	1177	2638	5089
Stockport	20908	4808	31852	6112	166257	18587	2697	9238	879	1970	3801
West Pennine	35356	8133	53881	10339	281243	31443	4562	15627	1487	3333	6430
Wigan and Bolton	44616	10270	68040	13056	355150	39706	5761	19734	1878	4209	8120
Wirral	26882	6180	40942	7856	213704	23892	3467	11874	1130	2533	4886
England total	1164862	267919	1775023	340607	9265113	1035810	150300	514812	48995	109759	211829

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Options for systematic collection and analysis of data reflecting the views of patients carers and staff

A compilation of research based reports
to inform the modernisation of community nursing services

report 4

Contents

Introduction

This report covers one of the objectives of the review

To develop options for the systematic collection and analysis of data reflecting the views of patients, carers and other staff

This report seeks to do the following

1) To discuss issues related to the collection of data on the views of patients, carers and staff. Some consideration of issues relating to report writing and dissemination of the results is also given.

2) To describe the range of methods available, their strengths and weaknesses.

3) To make recommendations based on (1) and (2) for future work in North Kirk Lees PCT

4) To provide a bibliography for further reading on the topic

chapter one

issues to consider in collecting and analysing data

This section looks at some of the issues that need to be considered before making decisions on the approach to data collection and analysis before embarking on a project. Mention is also made of issues about report writing and the dissemination of findings.

what is the question that you wish to answer?

It is important to clarify very precisely the question to be addressed before considering data collection. Apossible example is

'What are the views of patients, carers and staff about the proposed change to the provision of community nursing cover for evening and weekend visits?'

Having established the question the aims and objectives of the study should be identified. In this case aims and objectives may include the following

1) To understand patients, users and carers views of the current evening and weekend service and their unmet needs

2) To understand their views about the proposed changes

3) To monitor the changes over an agreed timescale

The question and aims will determine the nature and the sources of the information required. Having a clear question not only helps the person commissioning the research but also those whose support will be needed to complete the work. Using the example above it may be necessary to know what services were already provided by the community nurses and other agencies at weekends, perhaps less important would be what medication patients are taking, unless the change would affect supervision of its use. As an aid to clarifying some of the issues described an outline research protocol is given as Appendix 1.

what will the data be used for?

It is essential to identify from the outset whether the organisation will be able to change in response to the findings. If not it is important to have a clear understanding of how the information will be used. If these issues are not clear further work needs to be done to enlist the support of others to clarify them.

are there other organisations who need do be consulted or involved?

Care must be taken to avoid duplicating the work of others. Respondents in ScHARR's work, on public involvement [1] in decision making in primary care groups (PCGs), spoke of 'consultation fatigue' affecting local communities. With PCGs, local authorities, voluntary organisations and in some cases commercial organisations needing to get the views of users, carers and staff there is a need for work to be co-ordinated. Experience from carrying out lifestyle surveys in North Derbyshire has shown that response rates have dropped from 65% to 52.5% from 1994 to 1999[2]. It is thought that the reduction in response rate may be a reflection of a declining interest by the public in participating in health surveys.

at what level do you wish to involve respondents?

This again is an issue that needs careful thought. Experience from ScHARR's research in PCG public involvement determined that this was not always something that was thought through. In this research we made reference to Arnstein's ladder of involvement [3] which proposed 8 levels. A full description is given in appendix 2. The levels start from non-participation where citizens are placed on bodies to engineer their support, through levels of information where they are given with little or no opportunity to change things. Beyond that there are levels of consultation where citizens are asked for their views without any assurance that things will change and finally to increasing levels of involvement and control in the running of a service.

Experience from a recent program of public involvement research at ScHARR, suggested that most of the work carried out in the two PCGs was at the level of informing or consulting with the public. However in both there were examples of partnership, in one case through the establishment of a group with representatives from local practices and voluntary organisations and in the other case a community consultation on health needs. It may be difficult to achieve the levels of levels of delegated power and citizen control within the confines of a PCG.

is the exercise intended to be a one off or Part of a continuing dialogue with the group to be contacted?

This is something that needs to be clear to both the sponsors and also to those people taking part. On many occasions it will be appropriate to send out a questionnaire or to run a focus group to obtain information on a particular issue and then to make policy decisions based on this. Participants always need to be clear what is expected of them. They should be given feedback on what has happened as a result of their participation.

In some cases a continuing dialogue is needed. An example of this is the Kirklees Health Panel [4]. This has been running since 1994. It is a joint enterprise between Kirklees Health Authority, Kirklees and Calderdale Metropolitan District Councils. The panel consists of 1,100 local people sampled from the local patient registered who are invited to take part for a period of 2 years. They drew up an additional sample from the local ethnic minority populations. They are sent a questionnaire on health and topics of concern to the local councils three times a year. Data for the panel has been used to obtain views on a number of issues about primary care, including surgery opening hours. More details of the method are given in section 3.3 of the report.

can lessons be learnt from experience elsewhere?

There have been numerous examples of duplication of work by different organisations and a failure to learn from experience reported by others. A literature review can provide a lot of useful information about the development of services in other parts of the country and the ways in which policy has changed. A current project evaluating the Confederation of Adult Mental Health Services in North Derbyshire [5] is using a literature review and information on the development of local services to provide a backdrop for an evaluation which is taking place at a time of considerable structural change.

are sufficient resources available?

Obtaining the views of users, carers and staff takes time, money and needs a certain level of

expertise to do well. Experience from ScHARR's public involvement research indicated that the PCGs did not have the resources to dedicate staff or board members wholly to public involvement work. This task tended to be added on to their other activities. With full workloads staff and board members were only able to devote a limited amount of time to this activity. Consequently what was done tended to be fairly small scale and progress was often slow. In one of the PCGs staff with community development expertise were later seconded in and more activity took place.

Involving users, carers and staff does not come free, at a minimum there are likely to be postage costs for sending out questionnaires, room hire for meetings and so on. Buying expertise tends to be expensive. Interviews with board members of the two PCGs over a year period indicated that little if any training was available and that they learnt by experience. While there is no substitute for experience and a number of staff gained valuable experience as a result of the opportunities, inevitably some mistakes were made which could perhaps have been avoided by some training and advice. It is therefore important to be realistic about what can be achieved and do a few things well rather than more badly.

what happens to the results?

Data collection and analysis almost always takes place with a view to changing policy. It follows that producing a report with clear conclusions and recommendations is important. Something that can be overlooked is providing feedback to participants on the results and action to be taken as a result. As well as showing appreciation for their time and effort in participating it also makes in more likely that they will want to participate in future.

chapter two

choice of methods

The aim of this section is to describe some of the main methods that have been used to elicit the views of users and to identify their strengths and drawbacks. This section borrows heavily from work completed earlier this year by the Health Policy & Management section of ScHARR in conjunction with CHePAS.[6] References covering the methods are given in a bibliography at the end of the report. The choice of method depends on the question that is being asked and in many cases it may be appropriate to use more than one method. It can be tempting to decide on the method first and then work out what questions it should help to answer, this should be avoided at all costs as it is likely to result in a failure to address the original aims. A wide range of methods is described below. Several require specialist expertise in fields such as health economics and others would prove costly to use, however it was felt important to describe a wide range of approaches as there may be occasions in which collaborative work or external funding may make their use possible. The methods described are as follows

- Focus groups
- In depth interviews
- Health panels and citizen's panels
- Open surgery
- Rapid appraisal
- Questionnaire based surveys
- Deliberative polling, referenda and ballots
- Conjoint analysis
- Willingness to pay
- Consensus methods
- Citizen's juries
- Use of the Internet

focus groups

Definition

1) It involves 8 to 12 individuals who discuss a particular topic under the direction of a moderator

Who promotes interaction and assures that the discussion remains on the topic.

2) Provides rich and diverse data, which is mainly qualitative, although it is possible to collect some quantitative data as well.

3) It can work in conjunction with other methods or on its own.

Strengths and weaknesses

1) Provides rich and diverse data, validated through social rather than personal processes. It is the collective identity provided in the focus group which is likely to result in data reflecting the experiences of the community as a whole, which makes focus groups an ideal research method for exploring the views that different groups of health care users have.

2) Like interviews they are not dependent on participants reading ability.

3) They can be very intimidating for individuals.

4) Some people will not take part in them and there are real issues about confidentiality and ethics.

5) There can also be questions raised, as with other qualitative research methods, about how far the results represent the groups studied.

in depth interviews

Definition

1) A one to one discussion between an interviewer and a respondent.

2) They are usually semi structured, i.e. there is an interview guide covering specific topics, but the interviewer has some scope to explore answers and topics further. However there are occasions when unstructured interviews might be used and a respondent is asked to talk freely about a particular topic or experience.

3) They can be carried out face to face or over the telephone

Strengths and weaknesses

1) Good for discussing sensitive topics

2) Able to prompt and explore answers to a greater degree than other methods

3) Produces a lot of rich data

4) Time consuming to carry out interviews and analyse the results

5) Like focus groups they are not dependent on participants' reading ability

6) Interview skills needed to carry these out effectively

health panels, citizens' panels

Definition

1) A random sample of people drawn from the general public who agree to respond to questionnaires on health related issues on a regular basis. The people involved are intended to be a representative sample of a larger population group drawn from the local area and their views on various issues are sought repeatedly over a period of time

2) Panel members are normally recruited for a set period of time such as two years and the panel is refreshed on a regular basis with new recruits.

Strengths and weaknesses

1) Representation, no matter how carefully populations are sampled selective participation may make responses less representative.

2) Panel members agreed to participate and are therefore more likely to respond

3) The panel can be used to gain an understanding of public views and perceptions on general issues such as their understanding of the health service structure. They can also be used to understand public feeling on controversial issues e.g. attitudes to priority setting, charging for certain services.

4) Panel members can become more informed over time if information from previous rounds is feed back to members. This can be a potential weakness of the method as they become better informed and less representative of the population as a whole over time.

5) A panel is only as good as the sources of names and addresses it is drawn up from, thus it will not pick up people not registered with a GP or on the electoral roll unless special attempts are made to target these groups.

6) Panels like other methods based on reading and writing exclude people who can do neither or without special measures those for whom English is not their first language.

7) It is possible to use the sample for other more qualitative work.

8) Specific groups such as ethnic minorities are unlikely to be represented unless specific measures are taken to address this.

9) Even where specific sub groups are represented in proportion to their numbers in the population the method may not be appropriate for exploring their views because of the small numbers actually recruited.

10) The establishment and maintenance of a panel can be relatively expensive and time consuming.

11) It may be difficult to regularly address issues, which are of interest to the majority of panel members and the investigators.

12) The questions should be simple, obvious and unlikely to be open to misinterpretation. This restricts the issues, which can be explored by this method.

open surgery

Definition

Open surgeries are at a time when members of the public can 'drop in' to meet with a representative of the organisation (s) to discuss their concerns. The representative needs to be someone at a senior enough level to have a sufficient overview to be able to deal with a range of queries.

Strengths and weaknesses

1) The use of open surgeries can build alliances between organisations

2) Continuous dialogue can be established

3) It helps accountability and gives a channel for people to challenge and question.

4) The initiative can be linked with GP surgeries, Council for Voluntary Services etc.

5) It may be perceived to be for complaints only

6) The same people may attend all the time or very few attend.

7) It takes up the time of one or more senior people

8) Clarity would be needed about the purpose of the surgery and how the information would be used.

rapid appraisal

Definition

1) Aims to help plan health services and ensure that the distribution of resources reflects local needs. It involves a community in diagnosing needs and formulating action plans to meet those needs.

2) A variety of methods and techniques are employed: written records, observation, focus groups, structured questionnaires, interviews with key informants within the community.

3) Results are fed back to the community for prioritisation and to determine solutions to the problems identified.

Strengths and weaknesses

1) The priorities of communities have been shown to be different from the priorities of professionals. This methodology allows the views of the community to be heard.

2) It is a relatively quick way of involving a whole community compared with community development.

3) It places health issues within the contest of other issues such as education, security, environment, etc. Thus it takes a holistic view of people's experiences.

4) It is a flexible method, which can be adapted for each community

5) It can identify the strength of feeling about problems rather than just the problems themselves

6) The community identifies the solutions as well as the problems and thus can influence, and sometimes be directly involved in, in the decision making process. This can be an ongoing process.

7) Getting data from a number of sources means that the results can be compared which makes them more scientifically reliable.

8) People without a research background can successfully use this technique; in fact if the research team are local workers or local people then ownership of the results is likely to increase.

9) A multi agency team can aid collaboration between agencies

10) The process itself can generate change more quickly than other methods of identifying health needs such as postal surveys and the analysis of routine data.

11) It can only be undertaken in relatively small communities 10,000 at most. Even within a community of this size there will be 3 or 4 sub communities.

12) It takes a broad approach and cannot answer specific questions. For example it can identify what the problem is, but cannot answer the question of how many people suffer from a problem. To answer this it would need to be used alongside another method such as a postal questionnaire.

13) It is difficult to generalise the findings, although rapid appraisal exercises in different communities tend to find similar issues.

14) It is intensive and can be time consuming for health professionals to undertake.

15) It is open to unrepresentative sampling of key informants

16) It may not be fully participatory due to lack of time.

17) Like other methods is important to establish that the sponsoring organisations are open to change before starting work, otherwise there is a danger that it will be a theoretical exercise.

questionnaire based survey

Definition

1) A set of questions on a form with a choice of answers for the respondent to select (closed questions) and or space for them to respond freely (open questions).

2) The questionnaire can be distributed by mail or post

3) The data can be analysed statistically and is normally entered onto a computer database to do this.

Strengths and weaknesses

1) A relatively cheap way of getting information from a large group of people. Costs include postage and printing. Help with data management may be needed unless staff with the skills and time is available.

2) It can be used in conjunction with other methods such as telephone or home interviews to obtain responses form persistent high responders.

3) Particularly valuable when the population of interest is widely and thinly spread e.g. parents of children with a very rare medical condition.

4) Information on a wide range of variables for a large group of people can be obtained. It is usually very easy to repeat the exercise to look at change over time.

5) Advice should always be sought on sampling the group to be contacted and on sample size.

6) Unless the project is very small scale access to computer analysis package will be needed.

7) Caution has to be exercised in the interpretation of the results to ensure that they are statistically valid. This is particularly important where small numbers are involved. It is also important to be careful about making assumptions about relations between factors studied. For example a difference on a health variable may be found for people from ethnic minorities. However here it would also be important to look at poverty as people from ethnic minorities tend to be over represented in the lower income groups.

deliberative polling / referenda / ballots

Definition

1) People are asked to vote on an option or a number of options

2) In a deliberative poll a representative sample is asked to vote after which they learn more about the issue through being given more information via workshops and the opportunity to question experts. They are then asked to vote again.

Strengths and weaknesses

1) Provides clear results in a statistical form

2) It is fairly easy for people to participate, especially with postal voting mechanisms

3) Depending on the response rate and participants it can be representative of the wider population

4) Results may be influenced by media reports rather than based on a personal informed view

5) There may be a poor response rate

6) The use is limited to where responses are of 'yes/no' or a simple checklist format.

conjoint analysis

Definition

1) This process developed in health economics has been designed to take account of factors beyond health outcomes. It is used to measure the strength of preferences and trade offs that people are willing to make between different processes and also between processes and outcomes. It has mainly been used to assess the preferences of users of services e.g. patients who have undergone a life saving treatment,

2) The following steps are taken

   a) *Defining the attributes of a service*, for example distance to travel and waiting time

   b) *Assigning levels to attributes*, these need to be plausible, actionable and capable of being traded off. For example, waiting times might have three levels: one month, three months and one year.

   c) *Creating hypothetical scenarios* with different combinations of attributes and choosing a small subset to present to individuals.

   d) *Establishing preferences* for scenarios by using a postal questionnaire or interviews and applying one of three methods, ranking exercises, rating exercises and discrete choices.

   e) Analysing responses by estimating total and marginal utilities using statistical techniques.

Strengths and weaknesses

1) Measures the strength of preference rather than simply preference

2) Identifies the trade offs individuals are willing to make; this is more akin to the real world and real policy decisions

3) Identifies the trade offs between processes and outcomes as well as different aspects of processes

4) Measures preferences for services which may not exist, as well as existing services

5) Can provide 'willingness to pay' if cost is included (see 3.9)

6) Methodological research has been undertaken to show that it has internal validity, consistency and is not sensitive to ordering effects.

7) Results have been found to be consistent with economic theory.

8) It is acceptable to users in that it can achieve relatively high response rates and can be quick and easy to answer.

9) The researcher must identify the attributes important to users otherwise misleading results can be obtained.

10) Attributes are pre-specified and thus restrict the aspects that respondents include in their deliberations.

11) It needs specialist health economics skills and analysis packages

12) The scenarios selected for use in the questionnaire are selected at random from hundreds of options. Adifferent selection may give different results.

willingness to pay

Definition

1) Based on the premise that the maximum amount of money an individual is willing to pay for a commodity is an indicator of the utility or satisfaction with that commodity.

2) It has been used to measure the strength as well as the direction of people's preferences for process attributes in the provision of care. For example if a PCT wanted to know the value that the public placed on a service provided in a particular way they could use this technique.

3) There are four main techniques

   a) *open-ended,* where respondents are asked directly what the maximum amount of money they would be prepared to pay for a service

   b) *bidding-card,* where the individual is asked if they would be willing to pay a specific amount of money. The interviewer increases the bid until the individual says they are not willing to pay and then lowers it until the maximum amount is found.

   c) *payment scale* where respondents are presented with a range of bids and asked to circle the maximum they would be willing to pay.

   d) *close-ended,* where individuals are asked whether they would pay a specified amount for a commodity and are able to give a yes/no answer. Different bid amounts are given to different respondents and everyone is asked whether their maximum WTP is above or below the bid given. There are two variants to this approach, with or without follow-up.

Strengths and weaknesses

1) Provides a single measure of the value of the benefits of healthcare

2) Firmly rooted in economic theory

3) Easily understood and therefore acceptable to the majority of respondents

4) Behaves as might be expected!

5) Does not predetermine what people think about their deliberations. They can incorporate anything into their thinking

6) Can be used in a randomised control trial, although use so far has been very limited and problems with its use there have started to emerge.

7) Politically sensitive for use in the NHS where it could be seen as attempting to privatise the NHS.

8) Users can respond with protests bids because they object to being asked to pay even in theory.

9) Retired people may not think the technique applies to them because they do not pay taxes. Those on lower incomes may have different views on their willingness to pay from those on higher incomes.

10) Unclear whether willingness to pay increases as the benefit increases or whether people are just willing to pay for a good cause.

11) The technique is sensitive to the starting point used for bidding, the range used in bidding in the payment scale method and the allocation of individuals to each level if bids in the close-ended technique.

12) It needs specialist health economics skills.

consensus methods

Definition

1) The aim of these techniques is to obtain general agreement through a formal process

2) There are three main methods

   a *Delphi method*; where expert individuals are contacted using mailed questionnaires. They do not meet face to face or interact directly, instead they are asked to give their views on items suggested by themselves and other participants. They make decisions privately. The findings are summarised and fed back formally to individuals who can revise their judgements in the light of this feedback. This process can be repeated. Views are aggregated using statistical techniques, sometimes weighting views by expertise.

   b *Nominal Group Technique,* aims to structure interaction within a group of experts. There is face-to-face contact, where each person contributes an idea in turn until all ideas are listed. A facilitator runs the group, records the ideas and ensures that idea is discussed by the group. Individuals privately record their judgements or vote for options. Further discussion and voting may take place. Judgements are aggregated statistically to derive the group judgement.

   c *Consensus development conference,* brings together a selected group of about ten people to reach a consensus on an issue. The meeting is open, operating as a public forum for discussion. Experts or interest groups, who are not members of the decision-making group, present evidence. Implicit aggregation of views takes place by the group retiring to make a decision.

Strengths and weaknesses

These are listed by technique; with the more general ones listed under consensus development conferences

1) *Delphi method*

   a) Gives numerical estimates of participants' views

   b) Allows the exchange of information at low cost

   c) No face-to-face interaction to determine reasons for disagreements, although sometimes participants are allowed to meet once.

2) *Nominal Group Technique*

   a) Allows all members to express their ideas

   b) Allows articulation and discussion of all ideas

   c) Reduces the dominance of some members

   d) It has been likened to focus groups, but is undertaken with a single goal in mind rather than to generate a range of ideas

   e) No weaknesses listed

3) *Consensus development conference and general issues*

   a) No specific strengths or weaknesses identified in the literature, although like the other two techniques the way that information is presented affects the decisions that are made.

   b) Like the other techniques, its use has been confined to professional groups and not used with patients or carers. It is known that users and carers have different views on health care. An example being patients who had suffered a stroke generated different items for communication issues for quality of life measures than a group of clinicians.

c) The choice and balance of groups will affect the conclusions they draw. An example was a study of consensus views on medical education about end of life care in intensive care. The group included three specialists in critical care, six in palliative care, seven in medical ethics, three in medical education, one in communication and one consumer advocate. This power in balance between experts, in particular health professionals and patients, needs to be addressed.

citizens juries

Definition

1) A citizens' jury brings together a group of between 12 to 16 randomly chosen citizens, to deliberate on a question or set of questions. They are enabled to make an informed decision through the provision of written information and through hearing from expert witnesses.

2) Over a number of days, typically 2-4, participants are exposed to information about the issue and hear a wide range of views from witnesses, who are selected on the basis of their expertise or on the grounds that they represent affected interests.

3) With the help of trained moderators the jurors can cross examine the witnesses and call for more information.

4) Following the deliberation the jurors produce a decision or provide a report of citizens' recommendations.

Strengths and weaknesses

1) People participate as citizens not patients or carers and so should provide an objective view.

2) Can be a way of achieving organized public participation.

3) Participants can be chosen to broadly reflect the characteristics of the wider population.

4) Citizens' juries are considered to play a part in democratising decision making processes and enabling a more active form of citizenship.

5) They can enable people to become more competent in decisions and develop a habit of participation.

6) Their greatest strength is the opportunity for informed deliberation jurors can call in other people: professionals, patients, etc to give evidence so they are able to get a rounded understanding.

7) They can be used as a method for priority setting where the subject is emotive, and controversial and depends on value or moral judgements

8) The process is not rushed, so jurors can think carefully and discuss things over with fellow jurors.

9) As a relatively small group, the jurors view may not represent the views of the wider population.

10) Jurors may be introverted and unable to make their views known.

11) There may be a range of issues requiring decisions and it can be difficult to narrow them down so that they can realistically handled by the jury in the time given.

13) The value of the jury can depend on the precise phrasing of the question.

14) Organisation of a jury can be costly and take months.

15) A consensus may not be reached.

16) Little work done to address public acceptability of this method.

17) Not suitable for all issues.

use of the internet to elicit user views

Definition

Most proposed applications of the Internet merely seek to reproduce established methodologies in a way that is facilitated but not extended by the technology for example

a) A questionnaire is translated into an online questionnaire, distributed by email or as an email attachment

b) An interview is conducted over time by email or live via an audio or video link

c) A focus group is run over time by a mailing list discussion group or live via a chat room or virtual meting room

d) A Delphi process can be achieved through successive rounds of staged email messages.

Strengths and weaknesses

1) Research has shown that postal surveys achieve better response rates, although costs are higher

2) Email interviewing, either one to one or via an electronic focus group reduces the problem of the interviewer effect. It can also reduce problems caused by dominant or shy participants. However the richness of the data obtained is not comparable to that of face-to-face interviewing.

3) There are a number of specific data collection problems such as the problem posed by multiple email addresses, difficulties in identifying respondents and verifying their identities.

4) Although access to the Internet is improving it is still selective and some staff, user and care groups are much more likely to have access to the Internet than others. Thus coverage by the group to study is an important issue to address.

chapter three

recommendations for work in north kirklees pct

Collecting and analysing data reflecting the views of patients, carers and staff is an important part of the work of a Primary Care Trust. It helps to ensure that the decisions the PCT makes take account of the views and needs of the staff and the population it serves. It can also be very rewarding not only in understanding and valuing their contributions but also in framing appropriate policy.

The first consideration before collecting data should be the formulation of a clear research question and the aims and objectives that follow from this. It is important to establish what change is possible as a result of the data collection. If it is unlikely that any change is possible than there needs to be a clear reason why data is being collected. Support of key stakeholders within and where appropriate outside the PCT is crucial from the start.

It is also important to establish what other work has been done in the field locally and in many cases nationally. Liaison with other agencies is important to ensure that the project does not duplicate their efforts.

Once the aims and objectives are clear the choice of methods(s) of data collection can be made. This also needs careful thought and there are many occasions when more than one of the methods described can be used. A key issue here is the availability of time and skills to carry out the work. Some of the methods described need specialist input. All forms of data collection and analysis take time and use up resources, often more than was originally anticipated. In some cases data collection may take place over a long period of time or may be part of a continuing dialogue with a group or community.

From the analysis of the data should come conclusions and recommendations for future action; this must be the ultimate purpose of the exercise. These need to be fed back not only to the sponsors of the work but also to the participants.

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appendix 1

an example of a research protocol

This is adapted from the one currently in use in North Derbyshire Health Authority.

TITLE OF PROJECT:

AIM OF PROPOSED RESEARCH:

OBJECTIVES:

1.

2.

3.

OUTCOMES OF RESEARCH:

START DATE: **FINISH DATE:**

LEADER OF THE PROJECT:

Name: JobTitle:

Location and address:

Tel: Ext:

If there are other people involved please list them below.

METHODOLOGY:

Please describe what you intend to use, i.e. Questionnaires or interviews. You should also include information about the target population, how you will sample them, etc.

HAVE YOU DONE A LITERATURE RESEARCH AND WHAT ARE THE KEY CONCLUSIONS FROM THIS?

You will need to show why local research is necessary, if national research exists.

ON WHICH AREAS DO YOU NEED SUPPORT? PLEASE TICK

Drawing up the proposal	☐	Choice of research methods	☐
Sampling	☐	Collecting research data	☐
Analysis of research data	☐	Report writing	☐
Making recommendations	☐	Other (please specify)	☐

.....

WHAT COSTS ARE INVOLVED IN THE PROJECT AND HAVE YOU IDENTIFIED A SOURCE OF FUNDING?

WHAT ARRANGEMENTS HAVE YOU MADE TO DISCUSS THE PROJECT, PARTICULARLY THE RESULTS, WITH PARTICIPANTS?

HOW DO YOU INTEND TO CIRCULATE THE RESULTS?

Please state the group(s) you will be reports in back to and who will be responsible for any follow up action.

You may wish to enclose additional information in support of the application. Please feel free to do so.

Criteria for acceptance of your research proposal

The form attached asks you a number of questions about your proposal. There are a number of issues your replies should answer and these are listed below. These issues will form the basis of decisions on the priority to be given to supporting your project.

1) How the proposed research will answer current health service concerns within the PCT area?

2) Has a comprehensive and literature review been carried out?

3) If similar work has been done elsewhere, what are the reasons for repeating it locally?

4) Should this research be done locally or in conjunction with other health authorities?

5) What is the question that the research is trying to answer?

6) Do the methods proposed appear to be the most appropriate to obtain the data?

7) Does the research incorporate the views of users of the service?

8) What are the resource implications of doing the research?

9) How it is proposed to disseminate the results to the sponsors and participants?

10) How action will be taken to follow up the results of the research?

11) Does the research have (or need) approval by the Ethics Committee?

appendix 2

arnstein's ladder

The levels in Arnstein's ladder of involvement are described below.

1) *Manipulation* level of non-participation where citizens are placed on bodies for 'educational purposes' or to engineer their support

2) *Therapy* another level of non-participation where citizens are involved in some form of group activity to 'cure ' them of their 'pathology'

3) *Informing* - where citizens are informed of the proposal and decisions of officials, often at a late stage where they can have little opportunity to change things

4) *Consultation* - where citizens are asked for their opinions, but without any assurance that their views will be taken into account.

5) *Placation* where citizens begin to have some degree of influence, but this is still tokenistic. Possible example being where they have representatives on a group but this has an inbuilt majority of staff.

6) *Partnership* where power is in fact redistributed through negotiation between citizens and stakeholders. They agree to share planning and decision making responsibilities

7) *Delegated power* where citizens are given dominant decision making authority over a particular plan or programme area

8) *Citizen control* where citizens are given control of a programme through a neighbourhood group