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A research and evaluation Report for the Foxhill & Parson Cross Sure Start

An evaluation of the involvement of health visitors in the Foxhill & Parson Cross Sure Start

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EXECUTIVE SUMMARY

PURPOSE

This study was undertaken to evaluate the impact of a new Sure Start programme in Foxhill and Parson Cross, Sheffield, on one of the local statutory services, namely health visiting. Commissioned by Sure Start Foxhill & Parson Cross the study was designed to address the following research questions:

1. What has been the contribution of Health Visitors to the Foxhill & Parson Cross Sure Start programme?
2. What has been the impact of Sure Start on Health Visitors in the Foxhill & Parson Cross area?
3. What views do Health Visitors in the area have concerning the value and effectiveness so far of the Sure Start programme?

METHOD

The study used a qualitative design with data generated through focus groups and in depth interviews. A topic area list with a number of alternative questions was used to guide questioning. A total of 23 health visitors and Sure Start staff participated in the study, including 2 managers. Content analysis was undertaken and data was categorised by themes, both those predetermined by the research questions and those arising from the data itself.

FINDINGS

Six major themes emerged from the data. Of these three directly related to the original research questions, the others arising as consistent themes from a cross sectional analysis of all the data.

➢ *INITIAL EXPECTATIONS*

Most Sure Start workers had few explicit expectations of health visitors. Some, however, had hoped for closer collaborative working relationships than those which have developed. Most HVs felt they had underestimated the impact of SS and felt that the programme had exceeded their expectations.

➢ *WORKING TOGETHER*

It was acknowledged by many respondents that current structural arrangements made it difficult for HVs to be part of the SS team, a supportive network which was highly valued by SS staff. Continual negotiation was thought necessary to clarify roles with the emergence of new SS positions and this had not always been given sufficient attention. As a consequence a number of respondents, both HVs and SS workers, felt that their contribution to the health and well being of families in the SS area was not always understood and appreciated by others. This had caused difficulties for some in the development of the interpersonal relationships felt to be crucial for effective joint working. Expectations regarding the extent and depth of information to be shared varied and there was ambiguity around the term 'case co-ordinator' used by HVs to describe their role.

➢ *CONFLICTING PRIORITIES*

Health visitors reported difficulties in accommodating the demands, requests and needs of families, managers, SS workers, policy directives and local 'rules' for practice. Tension was caused for HVs by the need to provide services for families inside and outside the SS area and by the differing agendas of General Practice, Sure Start and the PCT. The diversity of views and working practices of HVs and their need to accommodate a wide range of demands on their time has resulted in divided opinion about the best way to interact with SS. This in turn has led to difficulties for SS staff who are uncertain what they can expect from their HV colleagues.

➢ *HEALTH VISITORS' CONTRIBUTION TO SURE START*

Despite these various difficulties, health visitors were felt to have significantly contributed to the development and progress of the SS programme. They were seen as a vital resource in efforts to ensure that local families were aware of the programme and joint family work, although infrequent, was viewed positively by all.

➢ *THE IMPACT OF SURE START ON HEALTH VISITORS*

Most HVs found SS presented them with opportunities and difficulties. New opportunities for training and new resources in the form of a jointly funded HV assistant post were highly valued. However, it was felt that HVs had not always made the most of the new opportunities presented by SS.
HVs felt that SS had placed an additional burden on them in the form of increased paperwork. Opinions were divided on whether the arrival of SS had prompted a change in the role of HVs, and examples of changes given were those of emphasis rather than approach or direction.

➢ *HEALTH VISITORS' VIEWS OF SURE START SERVICES*

Whilst some HVs were uncertain about the specific nature of the services being offered by SS, most were extremely positive about the programme feeling it was making a valuable contribution to the health and well being of local families.

Recommendations
The recommendations are summarised below with an indication of the agency to which they are addressed

RECOMMENDATION	*National SS*	*Foxhill/ Parson Cross SS*	*Local PCT*
1. Development of a framework for HV practice which establishes clarity of purpose and priorities, taking into account the opinions of SS & PC colleagues			✔
2. Agreeing responsibilities of 'case management/co-ordination' and clarification of accountability issues		✔	✔
3. Further consideration of attachment of HVs to SS team	✔		✔
4. Increased support for the clerical tasks of HVs	✔	✔	✔
5. A review of the inter-professional and organisational communication systems		✔	✔
6. Sharing experiences and acknowledging expertise		✔	✔
7. Commissioning of comparative evaluative research in other SS programmes	✔		

CONCLUSIONS
This local case study of the difficulties and triumphs of developing local inter-professional and inter-agency working has revealed that the arrival of SS has had less impact on local health visitors than some originally had envisaged. The reasons for this are complex, including a lack of clarity over priorities, structural ambiguities and a range of professional opinions. The study revealed the local factors that have impacted on the implementation of a national strategy and highlights the need to consider pre-existing structural arrangements and service obligations when expecting a group of professionals to accommodate and work with a new initiative. Finally the study highlights the complex nature of inter-professional relationships and reinforces the message that such relationships need regular attention to ensure that they succeed in working profitably for the benefit of service users.

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BACKGROUND

Sure Start (SS) is a cross-departmental national Government initiative that "aims to improve the health and well-being of families and children before and from birth, so children are ready to flourish when they go to school"[1]. Based on a model from the USA (Head Start), Sure Start is targeted at families with children under four in areas of deprivation. The programme aims to change and add to existing services in order to create improvements in access, service co-ordination and levels of provision. Well over 300 local programmes are already in progress and it is expected that by 2004 there will be at least 500. In the longer term it is expected that Sure Start approaches will be adopted by statutory services so becoming part of 'mainstream' provision.

Sure Start Fohxill & Parson Cross

Foxhill & Parson Cross Sure Start is a trailblazer site whose programme commenced in November 1999. It provides a wide range of services for 920 children under 4 years, with a 2002/3 budget of £900,000. Local health visitors, along with other local workers and parents, initiated and wrote the original application for SS status. One of these original health visitors is now the programme manager. NCH is both the lead and accountable body for this programme and the programme manager is seconded to them by North Sheffield PCT. Local research and evaluation projects are supported by a collaboration with the school of Education at the University of Sheffield.

Health Visitors in Foxhill and Parson Cross

The health visitors working with this programme are GP attached. Each works with a number of families registered with a specific GP. This arrangement means that each health visitor will be working with some families within the Sure Start area and some outside it. All are currently located in GP surgeries, although some are soon to move into Sure Start premises. In addition a new Sure Start programme has been proposed for an area adjoining Foxhill/Parson Cross, which may result in some health visitors working across two Sure Start programmes. This is a challenging area within which to work and, in common with many other similar areas, Foxhill and Parson Cross has seen a high level of staff turnover with ¾ of the health visitor positions becoming vacant during the initial 3 years of the programme.

The Researcher

The researcher is a former health visitor who now works as a research and development facilitator in the School of Health and Related Research (ScHAAR) at the University of Sheffield. She has undertaken a number of development programmes and research studies in the areas of public health and nursing.

THE STUDY

This study explores the impact of a new Sure Start programme in Foxhill and Parson Cross, Sheffield, on one of the local statutory services, namely health visiting. Commissioned by Sure Start Foxhill & Parson Cross the study will be used to inform decisions taken by them, the health visitors and the health visitors employing organisation, a Primary Care Trust (PCT). The research arose from a desire to improve working relationships with local health workers and so strengthen the health component of the Sure Start activity.

It is hoped that the results of this study will:

- Assist all involved to hear the views and experiences of others
- Identify areas of difficulty and success
- Raise issues for further discussion and problem solving
- Assist in the identification of possibilities for change and growth

Research questions

The study was commissioned to address the following research questions:

1. What has been the contribution of Health Visitors to the Foxhill & Parson Cross Sure Start programme?

2. What has been the impact of Sure Start on Health Visitors in the Foxhill & Parson Cross area?

3. What views do Health Visitors in the area have concerning the value and effectiveness so far of the Sure Start programme?

Some additional themes emerged in the study and will be reported later.

RESEARCH DESIGN

As the research sought to study and interpret the experiences and perceptions of those involved in the delivery of Sure Start and the health visiting service, a qualitative design was utilised.

Method

A number of sources and two data generation methods were used to provide breadth and depth of data. This triangulation, or use of multiple methods and /or sources, was used to ensure an in-depth understanding of the subject matter and enhance the credibility of the study.

Data generation

Data was generated through interviews and focus groups. Most took place in the interviewees' own workplaces in July/August 2002 and lasted between 40 and 50 minutes. Interviews and focus groups were largely unstructured, allowing the exploration of complex issues. However, to provide clarity of the research area, the following areas of interest were used to guide questioning:

- The nature of health visitors' contribution to the Sure Start programme
- The level and nature of interactions between Sure Start workers and Health visitors
- Challenges and opportunities for statutory services arising from the arrival of Sure Start
- The nature of any changes prompted by the arrival of Sure Start
- Personal experiences of the changing health and social care provision
- Health visitors views on the effectiveness of Sure Start provision

Notes were kept of interviews and focus groups and all were recorded (with participants permission) and later transcribed.

Sampling
Research informants were selected by purposive sampling, on the basis of the insight they could bring to bear on the research questions. All health visitors working with families in the Foxhill & Parson Cross Sure Start area were invited to participate, along with those Sure Start workers who would normally have contact with health visitors. The groups involved and data generation methods are shown in table one.

Table one: study respondents

1. Health visitors Ten health visitors were interviewed, four alone, and six in pairs. Some health visitors had a large number of clients within the Sure Start boundaries and some very few.
2. Health Visitor Manager, North Sheffield PCT Interviewed alone
3. Sure Start programme lead Interviewed alone
4. Sure Start team members A total of eleven Sure Start workers contributed their views in four team-based small focus groups. The numbers in each were: Breastfeeding (BiBS) team, 3 Outreach team, 2 Family support team, 3 Nursery staff, 2

Data analysis
On completion of data generation a cross sectional analysis was undertaken, including all the data. Content analysis was used, and data was categorised by themes, both those predetermined by the research questions and those arising from the data itself.

Ethical Issues
Participation in the study was voluntary. Individuals retained the right to withdraw from the study and/or retract consent at any stage. Permission to record was requested for each interview/focus group. Recorded data was managed safely at all times.

Each participant was informed that the research findings would not identify individual comments by name. However participants were made aware that, due to small numbers, it was not possible to assure anonymity in any reports arising from the research. Because of this issue and the sensitive nature of the research findings, all respondents were given the opportunity to amend or withdraw comments made in the original interviews prior to publication of this report. To this end each participant was sent copies of the quotes from their interviews, which were intended for use in the final report. One participant asked for a small number of comments originally made to be amended or withdrawn.

The study did not require ethical approval as it was considered as a service evaluation by the Sheffield Health and Social Care Research Consortium.

Comparative studies
This case study of the impact of SS on health visitors is site specific. It relates only to a particular place at a particular moment in time. An attempt was made to locate other research in this area to compare findings but after literature reviews, a search of the national Sure Start website and informal enquiries, no comparative study was found. It would appear that this may well be the first case study undertaken in this area and as such there can be no certainty that the issues raised by this study are replicated elsewhere. Informal enquiries of other SS programmes have revealed that structural arrangements between SS and HVs differ, as do local programme contents. Nevertheless, as some of the issues raised by this study relate to national decisions and structures, it seems likely that at least some of the findings would be replicated elsewhere.

FINDINGS

Six primary themes emerged from the data, encompassing both those answering the original research questions and others that arose from the data itself. These were categorised into the following areas:

- Initial expectations
- Working together
- Conflicting Priorities
- Health visitors' contribution to Sure Start
- Sure Start's impact on health visitors
- Health visitors' views of Sure Start Services

The last three of these relate to the three research questions listed earlier in this report. All six themes are explored in greater detail below.

INITIAL EXPECTATIONS

Both Sure Start workers and health visitors were asked about their initial expectations of each other.

Sure Start workers expectations of Health Visitors
Most SS workers when asked had rather indistinct expectations of HV colleagues:

"...we would be able to support their work and they would be able to support our work." (SS team 4)

The SS programme manager however, as a former heath visitor, had a very clear vision of the close working relationships she expected to emerge between Sure Start workers and HVs:

"I expected them to continue with their public health role in profiling. I expected them to work alongside the nursery nurse team, the antenatal team and the family support team. I expected a lot of joint working, joint visits, sharing their skills ... I expected them to continue to do their initial family health and social needs assessment and then tap into Sure Start to help them to meet the needs of that family." (SSM)

Unfortunately she felt that, for a number of reasons, these expectations had not been met. Another colleague had also hoped that the HVs would be able to be more actively involved with the SS programme than had been the case:

"I thought maybe the health visitors would be more willing to take more initiative in terms of setting up some clinical work around common problems..." (SS team 4)

Health visitor expectations of Sure Start

Health visitor respondents often felt that they had underestimated the impact of Sure Start at the outset:

" it's taken me a long time to understand what SS was all about really, I think initially I saw it as a referral service." (HV 3, 4)

"I don't think I realised quite how big a venture it was going to be and how it was going to impact on everybody, both work wise and improvement wise, and I suppose it came along and it was exciting and it was a new thing but at the same time another change, another challenge." (HV 9)

This uncertainty had initially led to some strong feelings:

"I think right at the beginning there was a bit of confusion as to where our job was going, what our role was going to be, are they going to take over, are we going to be able to work, there was quite a lot of strong feelings around at one time and I think they've been put on the back burner." (HV 7, 8)

Uncertainty over the longevity of Sure Start and changing organisational structures and policy initiatives had all had an effect on how Sure Start was viewed by health visitors. However, it was felt by most that the programme had exceeded initial expectations:

"Its been a good opportunity to work with ...Sure Start to look at supporting families in this type of area." (HV 6)

WORKING TOGETHER

Most of the participants in the study acknowledged the need for staff from Sure Start and health visitors to work together for the benefit of clients:

"we want to support the health visitors and ease their burden, we should be working together, we've all got the same aim, the welfare of the children and mums." (SS team1)

"We work together really, with the family as well. We have a plan then it has to be agreed with the family as well and we work as a team, offering support and seeing how things are." (HV 6)

However there were a range of factors which made this difficult.

Teamwork

The Sure Start participants had a clear view that being a member of a team brought strong benefits:

"..being in a team, you can bounce off each other of what's worked for you and straight away you've got that team support"(SS team 2)

Health visitors, however, did not feel part of the Sure Start team:

"We could live an existence parallel to each other and not really know what the other's doing and I think I am probably at a point where that slightly happens." (HV 2)

There is a lot of stuff with SS that's doing well but as I said I think we need to work a bit better as a much larger team, and it needs to be seen as a team."(HV 7, 8)

Their SS colleagues agreed that health visitors were not really seen as part of the SS team:

I feel that they're somewhere in between there [inside/outside the SS team], they know it's there and they're just on the boundaries." (SS team 1)

The issue of geographical location was felt to have played a large part in this:

"...if they [HVs] were all in the same building you'd get to see them all and you'd get relationships with them as a team." (SS team 2)

"I think being located in the same place would be great, I don't know how that would be in relation to other workers, but from our point of view it would be great." (SS team 3)

The fact of working with families both within and outside the SS area had also had an impact:

"I think to some extent, that [not being dedicated SS staff] slightly disadvantaged us because we're not really part of the team." (HV 2)

However health visitors seemed unsure about whether they should commit themselves to joining a Sure Start team:

" I suppose if any team is to work well it needs to be seen as a team and be a team and is this the way forward? I don't know." (HV 7, 8)

One Sure Start respondent was equally unsure, feeling that health visitors had a very different approach to their SS colleagues:

" I think that the health visitors have very much of a preoccupation with home visiting and they see that they have this special clinical relationship...and I'm not sure that Sure Start really fits into that..." (SS team 4)

Role boundaries

Many respondents highlighted the difficulties of working closely with other professionals and agencies and with newly emerging roles. Many had found it difficult to keep up with the changes in services introduced during the life of the SS programme and this had led to misunderstandings and, at times, hurt feelings (see 'feeling valued', below). In addition some respondents felt that the number of staff offering services has the potential to overwhelm clients:

"I think for the clients as well, they seem to have an awful lot of people involved sometimes and it becomes very confusing. I think the way it's structured could be streamlined so that we've got less people going in and they could possibly be amalgamated." (HV 3, 4)

In order to counter the difficulties sometimes caused by new services Sure Start staff felt that a continual process of negotiation was required to clarify roles:

"There was a lot of non clarity about the role and I had quite a job at the time clarifying that the nursery nurses were not social workers." (SSM)

" ...there is a role conflict of whose role is it to do the routine visiting and whose role is it to do the clinical role..." (SS team 4)

"it's just this sort of like lack of communication between us ...I think we do need a good meeting together so that we can actually say what we've been doing, these last 2 years and then they [HVs] can actually say well right, where do we think it develops from here then and how they can use us better." (SS team 2)

One HV respondent agreed that making the time to ask and listen to others was crucial as roles emerged and developed:

".. it's clarity of roles that's probably the issue here and I know what my outreach worker does because I've asked her and said what do you do and I think that some health visitors haven't got the time and they are not using them as they should to be honest." (HV 1)

Feeling valued

Feeling that their personal or professional contribution to the health and well being of families within the Sure Start area was valued was important to all respondents. However, a number felt that their contributions were not always understood and appreciated.

"... what I feel is that some of the HVs ...I'm sure they don't understand fully what we do." (SS team 2)

"I think there's not an appreciation of the fact that we can co-ordinate care." (HV2)

Sometimes it was felt that the skills of others were not adequately acknowledged:

"..quite often they've [SS workers] got a lot to offer these families and the families don't realise it and basically their experience is not acknowledged by the families and by some of the HVs as well I think." (HV 1)

"..so I think we could work better with them [SS workers]...if we recognised their skills." (HV 1)

"...there's some damn good work and we're in this area trying to show that ... we need to show somewhere... that we do this within SS as well." (HV 7, 8)

Health visitors generally felt that as the long-standing service providers their contribution was largely taken for granted. The new workers in Sure Start were coming to the area fresh with ideas and enthusiasm to do the work health visitors had long wished for the resource to undertake themselves:

"They've [Sure Start] got the money and we haven't and we do feel like the poor relation quite often and it would be nice to see some money coming this way to develop our services because we can't do what they do and a lot of it is to do with finances, not ability or commitment, it's money and space." (HV 3, 4)

This meant that they continued to undertake the "boring bit" of the work:

"Sometimes I think we get the boring bit and everyone else gets the nice bit, we pick up on the problems and then pass them on. They're doing the health promotion stuff that actually makes it better." (HV 3, 4)

In addition there was for some a feeling that Sure Start was taking the credit for the work of health visitors:

Well it's us and them, it means they start and develop all their whatever they're going to do, but we've done the groundwork and then the other thing is all the referrals in, all the work we are doing, where is that shown, because every figure is SS, the breastfeeding figures, where's ours in that? " (HV 7, 8)

For the Sure Start workers the issue was mostly around gaining acceptance into an already established set of practices. This at times has been very difficult:

"At one of the surgeries, one of the HVs was very frosty and I had to explain why I was coming in each week." (SS team 1)

In trying to explain why they had sometimes been made to feel unwelcome the Sure Start staff had developed a number of theories. The first of these was that their relatively low level of training and pay was a barrier for health visitors:

"I just feel like that if we were health professionals it would be totally different, they'd look to us. If we were a trained nurse or a midwife that had gone into specialities .. it would be different.... That's really the sad thing about it, I just felt like, perhaps they don't feel like we are on a level with them." (SS team 1)

"...we were having a conversation about something and she [HV] said well that's why I get paid what I get paid and you get paid what you get paid." (SS team 2)

Another theory advanced was that their resistance to undertaking only the more mundane delegated tasks had caused difficulty:

"..they [HVs] want us to mop up the things that really they feel aren't that important for them to do ...and some of the things that we're more capable of doing, they want to keep hold of." (SS team 2)

For others the issue was about individual personalities:

"...obviously there's certain people that you can work with and there's certain people that you do struggle and I think straight away I struggled, so then you don't actually want to up and visit the surgery because you don't feel comfortable." (SS team 2)

Or having set opinions:

"...the set opinions or not open to what evidence I'm showing them and perhaps they could try this way ...I just wish they would take a step back sometimes and think." (SS team 1)

Or protectionism:

"...a lot of people find that hard, they're quite protective of their job and what they do and they don't want to open that family up and know that other people can be in doing as good a job in a different way." (SS team 2)

However when positive feedback about work undertaken was received or joint work made possible it was very important to the staff member involved:

"A HV I spoke to yesterday who was really grateful for the input I put in with two of her families ...she did say she appreciated it, which was nice." (SS team 3)

"... it feels nice, when you do work together, you wish it was like that in every surgery." (SS team 1)

Communication & information sharing

Almost all the health visitor respondents made comment on the positive effect of their monthly meetings with the Sure Start programme manager. As a result of these they felt generally well informed about the programme and felt they had an opportunity to influence its direction.

"The main thing that gelled health visiting and SS together has been our monthly meetings." (HV 7, 8)

We've been well informed about what's happening in SS area and we have been invited to regular meetings within SS." (HV 10, 11)

However opinions on the sharing of information regarding work with individual families were more varied. Some respondents felt that communication levels were good:

"Generally we have quite a good communication, once we're involved in a family, with the family support and outreach workers, they all come and ask you or tell you what they're doing anytime. I think generally there is an understanding of what we do, and usually when they talk to us they talk fairly appropriately about what they're doing and we should know." (HV 3, 4)

"I've had really good communications with HVs, no problems with returning calls and just passing information that needs to be passed back." (SS team 3)

" we've been able to talk to each other as well without the family so that we are sure that we have made a package that protects the child.." (SS team 4)

However for some the level of communication was felt to be inadequate:

"We've done a lot of referrals and we don't know whether they've been picked up or not, has she done something with it." (HV 7, 8)

"Well we've even less patients or families [in Sure Start] because we're on the fringe of it, but we have got some, but our problem is that we don't see anybody, we don't hear from anybody, we have very little feedback." (HV 10, 11)

There was an understanding of the problems involved with this issue:

"I think feedback is an issue and getting hold of people, but then again I know they've got a huge issue with us about that, it's difficult isn't it when you are working out and about in the community." (HV 1)

"...because they are under established it may be that they are prioritising work in a way that says that, well Sure Start is getting on with it , if there was a problem they would be in touch with us..." (SS team 4)

Finding the balance between passing on information about family-based activity, whilst respecting the need for confidentiality and preventing unnecessary time on this activity challenged all concerned.

"I don't think we've fully come to terms with the exchange of information, I think we tend to exchange information freely with HVs when perhaps we shouldn't." (SS team 3)

"... it's thinking of a way that isn't time consuming bureaucratically and how much people to need to know." (SS team 3)

"They [HVs] actually might be afraid of saying things which maybe they see as confidential...they don't realise that to help the child we need a bit more information..." (SS team 4)

For one SS team this problem was addressed by only giving feedback when something untoward happened:

"It tends to be only problems, big problems that need to be dealt with." (SS team 1)

These difficulties were compounded for SS staff by the fact that HVs are on multiple sites, and for HVs by the range of SS staff and services. One participant offered a practical suggestion to help the issue:

"I think we would like just something to say who the worker was with the families and phone number so that we would know who they were so that we could contact them if we needed to." (HV 10, 11)

Most Sure Start staff were also considering developing new communication systems:

" I'm open to developing some new systems of communication, I mean I think one of the things that you can forget about is that there are so many things to set up when you're a new service." (SS team 3)

Agreeing and implementing appropriate communication systems continues to be an issue for both health visitors and Sure Start workers.

Health visitor as case co-ordinator

Part of the reason why communication over work done with families is so important to health visitors is their understanding of their role as case co-ordinators for families, a role that was elaborated by almost all the respondents:

"What I think I do is pull it together, for example if there is a client that they're working with I think I'm the one that more or less co-ordinates that clients care, but they probably don't see that. They might not know that I know that they're going in or that's what's happening with that client, but I do. That is important and that's more or less how I perceive my role." (HV 2)

"I see the HV co-ordinating the services that families are receiving. Making sure there is good communication between every agency and get the best outcome for families." (HV 6)

"..sort of a case manager, where you can assess their needs, you can't always meet that need yourself, but you know where that need can be met."(HV 9)

"One of the roles as we know as HV is also co-ordinating, you're doing the whole family assessment, their family health needs."(HV 7, 8)

The Sure Start Programme manager also saw health visitors in this role:

"now with Sure start hopefully we've got a care package that can be overseen by the health visitor and tailored to meet individual family needs." (SSM)

as did one of her colleagues:

"...when they do well they do good case management and they co-ordinate the information from a range of different sources." (SS team 4)

Part of the function of a case manager was articulated as the assessment of a family situation and the delegation of work required to others. Health visitors in the study did not feel they were in a position to do this with SS workers.

In addition some Sure Start workers expressed a concern that close links with HVs would lead to a lessening of their autonomy to develop their own services:

"I think by being separated from the HVs we've sort of been able to develop our own, not status but our own team as opposed to being seen as a gofer." (SS team 2)

Whist others definitely saw themselves as determining the level of service a family would receive from them, which may or may not coincide with the views of health visitors:

"...we take on the issues that professionals want us to think about, but with all families no matter who they are, we go out and ask them what they want, so hopefully some of it is what HVs are suggesting, but a lot of it might be other stuff, might be completely different to that..." (SS team 3)

Thus whilst health visitors saw themselves as assessing family needs and referring families on to SS teams to address specific issues, SS workers saw themselves as autonomous teams who would make their own assessment of families. This difference in perception and the consequent mismatch of expectations appears to have contributed to difficulties of communication and in relationships.

Interpersonal relationships

Almost all participants in the study saw interpersonal relationships and trust of each other as important contributory elements to successful joint work.

"I built up a really good relationship with SS initially in the early days and I think that's really helped because now there's a trusting relationship there and I don't feel I need to be on her case, she just rings me if there's a problem to just let me know." (HV 2)

"... if you've got that interpersonal relationship, sometimes it's easier to pick up a phone to somebody you know and get on with, in the way that they know what you want or if they can't provide they'll tell you they can't provide it." (HV 9)

We did have very good contact with the previous worker but she was around here a long time and knew us very well and she was very good at liaising..." (HV 7, 8)

"I think it's building up that trust with someone isn't it, that when I hand this work out, are they going to do it as I do it, so that relationships got to be there for them [HVs] to feel confident that they're passing it on to someone who is capable of doing it." (SS team 2)

Most felt they had established some good interpersonal relationships:

"I think they feel confident who I am now and I feel confident contacting them, because you get to know who's who, so if I've got any problems, I just pick up the phone, there's no hesitation." (SS team 2)

"I think we've got quite a good relationship with most of the HVs." (SS team 3)

" its good to have a relationship with the health visitor because they know and they feel comfortable knowing they can come and tell you things." (SS team 4)

Others, despite their importance, had struggled to establish them:

"[when we discussed differences] we started getting wires crossed so we agreed to disagree. I didn't want to pursue it at that time, so I'll wait. It's difficult, you don't want to put oil on the fire really, it's already strained as it is." (SS team 1)

"I think the relationships can get better but we just need to set some time to do it, and find out what they do want, because if our job is developing, then there might be certain things that can be developed into our job, but it's growing, we're not going back to what they probably want." (SS team 2)

"They don't always get what they want because of that lack of relationship." (SS team 4).

CONFLICTING PRIORITIES

A major theme to emerge from the data was that of conflicting priorities. These were talked of by all participants in relation to a range of issues. A picture emerged particularly of health visitors struggling to appreciate and accommodate the demands requests and needs of families, managers, Sure Start workers, policy directives and local 'rules' for practice.

"What's happening in Health visiting at the moment is we are getting pulled in different directions and where do we want to go?" (HV 6)

There was a need for HVs to prioritise these competing demands but this was felt to be difficult:

"I think you've got to give up something to take on something else, and you're not sure which are the right things to give up because I don't think you can have it all." (HV 3, 4)

In addition some felt that too many initiatives would put 'basic' health visiting at risk:

"The basic health visiting that's still going to have to be kept going, it can't be discontinued at the expense of pushing forward SS initiatives." (HV 10, 11)

In & outside Sure Start.

For many health visitors the tension of working with families living both inside and outside the Sure Start area has been a source of pressure and frustration for them from the outset:

"It's frustrating when you can't access services like Sure Start when it's not in your area and perhaps some of them need it more, but that's the way things are really." (HV 6)

"We don't want to work completely within SS do we, because we have got clients outside and we have got to think about those and we would be neglecting those people, if we worked completely within SS. It's a bit of a dilemma really." (HV 3, 4)

"..at the end of the day we're giving nursery places to those in SS and there's others outside that need it far more than they, so who are we helping here? It sometimes gives us some ethical dilemmas." (HV 7, 8)

"I think one of the things with it is it's very difficult if you've got a very small proportion in the area and they are getting the service that the others cannot get and that is what we find quite difficult and families that maybe live on one side of the road get a service who maybe don't particularly need it and someone on the opposite side of the road that we feel would benefit from those services aren't able to get it and that is quite frustrating for us." (HV 10, 11)

The issue of a geographical area within which Sure Start services can be obtained has also caused complaints from families. Both health visitors and PCT managers have had to respond to these complaints:

"We get a lot of resentments from families that are saying well why can't I have that, my neighbours got it and just because she's in Sure Start, we still do get that." (HV 1)

"The cheaper safety equipment can be an issue. You get people saying, my brother's had this cheaper safety equipment and I've not been able to get it and it does cause the occasional bit of frustration." (HV 3, 4)

"I've had one or two clients say, well my friend down the road has this or that, and I have to say well I'm sorry." (HV 9)

"..we have a strict cut off point, so we've got next door neighbours where one can and one can't, so that's created an issue with some families hasn't it. ." (HV 7, 8)

"I think one of the dilemmas its thrown up for the staff...is this real dilemma because they can offer some families the services and they can't offer them to others and it puts them in quite a sort of precarious position I think." (HVM)

"I think certainly because of complaints that have come into the PCT or voices raised by people outside Sure Start, our feeling was that the concerns being raised almost were drowning out the good things that were happening in Sure Start." (HVM)

However, the SS programme manager felt that much of the health visitor anger caused by this issue had been focused on her when it should have been directed elsewhere:

"I think the HVs who have half their caseload in and half their caseload out quite rightly have become increasingly angry, but what I find is that they're angry at the Sure Start when they should be angry with other services that don't meet the needs of families outside of SS areas." (SSM)

General Practice /Sure Start agenda

Tension was also caused for HVs by the competing agendas of Sure Start and General Practice. All health visitors are currently 'attached' to GP practices and as such are part of a primary health care team. Like most areas of the NHS, primary care has its own priorities for action, both those of policy and those generated locally. As part of this team HVs are expected to contribute to these priority areas. These do not always coincide with the priorities of Sure Start.

Health visitors' strength of feelings about their allegiance to primary care appeared to be largely determined by personal experiences of GP colleagues, which was very variable:

"I think it all depends on your relationship with your practice, because I think you can get good and bad practices, can't you and some are really on for your innovations and they want you to fly with stuff and then others it's like stirring treacle." (HV 2)

"..they do see me as being part of the team in certain instances, but then in other instances, its well you're not employed by the practice as we are, and you're not here full time, so basically you're not one of us... (HV 1)

"I don't think all GPs realise what a HVs role is or what skills they may have." (HV 9)

"I have difficulties with my GPs really and it's hard to work in a GP surgery and be able to say, I'm sorry but I'm not doing that, I'm doing this with SS." (HV 9)

"...it does on the whole work here, where there's easy access to all the medical records and open access to the GP's where we have meetings every Friday, where we can talk about anything we're worried about and pass things on and it is a very supportive environment." (HV 3, 4)

Most health visitors felt there were some advantages to GP attachment but also that there would be advantages to working purely within the Sure Start geographical area. For this reason no decision had been reached about change and as a consequence HVs were working with two divergent systems:

"We're GP attached at the moment, there's plusses and minuses for GP and geographical attached and at the moment we are trying to run both because SS is geographical." (HV 9)

The SS programme manager understood and sympathised with the difficulties this created for HVs:

"I think they're absolutely torn, I think when they're here and they're with us, I think they'd like to be part of Sure Start and much more integrated into the Sure Start team and obviously I'd be happy with that, but they're absolutely torn you know because they've had 10 years working alone in GP practices." (SSM)

Nevertheless, changing circumstances were forcing some to move somewhat further towards the SS way of working:

"this GP practice is overflowing at the seams and the [healthy] living centre's not finished yet, they are needing more rooms for their practice nurses, so we're ousted, we're moving in with SS, so this might be the new suck it and see, well does this, will this work ." (HV 7, 8)

The HV manager was also conscious of the tensions involved in working within these two fields. She, however, was also very aware of the need for her organisation to gain acceptance for such a major change as moving HVs from GP attachment:

"Well while we are GP attached that's difficult because even looking at working on a community base X [PCT chief exec] is quite anxious that we get it right and that we get the support. So the plans that we are going to pull together for working in more of a community way he wants us to ...present it to the executive and the Board. Because he feels if we need their support and approval ...until then he is not willing to change it." (HVM)

The Sure Start programme lead, however, felt that if staff worked together they could find a way to accommodate the demands of General Practice and the geographical nature of Sure Start:

"I don' t think there's a massive reorganisation that needs to happen, but what I would have liked to have seen, and I have to be really careful because I'm not their manager, I'm not their leader, but what I think could work, if they work together as a team and think about it, they could keep the GP attachment, but maybe they could have their Sure Start families as a joint caseload and find a way of managing it between them." (SSM)

Primary Care Trust / Sure Start agenda

Another area of tension for health visitors was that between being an employee of the Primary Care Trust (PCT), with all the attendant priorities and obligations, and being seen as contributing to the success of Sure Start:

"I feel pulled in many directions and I'd like to feel part of any team. I have to feel part of the team because we have to work together, however, SS team and the PCT team don't always go in the same direction." (H V9)

Some interviewees felt they would like to work more to a SS agenda:

"I guess if SS wants to release us to work in a different way, I would like to do that, but whether the PCT would allow that to happen I don't know." (HV 3, 4)

"I can see advantages to community development and public health in being geographical. I love that sort of work so I can see where the benefits lie and I do see that Sure Start offers us that opportunity." (HV 2)

"I think I'd like to see it [health visiting] more as a SS model, it's a more community based, health promotion model." (HV 9)

"I think that [SS] could be one case where you could put forward a ...good reasoned argument for a geographical HV." (HV 10, 11)

Others were less certain, either because of questions around the longevity of Sure Start:

"I think I would still prefer to be part of the PCT rather than Sure Start because you still get people that are saying Sure Start won't last forever..." (HV 1)

Or because they were concerned about the constraints of the Sure Start 0-5 years focus:

"The families that have children with behavioural problems need that support beyond 5yrs and if HVs were fully Sure Started, it would mean we would be under the same [0-4yrs] constraint in the future." (HV 3, 4)

"are we 0 - 4 or do we go for the public health role, is that 0 - 5's or is it generic?" (HV 9)

Or because they felt they needed more flexibility to respond to very local needs and agendas:

"I think health visiting is very much to what you're doing within your community and what's best for that community really and at times the priorities are very different, sometime they are very much similar and that's fine." (HV 9)

Others felt that their own views were not being taken sufficiently into account:

"Now although we've been given extra help, it's often been which way do I go first and how do I justify it to which manager, because my contract's with the PCT and it's not always been where I've wanted to go." (HV 9)

The HV manager reported that she, and her PCT colleague, struggled with the fact that an external body such as the national Sure Start felt they could impose objectives on NHS staff and resources without consultation:

"I find [national] Sure Start faceless and I can find myself getting really irritated and angry with Sure Start. Do they have to keep sending down these sorts of objectives to be achieved? They can't achieve them on their own so really they are pushing them down on us and you have to say well excuse me but I don't actually agree with that objective." (HVM)

National decisions by Sure Start about priorities and targets which expected health workers input but which did not offer them additional resources also caused difficulties:

"..a lot of the targets that Sure Start set to be achieved they need a lot of input from health and yet there isn't that recognition and financial input to help them do that, I think they do need to think about that." (HVM)

As a consequence the PCT managers were not always willing to commit HV resources to SS work, which in turn caused difficulties for the SS programme manager:

"HVs have told me that [PCT] senior management tell them that Sure Start is not a priority for health visiting and that's a struggle for me." (SSM)

However, although the health visitor manager was committed to helping SS as much as possible she continued to struggle with SS objectives that did not coincide with local priorities:

"I don't feel I've got to take it on really. I can help her [SSM] as much as I can, but I can't help her achieve something I don't even feel committed to really." (HVM)

Pulled three ways

As a consequence of these differing priorities and organisational constructs health visitors felt very real tension and decisions over priorities for action were often very difficult:

"..there's practice meetings and there's the nurses team meetings within the practice, we're supposed to get an integrated nurse team within there so how much time do you put to that? If we're integrated then that's full time into that, full time into SS, full time into North PCT, 3 into 1 don't go, you can juggle all you like." (HV 9)

"We've got our core work and we're GP attached...we've got our foot in a number of camps and we're not totally geographical, we're not Sure Start and so dedicating yourself to any one end is very difficult." (HV 3, 4)

The thought of another SS programme arriving in the area with possibly different priorities, services and structures would only add to this difficulty:

"I think the difficulties will arise when, our practice in particular could be on the boundary of two SS that will possibly be managed in different ways and the vision I have for that is total confusion for me and my colleagues." (HV 10, 11)

For the SS programme manager the answer to this was simple for her. She wanted a dedicated SS team of HVs:

"If I could have a wish... I'd like four [HVs] working with me and dedicated to the Sure Start families. I think it would help them enormously, I think it would be fantastic for the families, they'd be very clear about everything. I think it would be brilliant for me and it would be very challenging, but I think also it would be a real chance for HVs reshaping the service. I do feel sometimes that I've been home alone with it and I feel a little that they just left me to get on with it and I feel a little bit let down by that..." (SSM)

Rules and Routines

Some health visitor respondents in the study felt that the routines and 'rules' governing their practice also restricted their ability to respond flexibly to the needs of new initiatives such as Sure Start:

"Routine assessments drives me crazy to be honest...I think time could be so better spent by doing them sort of ad hoc if you like or on kids that you don't see very often and things." (HV 1)

"... really it's being able to free up HVs time to be able to do these things and we haven't got the time, however much we would love to do it and I certainly would like to work in that sort of way but we just don't seem to be able to get out of the routine." (HV 3, 4)

The original source of demand for this routine work, whether professional, personal to each HV or managerial was unclear. However, one respondent felt that Sure Start had added to the pressure to continue with routine work:

"... it's been about all the child development assessments and SS, our energies might have been better spent doing other things, but management said, no you've got to do this and be involved with SS." (HV 9)

A Sure Start colleague was disappointed the Sure Start hadn't provided the means by which HVs could 'break away' from the routines of practice:

"I think Sure Start should have liberated the health visitors to break away from the routine and really make a difference to the families, I think they have got bogged down with meetings and giving information and doing mandatory visits that don't actually add to the families health." (SS team 4)

Differing approaches

A point of frustration for many of the SS workers in this study was the range of views and working practices exhibited by health visitors, their lack of a common approach:

"We see different HVs for different surgeries and it's so different how they work." (SS team1)

"...she [HV] was really good and I know that that's what that particular HV will do... but you can't always do that with some of the other ones." (SS team 2)

"...I don't feel as if they had a strategy, between them, I feel they're all separate." (SS team 2)

"Referral rates vary from HV to HV and I don't know whether that's a reflection of the work or whether that's a reflection of their awareness of what we're doing." (SS team 3)

"...I think some of the health visitors are up for it and some aren't." (SS team 4)

Their health visitor colleagues were also well aware of this diversity:

"I think the various skills we've got really, there's general HV skills that we all have and then individual skills and as a group we've got varied skills." (HV 9)

"There's got to be some changes in our working practice within the PCT, but then you come back to getting us all to agree, and there is division as to how we work currently." (HV 3, 4)

"..and I think there'll come a time when each HV will be able to say 'well for our community we think this way will work', I don't think that will be an easy discussion to have because I think we all have different views." (HV 9)

This divergence of views and working practices had resulted in Sure Start staff receiving mixed and sometimes contradictory messages about how to best work with HV colleagues:

"...but in one breath they do want it and in another no you can't have that, so in a way it's like 'well what do you want then?' and I would like to know actually what they want, what services do they want from us." (SS team 2)

Decision-making

There appeared to be an acceptance among the HVs interviewed that due to SS and the new policy agenda for HVs[ii] it was time to reassess the future of health visiting:

"I honestly don't know the way forward, I just know it needs looking at for HVs." (HV 9)

"I think it's just changing times and as HVs we've got to look at what can change and that depends on lots of things, strategies and documents and things like that." (HV 10, 11)

"I think we have a time within SS where the health visitors are trying to re-define our role." (HV 7, 8)

Most staff appeared to believe that health visitors should largely determine the future for themselves:

"..it's about how health visitors want to move forward, what direction do they want to move? That's a very important thing to take into account." (HV 6)

"Who should be directing health visiting?" "The [PCT] Director of Nursing and health visitors themselves together really." (HVM)

However, there appeared also to be an acceptance that gaining consensus amongst health visitors on the best future for the profession would be difficult due to the range of strongly held views:

".. each individual HV you talk to may have a different slant ..., actually getting them together and agreeing would be a big thing." (HV 9)

And individual preferences:

"On balance my future lies with community and geographical working and places like Sure Start, but in my old little practical world, I quite like the fact that I can have a nice little office with a phone and a refreshment corner, near where I live and that's the reality." (HV 2)

Nevertheless, the process of discussion appeared to have already commenced:

"We've had a lot of discussions about how health visiting is going and we have looked at ways of perhaps doing things in similar ways." (HV 6)

However most discussions appeared to have resulted in an impasse, leading to frustration for all concerned. The Sure Start programme manager was able to reflect on a number of situations in which divergent views had resulted in deadlock and consequent inaction. For example when the issue of becoming a dedicated health visiting team for Sure Start was debated by health visitors the result was:

"Half and half, I didn't even have a 60:40, it was straight down the middle and no strong voice." (SSM)

As a consequence no decision on change was taken and existing arrangements continued. In another instance the HVs were involved in creating an electronic tool to analyse case records. When the data collected was analysed it emerged that half the health visitors had collected the material and half had decided not to:

"We had a whole years data and when we pulled it all off and analysed the whole thing and gave it back to the HVs, the room couldn't have been more split, we had a straight 50:50 division." (SSM)

On another occasion HVs were offered the opportunity to become a Nursing Development Unit. Again the result was a split in views and hence no decision or action taken:

"X [external consultant] talked to them [HVs] about maybe becoming a nursing development unit but there were 4 who wanted to and 4 who didn't want to and on we go." (SSM)

Finally, when the issue of those HVs with very few families within SS giving care of those families to colleagues with greater numbers was debated, again individual HV views ruled the outcome:

"The HVs that we did meet with that were based outside the area had no objections to Sure Start or anything like that, but they had got big objections to handing any families over." (SSM)

This divergence of views and actions and the block to decision taking it appears to induce was inevitably a source of frustration for the SS programme manager. As she was not the HVs' employer she was unable to act in a leadership role:

"I hadn't and still haven't got that power to say: 'well just do it and lets suck it and see'..." (SSM)

The HV manager was in agreement that SS was not in a position to determine the actions of HVs:

"..they [National SS] almost want to direct the way that health visiting is going and my feeling is that health visiting will be influenced by Sure Start, and will be influenced by the services that are being set up, but I don't feel Sure Start directs health visiting. I think we have got to be listening to each other and we have got to be adapting but I don't think it takes a lead on what Health Visitors do." (HVM)

Sure Start is expected to influence local delivery of statutory services. However, it would appear that only rarely is SS the employer of these staff. Predominantly HVs remain the employees of PCTs who may or may not second them into a Sure Start programme. In this instance the HVs were not seconded and therefore the SS programme manager had no direct influence over their services. Although she had managed to evoke a large amount of goodwill from these healthcare staff and their manager, she has no formal mechanism through which to exert influence over decision-making. As a result she has only been able to encourage debate, which in relation to at least four important issues has led to divided views and a consequent lack of action. The alternative views apparent amongst HVs are hardly surprising given the backdrop of policy change and multiple agendas outlined above.

Organisational changes in the NHS during the life of the Foxhill and Parson Cross SS have meant that formal agreements with HV employers have been slow to emerge,

although the two managers in this case have evidently attempted to support each other despite these difficulties. External demands for health outcomes from the national SS organisation, implying the involvement of health care workers, appear to have antagonised local PCT managers already dealing with limited resources, vacancies and a multi-layered policy agenda.

HEALTH VISITORS CONTRIBUTION TO SURE START (Research question 1)

Despite the various difficulties health visitors and Sure Start staff have encountered since the inception of Sure Start Foxhill and Parson Cross, it was felt that health visitors had significantly contributed to the development and progress of the programme.

Influence

Health visitors and SS staff alike commented on the fact that HV views were often sought, always welcome and taken into account as the programme developed:

"I think they've been quite receptive to my input, to what the future should be like, with the employing of the HV assistant. They've involved me and if there's something I haven't known about, I pick up the phone and ask."(HV 9)

"They're quite happy to come in here and tell me when something's not right and quite happy to come and tell me when something's good and I've listened to them very carefully over the years about the posts that they've wanted developing. We've worked together to develop them, like the dietician, the speech and language therapist and the HV assistant post. It's not always been smooth but we've got there together." (SSM)

"..there's lots of informal...opportunity to come in and comment on things." (SS team 4)

However, some HVs were less sure of their influence:

"I'm not sure that I've influenced the way it's developed, ... I feel like I am part of the network definitely, sometimes I feel a bit closed off from it if I haven't got clients that are using the service." (HV 2)

Nevertheless, HVs were seen as important advocates for families, enabling them to gain access to SS services:

"...they do articulate needs that families aren't always able to articulate themselves." (SS team 4)

'Selling' Sure Start

Health visitors were seen as a vital resource in the campaign to ensure that local families were aware of the SS programme:

"they wouldn't reach the families if we weren't there giving information out, and they do acknowledge that and respect that." (HV 1)

"I think it's mainly promoting SS and encouraging people to use it." (HV 10, 11)

"..some [HVs] have been brilliant at getting families consented into Sure Start for us at the new birth visit and some have been brilliant at telling people about Sure Start in a positive way." (SSM)

The fact that HVs were already known workers in the community was seen as giving SS an advantage as they worked to establish their own credibility:

"The fact that we were already out there with the families and the community and we were a trusting faith if you like, I think that was a very positive influence." (HV 9)

Joint work

Working together for families was also seen as a positive outcome of HVs involvement with SS:

"I regularly do joint visits with X the outreach worker and she picks up anything I ask and she always feeds back to me." (HV 1)

"... they [HVs] certainly do undertake some joint visits with staff, particularly the family support team and the outreach team." (SSM)

However for some staff there was a feeling that this could usefully happen more frequently:

"..there's so many instances where if they just looked at it or passed it over and worked together, we could have got it solved in a better way." (SS team 1)

"...it should be that we're all here together. We're not important, they're not important but both together we are important, so I just think its so much more of a result when you are working with them together. " (SS team 1)

THE IMPACT OF SURE START ON HEALTH VISITORS (Research question 2)

Most health visitors in the study had found Sure Start presented them with opportunities but also difficulties:

"it's a double edged sword, I think Sure Start can be a bonus but it can also cause us headaches." (HV 3, 4)

New opportunities

When asked about the new opportunities SS offered for HV staff most respondents were very clear that the opportunities existed:

".. it has given the opportunity to think about skill mix and it's going to give them skills in managing staff with different skills, they have done a lot more group work a lot more teaching and the inter agency working I think has just been good really. So yes I think it's developed good opportunities and I think broadened a lot of their thinking." (HVM)

However, a number of staff recognised that it was up to the health visitors themselves to make the most of those opportunities:

"I'm beginning to see that there are opportunities for HVs if you want to make them, they won't come and sit on your lap and say please come and do this for us, but if you can think of an idea or you want to go and do something, they can provide some money for you." (HV 3, 4)

"I think X [SS programme manager] has given opportunities and it's really been up to us to either run with it and get money from her and get support from them." (HV 2)

However, many of these opportunities had not been taken up. One HV felt the reasons lay within health visiting:

" I think X [SS programme manager] has tried her best with us but generally we're passive." (HV 2)

However, for one Sure Start worker this had led to a credibility gap:

"We've got this very well resourced parenting programme which should be helping health visitors and lots of them have done the training but none of them are co-leading groups. There is a sort of credibility gap between what they could be doing and what they are actually doing." (SS team 4)

Increased resources

It was also acknowledged by many that SS had provided some additional resources for health visiting, both directly in the form of a health visitor assistant post:

"I think they are grateful for the contributions [of HVs] and that's why we have funded X's [Health visitor assistant] role because they do appreciate that it is extra time, certainly extra visiting." (HV 1)

"Providing money for the HV assistant, that's alongside X PCT, but SS have listened basically." (HV 9)

"We've got this health visiting assistant in post and that just felt like more partnership work and its a recognition of the fact that Sure start does need so much input from the health side of it in order to achieve its targets." (HVM)

and indirectly from the increased resources for local families:

"I'm sure it's had a big impact on them, knowing that there's extra things they can get for their patients." (SS team 1)

Training

Health visitors had been both the recipients of training paid for by the SS programme and providers of training for SS staff:

"I've done some training, we've done joint training where I've been there as one of the people being trained with the outreach workers and the BIBs workers." (HV 9)

"We've had good training, we've had excellent training, superb, baby massage, child behaviour, and that's opened up large opportunities that we wouldn't get with the health service. ." (HV 7, 8)

What they have done is they've been in and had some training, such as breastfeeding training, baby massage, parenting training and speech and language training and other training...any training that's offered to our staff I would put it out for the HVs. I've also offered conference fees and I've offered resources for group work within Sure Start." (SSM)

However, there was a feeling that the training HVs had received had not always been used in practice:

"So they've all done their La Leche breastfeeding training but none of them, to date, have used their training to train local women in peer support." (SSM)

Bureaucracy

However, on the more negative side, it was felt that SS had added to the bureaucratic burden on HVs. The increases in form filling and data collection led to a number of pleas for clerical assistance:

"If we have a family that we want to refer to SS, and we want to refer them to a number of services it's not one form, it's a lot of forms. It's the routine forms as well isn't it for all families whether they're using the services or not. Antenatal forms, consent forms, questionnaire, referral for safety equipment, and they're standard for everybody whether they're picking up a service or not. And then of course there are all the other forms if they need to see someone specific. It could be made easier and from our point of view as well, it could be improved of we had more clerical help." (HV 3, 4)

"Sometimes collecting the statistics can be a bit of a pain, I think targets are a real tension at times." (HV 3, 4)

"Paperwork can be a bit of a pain that has to be said." (HV 2)

"There's more paperwork for SS, which they need, I'm not saying I'm not doing it or it's not good, but there is more." (HV 9)

"It's increased our workload with number crunching and form filling, referrals and attempting to link as well." (HV 7, 8)

We've got more paper round here than we had before and I say I didn't come in here to be a clerk. ." (HV 7, 8)

"..it's difficult keeping up to date with what paperwork I am supposed to be filling in, that's appropriate for SS." (HV 10, 11)

Changing role

Questions about whether the addition of SS to the range of local services had provoked a change in the role of health visitors brought forward a range of responses. There were some who felt the role had changed:

"Well yes it's give and take isn't it... I can think of half dozen families where I would be having to go in more regularly to give parenting advice where as they are going on a parenting course." (HV 1)

"You think this person needs this, this and this and you know you can get it within a reasonable length of time, there is something that you can offer them rather than saying I don't know what there is really, and you know you're not offering them a very good service, so I suppose in that way it has changed health visiting hasn't it?" (HV 3, 4)

"I don't think my contact is needed as much because I know that there's other people that are around making that contact, and probably meeting the need far better that what I may have at that point, because my skills are different." (HV 2)

"...the fact that having workers going to more intense families it does free me up." (HV 2)

"...having workers you can refer something to and not feeling you have to keep going in for support." (HV 6)

"The Health Visitors say their role has changed and I think a lot of key things they have been able to hand over and concentrate on other things so they say yes their job has changed." (HVM)

".. they are able to devote a lot more time to the more chronic sort of families where there is quite a lot of in-depth specialist work I think. Or even just spending more time persuading people or identifying what services could help some of those more entrenched families or hard to reach families or the ones with more problems." (HVM)

There were others who felt the role had not changed:

"I don't think it's [HV role] particularly changed, obviously there are additional visits that we need to do, but no, it's not generated [anything] other than paperwork... and the time spent just explaining what Sure Start is." (HV 1)

"I think it's a good support to HVs in an area where they are established, I don't think that it changes the role of health visitors, it may make you adapt the way you work with a particular family, but I don't think it particularly changes your role." (HV 10, 11)

... in terms of whether their [HVs] workload would be any lighter, probably not, because they do very different things that we couldn't or wouldn't do." (SS team 3)

There were yet others who felt there had been reductions in the amount of family-based work required, but increases in other types of necessary activity:

"In some cases where the outreach workers are going in regularly maybe I wouldn't go in as frequently as I would have done so in that respect perhaps but I would keep in touch so that I'm not missing anything. So it has reduced a little I would say, but there is the support and a lot of co-ordination which is not easy." (HV 6)

"I think it's made it easier on the practical side but it's made it harder from a paperwork side of things, keeping up to date and obtaining all the consent forms and things, but certainly to pass on and refer to experienced people, it's certainly made it a lot easier." (HV 1)

One team thought the effect would be emotional benefit rather than practical change:

"... if you've got somebody going in to a worrying family, it's always less worrying for an individual if other people are going in as well." (SS team 3)

From this range of responses it can perhaps be concluded that Sure Start has brought a differing amount of change to each health visitor depending on: the number of families the practitioner sees within the SS area; the amount of contact the practitioner has made with SS; the willingness of the individual to work with others and delegate activity and the amount of enthusiasm the individual has for changing roles. However, the examples of changes given were mostly those of emphasis rather than approach or direction.

HEALTH VISITOR VIEWS OF SURE START SERVICES (Research question 3)

All health visitor respondents were asked for their views of the services provided by Foxhill & Parson Cross Sure Start.

Positive views

Many positive comments were made about the SS programme:

"Most feedback from parents and families that I've had is positive about all the services." (HV 2)

"A big improvement, confidence booster in all sorts of ways, people that wouldn't get a job or people didn't think they were able to go out and get jobs and given them confidence to do that, and they are now encouraging other people to join SS, attending groups that they would never ever dreamt of attending and joining the community." (HV 9)

"... so they are offering lots of services and advice that we can just touch on but don't have the time to go into in any depth." (HV 1)

"Yes there are a lot more services ... when you look at issues like parenting and safety equipment and it's been better that what we had before." (HV 10, 11)

"I think the really good thing obviously is that you get additional resources into needy areas and that's good...Its an opportunity to have a new look at what's needed and to get heavy involvement from local people." (HVM)

Outreach
When asked their views of the SS outreach service, most were very positive:

"the outreach workers, who are mainly nursery nurses, have got a lot more knowledge and experience than I've got with regards to play and age appropriate toys." (HV 1)

"I think it's a brilliant service and I know they do far more that what I probably think is happening with my families." (HV 2)

"...they're the ones, if there's anything really silly like you can't get a pram from cot age, you can always guarantee the outreach worker will sort it you out. They're the ones who tend to be able to put the hands on that thing that you need, like X [name] who I really trust. The communication is excellent." (HV 2)

"We've had the outreach worker which is great because they can work with the families when you need them to." (HV 9)

"I think all our families have been seen by the outreach worker and [we are] getting positive feedback about that as well." (HV 10, 11)

However, one group of HVs remained unclear about the role and structure of the team:

"I don't know what they do to be honest with you, I'd like to know what they do, I know they are generally nursery nurses and they go in and they play with the children and speak to the mums about play but I don't know what their structure is." (HV 3, 4)

Family support
Comments on the family support service were also largely positive:

"It's a very good service that one, I think the problem is that they're over-stretched. They are finding that they are having to make choices, they're run ragged really, I think. But it's great work and really useful to us. I think the client's value it also." (HV 3, 4)

".. the safer care workers will do joint visiting and you can phone up for advice and [they are] very open to becoming part of the care plan."(HV9)

"When they've been needed they've been good, they've been prompt in seeing families." (HV 10, 11)

However, some staff were unclear about their specific agenda:

"...and really we don't quite know the safer care workers agenda as such, we tend to think the way it started was for them to work with families to prevent them from going on the register, but what we seem to find they seem to work more with families that are on the register." (HV 7, 8)

BIBs team
Questions about the peer/midwife support for breastfeeding service (BIBs) provoked the widest range of comments. Some had nothing but praise, referring to the BIBs service as *"very good." (HV 3, 4)*

A number of HVs commented positively on the effects of peer rather than professional support:

"I think it's that they're offering that support early on and they're from the community, they've been there, tried it and mother's obviously appreciate that support and it appears to influence their choices." (HV 3, 4)

"...it's peers supporting peers, and it's a project for local women and they've proved to work and be successful." (HV 2)

"..they relate well to the families because they are coming in as one of them." (HV 1)

On the other hand, three of the 10 HVs were more critical, speculating whether the strong focus on breastfeeding had made some mothers feel guilty for making other choices. One said,

"I think the breastfeeding workers are an important team, they do some very good work, but some people are made to feel guilty..." (HV 9)

Nurseries
The SS nursery provision was universally praised:

"I appreciate the nurseries, to refer the children to but also as a good source of information, if you're worried about a child's speech or eating, or behaviour, it's very handy to be able to contact the nursery to find out how they are there. " (HV 3, 4)

"When I've wanted a nursery placement to be increased or wanted a nursery placement for someone, they're as accommodating as they possibly can be." (HV 2)

We actually get good feedback from Wolfe Rd nursery, don't we, X [name] does ring us up if she's got a problem with any of the families or they are not turning up, she does contact us and she does give us feedback." (HV 7, 8)

"I think the nursery on Wolfe Road's been successful,.. I think they [local parents] really fully appreciate that and it gives them a break. ." (HV 7, 8)

It's nice that it's fairly local and it does make a big difference." (HV 10, 11)

Difficulties
Other specific difficulties HVs raised in relation to Sure Start covered a variety of areas

- Child protection:

This was felt sometimes to be area of confusion, with some concern that communication difficulties could result in a lack of co-ordination:

"We do have a problem with Child protection, and who's doing what." (HV 3, 4)

The concern in this case related to the increased number of professionals and the consequent raised likelihood of communication breakdown, known to be a factor associated with increased risks to vulnerable children.

- Hard to reach families:

One HV expressed the view that Sure Start was not managing to attract those families with the most entrenched and difficult problems:

"The calibre of clients that have accessed it [SS] themselves were quite empowered anyway and would take on board the information they were given. Families where I've made the referral [who have] more difficult complex problems, possibly will not if I'm being honest, but they might not have felt that about anything." (HV 2)

- Variety of methods

Some felt there was an over-reliance on groups as a method of working:

"There isn't a variety, it could be more varied what they are offering and more individual work which is more time consuming. This area is renowned for people not wanting to go to groups." (HV 3, 4)

- Resources

It was also felt that health visiting should be given a greater share of the additional resources SS brings:

"Certainly the setting up of Sure Starts does seem to take a lot of time and energy from health visiting...and I do think they need, Sure Start [nationally] needs to acknowledge that and put money in from the start." (HVM)

- Co-ordination

There was also a plea for better co-ordination between the different Sure Start programmes in the city:

"I think one of the big things about Sure Starts is that there hasn't been that citywide overview and the control and accountability that I think there needs to be." (HVM)

DISCUSSION
When new initiatives such as Sure Start develop, which expect a significant input from existing statutory services but do not bring direct additional resources for those services, it seems likely that one of two responses will emerge. Either services already provided will have to diminish or be undertaken by others as attention is diverted to accommodate the demands of a new initiative or staff will continue to act largely as they always have, interacting only minimally with the incoming project and disappointing those who hoped for their active involvement. It would appear that in Foxhill and Parson Cross individual health visitors have displayed a mixture of these responses. This range of response appeared unremarkable to those in the study familiar with the health visiting profession, who readily accepted that this group would have a wide variety of views in relation to professional priorities and practices and a number of demands on their time. However, the effect of this divergence within Foxhill and Parson Cross Sure Start has been to make decision-making on working arrangements between SS and HVs difficult. It has also meant that whilst some HVs are actively involved in supporting Sure Start by attending planning meetings, offering training to staff etc, many are not. Those who anticipated that joint work would extend beyond sharing information and joint visits with individual families to joint planning and delivery of new services have largely been disappointed.

Sure Start nationally sees health visitors as an integral part of the package of services offered to families under the Sure Start banner and therefore expects their work to be counted as a part of the Sure Start output. Locally, however, in Foxhill and Parson Cross the situation is more complex as health visitors work both in and outside the Sure Start boundaries and are employed by an organisation that does not necessarily accept the targets set by Sure Start nationally. This situation is no doubt replicated in other Sure Start programmes across the country. In addition; the divergence of views on priorities and working practices, the number of influences and local expectations of health visitors and recent policy initiatives identifying new roles for health visitors as a professional group, have led to uncertainty over their future, as was seen in this study. Any Sure Start programme manager working within this complex situation will surely face difficulties in asserting that the national Sure Start objectives should be a priority for these healthcare staff. Equally they will be hard pressed to gain clarity about the level of input to Sure Start that can be expected from health visitors. This has evidently been the case in Foxhill and Parson Cross.

The distance between HVs and Sure Start created by the set of circumstances described above has led in turn to difficulties in working relationships. Although the health visitor contribution to Sure Start is largely welcomed and the health visitors in turn have mostly very positive views of Sure Start, finding ways to work together which makes the most of all the skills available to families appears very challenging in places. In order to establish reasonable and agreed expectations of health visitors and plan for joint work to meet the health targets of Sure Start it would appear that a number of areas raised in this research will need to be addressed.

GP attachment/Sure Start neighbourhood working
The question of whether a dedicated team of health visitors should be created to provide services solely within the SS boundaries was a feature of many of the interviews and focus groups conducted. Here again responses were mixed. Sure Start staff understandably felt that this would be a benefit to them. The PCT manager,

however, was very aware of the need to maintain the balance between health visitor input to primary care services and the need for a more coherent response to the demands of Sure Start and other community based initiatives. The health visitor staff themselves expressed a range of views in this area, often related to the degree of acceptance they had experienced by their GP 'hosts'. No one clear view emerged from these practitioners, indicating that there had been no change from the mixed response this proposal received when the Foxhill & Parson Cross Sure Start commenced.

Nevertheless, having to manage the difficulties of working with families living both within and outside the geographical boundaries of Foxhill & Parson Cross Sure Start was raised as an issue by all health visitor respondents. It was also viewed with sympathy by the SS staff. Although the strong feelings this situation initially provoked appear to have diminished, health visitors and PCT managers continue to experience the ethical dilemmas this situation provokes and have to manage the real effects on local families.

PCT managers are currently re-visiting this area as the local situation changes again with some GP surgeries expressing a preference for 'attached' staff to be sited outside surgeries and an increasing number of Sure Starts planned. In the meantime there continue to be a number of health visitors with very few clients within the Foxhill and Parson Cross SS area and a number of staff who will probably in the future have clients in more than one SS area. Keeping these HVs up to date with changes in services and family responses to service delivery will surely become increasingly difficult to manage.

There are evidently losses and gains to be found for health visitors aligning themselves more closely to Sure Start. For this reason, although this proposal has been discussed at various points in the history of the programme, no really satisfactory conclusion has yet been found and the same questions continue to be asked. Although continual reflection on a changing scene may be the best response to this difficult issue, this is very unsettling to staff if not undertaken in a co-ordinated way. The PCT appear to be under pressure to use the same, limited, health visitor resources for a number of purposes. Clearly if these staff are spread too thinly they will go on failing to match expectations through no fault of their own. Decisions about how this unfolding situation is best managed will need to be taken to provide clarity for all working in the area.

Working together

Working together for families across professional and agency boundaries was seen as very important by most involved in this study. Nevertheless there were some problems in this area. For both SS and health visitor staff there were feelings that the contributions they were making to the health and well being of local families were insufficiently valued. Health visitors felt that SS was taking their contribution for granted, co-opting their work into SS outputs without sufficiently acknowledging their source. Some SS workers, on the other hand, felt that health visitors did not always acknowledge their abilities and were unlikely to encourage them to extend their skills. Sensitivities were displayed over role boundaries and skills, and there appeared to be a need for greater clarity in this area. Individuals who felt hurt by the responses of

others expressed some strong views and some distancing from others was apparent as a consequence of these emotions.

Good interpersonal relationships and trust were seen by many as vital to effective working practices, yet this was lacking in some areas. Although some had established effective working relationships, a number of poor experiences and lack of physical proximity combined with emotional distance between some health visitors and SS colleagues seems, at times, to have resulted in somewhat stereotyped views of other groups. It would appear that all staff need to 'hear the stories' of others work with families in order that the range of talents, skills and approaches on offer to families from health visitor and SS services can be appreciated by all involved. In addition it would surely be appropriate for all to heed the words of one respondent who said:

"...I would prefer it...for people to assume that we're doing good work and are very busy and are doing a lot of it, rather than assume that we're not..."

Communication

The issue of communication was raised throughout this study, although feelings about current approaches varied. At a general level information sharing about the programme was felt to be good, but at the interpersonal level it was much more patchy with varied opinions about appropriate levels of information transfer. As the SS programme has grown and new health visitors have arrived in the area it has become more difficult to ensure that sufficient information is passed between staff. A number of staff expressed the view that this may be an opportune time to reflect on current information sharing practices and agree the principles and procedures for the future. However, it would seem that the issue of case co-ordination will need to be addressed before this is possible.

Case co-ordination/management role

It would appear that although health visitors were asserting their role as case managers, their SS colleagues did not always share this view of their role. This seems to have led to a good deal of misunderstanding and difficulty. The authority to delegate work to others, rather than refer families for Sure Start assessment that would appear to go with the title of 'case manager' does not seem to exist for health visitors. Indeed it was not clear that all health visitors were envisaging such a role, with some describing it as a co-ordinating rather than managing role. Sure Start staff, for their part, were asserting their right to make independent decisions over family care.

If health visitors believe themselves to be responsible for assessing the needs of local families and agreeing the work required before delegating specified tasks to SS workers, whilst SS staff see themselves as making their own assessment of need, the clashes of views over authority and communication needs exhibited in this report are hardly surprising. The lack of clarity surrounding this issue seems certain to continue to cause misunderstandings if not addressed and will surely be a barrier to better inter-professional relationships. It may be that anxieties and uncertainty regarding the accountability of the various workers involved with a family lie behind this confusion. Health visitors, as nurses, continue to be accountable for the actions of those they delegate work to. The Nursing and Midwifery Council states:

"You may be expected to delegate care delivery to others who are not registered nurses or midwives....You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision or support is provided" (NMC, 2002)[iii]

Consequently if health visitors are unclear about whether they are delegating work within an extended Sure Start team or referring clients to an independent service, they will be equally unclear about their accountability for the actions of others. This issue surely needs further clarification.

Rules and routines

Every profession has a range of largely unquestioned 'norms' of practice, which new generations, new research or new developments frequently bring into focus. It would appear that for health visitors the questioning of these routines has already begun. A number of the health visitors interviewed in this study felt unable to respond fully to the Sure Start agenda by re-adjusting their priorities as they felt that current structures and 'rules' were prescribing their actions in a number of areas. Although some practitioners felt that the arrival of additional services in SS had to some extent 'freed up' their time by undertaking work that they previously would have done, they did not feel that this had been sufficient to allow them to act very differently. Indeed, some felt that SS had increased the pressure for routine work. A number of health visitors had not felt any decreased workload at all; expressing a view that increased paperwork and meetings had swallowed up any time benefits acquired. It seems likely that this area could profitably be explored further with the health visitors in order to create conditions in which staff are more able to respond to the newly emerging needs of their role within Sure Start programmes.

Decision-making

The range of approaches and views exhibited by health visitors in this study and described by their SS colleagues has resulted in a fragmented response to SS. Although some HVs had taken the decision to devote a significant amount of their time to supporting SS, this was by no means universal. This has created difficulties for the SS programme manager who has not been able to rely on a specific level of HV involvement when planning services. Whilst some individual differences of approach are to be expected, even welcomed, there are some decisions that need to be taken for the service of health visiting (e.g. continued GP attachment or SS attachment). Without a mechanism for this sort of decision-making, important decisions appear to have been shelved and opportunities have been lost as divisions in the views and actions of practitioners have led to impasse. In the absence of any mechanism for agreeing health visitor input into the programme this position seems likely to endure.

RECOMMENDATIONS

It is recommended that action be taken in the following areas:

- *Achieving clarity of purpose*

As many in this study stated, health visitors need the power and autonomy to make decisions in the light of local and family needs and act on them. However these decisions need to be taken in the context of an agreed framework, which

establishes clarity of purpose and priorities. At present health visitors feel overwhelmed by the large range of agendas and priorities they need to consider and appear to be responding to these largely according to their own set of beliefs and values, rather than as guided by an organisational framework. In addition they feel constrained by current work routines, which they believe themselves bound to follow. As a result these staff have exhibited a variety of responses to SS, but most report that SS has had little real impact on their working lives. Creating a mechanism to develop a clear set of priorities for health visitors will take innovative clinical and managerial leadership. Fieldworkers themselves will need to be fully engaged in the process for it to succeed and the researcher is aware that the PCT has already begun work in this area. However, given the variety of views exhibited by health visitors in this study it would seem that consensus over desired change is unlikely to be easily achieved. Therefore, a process for making decisions where opinions are divided will be required. If this is not managed, the current confusion over expectations and variations in working practices seem bound to continue, with a consequent impact on local planning. **It is therefore recommended that the PCT develop and agree a framework for health visiting practice, which establishes clarity of purpose and priorities and takes into account the opinions of Sure Start and primary care colleagues.**

- *Case management*

The confusion regarding the meaning of this term, as highlighted in this report, needs to be addressed. If health visitors are to act as 'case managers' they will need to be better informed about the skills of many SS workers and will need to be regularly updated on the progress of managed families. If health visitors are instead to be seen as 'case co-ordinators' there will need to be clarity over the purpose and scope of this role. **It is therefore recommended that the PCT and F&PC SS develop an appropriate mechanism through which to agree the role of the 'case manager/coordinator'.** In addition there may be a lack of clarity around the accountability of HVs for the actions of SS colleagues. **It is therefore also recommended that the area of accountability is discussed and agreed by the PCT and Foxhill & Parson Cross SS and some guidance is given to staff on the this issue.**

- *Teamwork*

It is apparent that another round of debate is currently underway regarding the benefits and disadvantages of attaching health visitors to the Sure Start team rather than primary care. Whilst it is not for the author of this report to recommend a decision on this difficult issue, it is recommended that this debate be informed by the experiences of other Sure Start programmes around the country, where a variety of models have been developed. Should GP attachment remain the optimum arrangement for health visitors in Foxhill and Parson Cross after such a review, **it is recommended that staff with very small numbers of families within the Sure Start area should transfer care of these families to colleagues who are more closely involved.**

- *Clerical tasks*

A uniform view from health visitor staff in this study was that involvement in Sure Start had increased the amount of clerical work they were required to

undertake. **It is recommended that this clerical work be supported in some way, either by reducing the amount required or by increasing clerical or IT support for the function.**

➢ *Communication systems*

As a number of participants in this study highlighted, contact and communication between the various staff members providing health and social care services to the families within the SS area has been insufficient to prevent misunderstandings and difficulties. Informal networking and formal contact for decision-making is important to the process of developing a coordinated response to the needs of local people. Finding the time for such exchanges is difficult; nevertheless the number of difficulties with communication highlighted in this report would suggest that it is required. **It is recommended that staff should:**

- **review together the needs and methods for transfer of information; taking into account issues of confidentiality, case management and child protection.**
- **Meet more often, informally and formally in SS and HV settings.**
- **Aim to develop an increased number of joint initiatives.**

➢ *'hearing stories'*

A number of staff in this study recognised that others had only a marginal understanding of the scope of their work. This had impacted negatively on feelings of value to others and interpersonal relationships. **It is therefore recommended that a mechanism be found to enable staff to see or hear about the full range of the work of others.**

➢ *Further studies*

As no other comparative studies could be found it is difficult to say to what extent the findings presented here are the result of local or national circumstances. The data generated appeared to indicate that a number of external forces such as policy frameworks, national targets and objectives and professional debates had all played a part in shaping the local picture. **It is recommended that further study is undertaken nationally to establish whether these findings are the result largely of local circumstances or are a pattern repeated elsewhere determined by national issues.**

CONCLUSION

This study highlights the real teething troubles that may occur in the local implementation of a national strategy. The expectation appears to be that SS, like many other newly emerging initiatives, will in some way 'co-opt' local statutory workers, influencing them to change their focus and ways of practice. As has been seen in this report, issues of structure, conflicting priorities, resource shortfalls and local history will all impact on the success of this venture. In this case study the SS manager is a HV with an intimate knowledge of local services and a great deal of personal influence which have all helped her to secure a continuing dialogue with her HV colleagues. However, these colleagues are unprepared to commit large amounts of their resource to developing new SS services as she had hoped, largely because

they are at the receiving end of a large number of demands on their time and they remain unclear about their priorities for action. As was stated earlier it is likely that these difficulties are being replicated across many of the SS programmes already in progress. Only further studies in other areas will confirm or refute this.

Despite these difficulties, this study has highlighted many positive features of joint working between Foxhill and Parson Cross Sure Start and health visitors. Health visitors are very clear about the benefits of the Sure Start programme and feel it will have a positive effect on the health and well being of local families. Sure Start staff are also positive about the contribution of health visitors and would like to see them as a more integrated part of the Sure Start team. However, the report has also highlighted a number of tensions and difficulties in relation to health visitor involvement. At the time of writing it is apparent that some work is already underway to resolve these. It is hoped that this report will serve to enable all involved to hear the views and experiences of others and highlight the areas where change and growth is possible. Looking to a future in which it is envisaged that Sure Start will become a 'mainstream' service reinforces the need to act to resolve current tensions in order that the families of Foxhill and Parson Cross receive the best possible service for their needs.

References

[i] Sure Start website www.Sure Start.gov.uk
[ii] Department of Health (2001) Health visitor practice development pack, DoH, London
[iii] Nursing and Midwifery Council (2002) Code of Professional Conduct, NMC, London