School of health and related research
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University of Sheffield

A Review of Community Nursing in Doncaster West PCT

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

Malcolm Whitfield, Kate Gerrish

A compilation of research based reports to inform the modernisation of community nursing services in Doncaster West PCT

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Professor Ron Akehurst,
Dean of the School of Health & Related Research

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Introduction

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

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

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

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

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

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

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Modernising Community Nursing in Doncaster West PCT

(The national policy objectives and their evidence base)

A compilation of research based reports
to inform the modernisation of community nursing services
in Doncaster West PCT

report 1

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chapter one
public health targets

health inequalities

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

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

a fairer society

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

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

building healthy communities and tackling inequalities

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

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

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

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

education and early years

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

employment

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

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

housing

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

reducing crime

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

transport and mobility

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

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

other public health issues

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

example 1

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

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

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

example 2

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

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

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

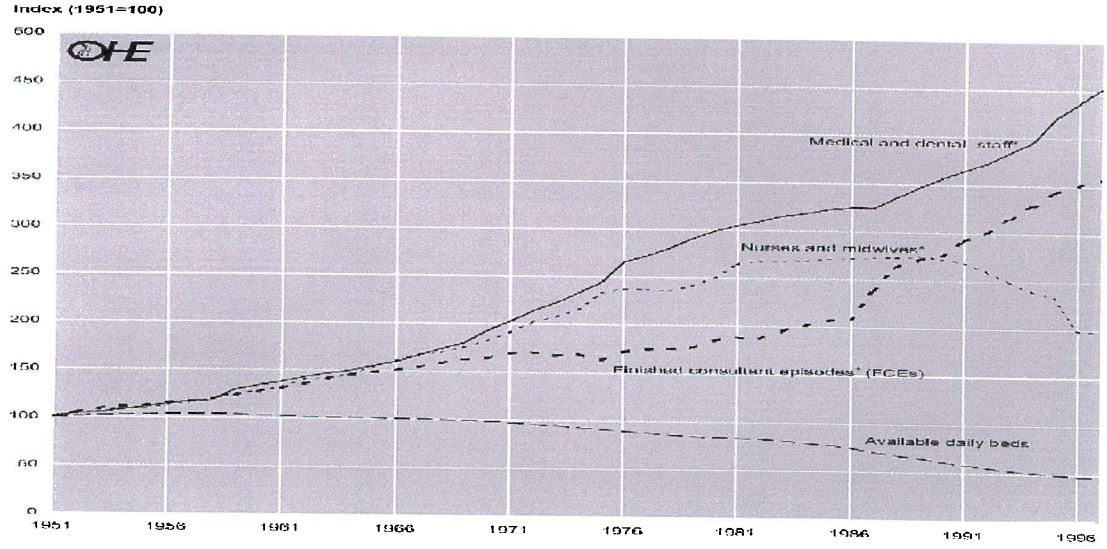
chapter two

the nursing workforce

recruitment and retention

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

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



Notes: *Figures relate to whole time equivalents (see also Table 3.6)
†Prior to 1982/83, figures relate to discharges and deaths
Sources: See Table 3.6

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

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

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

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

enhanced recruitment from ethnic minority backgrou

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

example

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

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

a) promoting culturally appropriate services.

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

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

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

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

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

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

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

an ageing community workforce

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

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

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

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

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

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

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

issues to consider

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

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

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

education and training

pre-education training

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

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

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

continuing professional development

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

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

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

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

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

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

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

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

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

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

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

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

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

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

improving working lives

modern career frameworks

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

flexible working - family friendly policies

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

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

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

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

reduce work accidents and sick absence.

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

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

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

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

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

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

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

chapter three

developing nursing services

enhancing the quality of care

clinical governance

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

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

evidence based practice

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

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

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

clinical benchmarking

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

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

example

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

enhanced professional development

professional self-regulation

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

strengthening leadersip

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

clinical supervision

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

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

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

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

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

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

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

Factors militating against the successful implementation of clinical supervision include:

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

Keys to success include:

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

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

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

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

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

extended roles

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

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

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

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

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

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

nurse practitioner roles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

working in new ways

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

The NHS Plan will mean:

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

Targets of importance to nursing:

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

Measures to reduce GP workload:

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

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

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

Other issues:

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

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

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

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

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

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

integrated working / nursing teams

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The aims of the study were to:

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

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

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

d) identify key areas for change.

e) define new roles and responsibilities.

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

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

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

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

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

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

nurse prescribing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

workload management

skill mix

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) Consider district nurses' understanding of complete care.

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

[35] McIntosh, J., Moriarty, D., Lugton, J. & Carney, O., "Evolutionary Change in the Use of Skills Within the District Nursing Team: a study in two Health Board areas in Scotland", *Journal of Advanced Nursing, 32 (4), (2000), pp. 783-790.*
[33] Humphries, J., & Tonge, J., "Looking Ahead: a forum on the future of school nursing", *Community Practitioner, 73, (12), (2000), pp. 881-883.*
[36] Rapport, F., Maggs, C., "Measuring Care: the case of district nursing", *Journal of Advanced Nursing, 25, (1997), pp. 673-680.*

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

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

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

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

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

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

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

to a mechanistic ability to carry out specified tasks.

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

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

caseload management and review

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

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

referral criteria

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

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

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

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

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

resource allocation

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

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

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

chapter four

service organisation and delivery

new model of service delivery

planning / commisioning

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

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

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

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

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

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

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

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

District nursing

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

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

School nursing:

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

Health visitors:

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

Other issues:

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

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

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

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

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

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

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

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

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

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

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

pms pilots-nurse led services

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

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

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

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

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

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

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

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

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

nhs direct, walk in centres and one stop shops

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

Walk-in Centres

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

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

intermediate care

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

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

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

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

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

out of hours services

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

pcg / pct development

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

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

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

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

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

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

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

[49] Centre for Innovation in Primary Care *"PCG Development: early perceptions from North Sheffield Primary Care Group, (CIPC, Sheffield, 2000).*

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

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

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

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

innovations in health visiting

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

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

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

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

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

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

health visitor / school nurse innovation fund[50]

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

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

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

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

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

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

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

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

delivery mechanisms

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

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

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

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

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

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

[52] Cowley, S., "From Population to People: public health in practice", *Community Practitioner, 72, (4), (1999), pp.* 88-90.
[53] Allen, D., "The Vision Thing", *Community Practitioner, 73 (2), (2000), pp. 461-463.*

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

The challenges were seen as:

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

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

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

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

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

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

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

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

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

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

innovations in school nursing

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

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

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

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

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

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

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

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

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

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

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

between school nursing and the education system.

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

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

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

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

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

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

practice nursing issues

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

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

[59] Humphries, J., & Tonge, J., "Looking Ahead: a forum on the future of school nursing", *Community Practitioner, 73, (12), (2000), pp. 881-883.*
[60] CPHVA, QNI, RCN, *School Nursing Within the Public Health Agenda: A Strategy for Practice, (CPHVA, London, 2000).*
[61] Centre for Innovation in Primary Care, *What do Practice Nurses Do? A study of roles and responsibilities and patterns of work, (CIPC, Sheffield, 2000).*

grade.

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

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

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

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

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

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The Review of Community Nursing Services across Doncaster West PCT

A Report on the Consultation with Key Stakeholders

A compilation of research based reports
to inform the modernisation of community nursing services
in Doncaster West PCT

report 2

Contents

Introduction

This report is one of a series produced as part of a consultancy project to generate research based information to support a review of district nursing and practice nursing services provided by Doncaster West Primary Care Trust and to advise the established multi-disciplinary Steering Group on issues of effectiveness, efficiency and compliance with the modernisation agenda. The project has been undertaken by the School of Health and Related Research and the School of Nursing and Midwifery at the University of Sheffield during the period August 2001 toApril 2002.

The key objectives of the project are to:

i. Describe the objectives and role of the current district nursing and practice nursing services and compare this with current policy requirements and established best practice.

ii. Examine the allocative efficiency of the current district nursing and practice nursing services in relation to demand, need and future trends.

iii. Review the technical efficiency of the district nursing and practice nursing services in relation to skill mix, workload management and organisation of service provision.

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

This report focuses specifically on presenting information collected from district nurses and practice nursing in the Doncaster West health community on their perceptions of the objectives of the current community nursing service in relation to the various policy objectives and their opinions on the future strategic direction for the service to take.

chapter one
method

The consultation process comprised a series of focus group discussions with two separate groups of district nurses and one group of practice nurses from Doncaster West PCT. The interview agenda explored the respondents' perceptions of the key priorities impacting upon primary health care as a result of the government's modernisation agenda, the current capability of the nursing workforce to respond to these demands, the constraints hindering community nursing's ability to engage in the modernisation agenda, ideas for how such barriers might be overcome, the strengths of the current service and opinions as to the future direction of community nursing. With the participant's permission some of the focus groups were tape-recorded and detailed notes were subsequently made of the points raised. All participants were assured that the information they provided would be treated confidentially and their anonymity would be preserved in the report of the consultation process.

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

This report begins by providing an overview of the organisation of district nursing and practice nursing in Doncaster West PCT and considers contextual issues that impact upon the modernisation of community nursing. It then considers the key issues that the focus group participants identified as being important to the future development of community nursing services. It concludes by summarising the main issues arising from the consultation process that need to be considered in taking forward community nursing services.

chapter two

the organisation of community nursing services

At the time that the consultation took place district nurses, together with health visitors and school nurses, were employed by Doncaster West PCT whereas practice nurses continued to be employed by individual GP practices in the PCT. District nurses were 'attached' to one or more general practices with responsibility for providing a service to the respective practice populations.

The PCT had established a Multi-Agency Steering Group within Doncaster West in order to inform the future development of the community nursing service.

The Trust had appointed facilitator posts in district nursing and health visiting with responsibility for supporting the development of clinical practice and clinical governance, and facilitating the dissemination and uptake of innovative practice. Plans were reported to be underway to appoint a similar post in practice nursing.

chapter three

the current context of community nursing in doncaster west pct

Community nurses in Doncaster West were seen to be working in a complex and changing primary and community care environment. The current Labour government's policy agenda to modernise health and social care was considered to be enormous and carried major implications for the development of primary health care services in general, and community nursing services in particular. It was recognised that a modernised community nursing workforce would need to reflect the modernised health and social care services that were needed. To this end, the review of district nursing and practice nursing needs to be seen as part of an overall strategic response to wider policy directives on improving health and health care in Doncaster West.

A number of contextual issues that have a bearing on the modernisation of community nursing in Doncaster West were identified

- The unit of general practice is seen as a significant strength in the provision of primary health care in the UK through providing a clear focus for service delivery to a defined practice population. Although this form of organisation carries many advantages (both actual and potential), for example in terms of collaborative team working and continuity of care, tensions can arise if community nurses see their role including responsibilities beyond the general practice, for example in respect of public health and community development. Quite how these tensions might be resolved by the future PCT is unclear. In the meantime, community nursing must take forward the modernisation agenda whilst at the same time recognising that the boundaries of primary care may shift in the future.

- Although there were clear examples of innovative practice in district nursing and practice nursing, such innovation was not necessarily widespread. Moreover, where innovation has occurred it has often been a result of the motivation and enthusiasm of individual practitioners rather than strategic managerial leadership. Practice nurses in particular, were heavily dependant on the support of General Practitioners and Practice Managers to take forward innovation.

- There was a general perception among district nurses that they were at times over stretched. Problems arose in particular if staff were sick or in covering study leave.

- There appeared to be no perceived in-equality in the distribution of staff between district nursing teams although it was acknowledged that some practices received a more comprehensive service than others. This seemed to reflect differences in referral patterns and the availability of practice nursing alternatives for some functions.

- Doncaster West has a higher proportion of single-handed GP practices in comparison to other parts of Doncaster. As a result, some district nursing teams were attached to a number of general practices and this hindered the extent to which they were able to liaise with members of the primary health care team in each practice. Moreover, practice nurses employed by single-handed general practices generally worked in isolation and lacked peer group support. This situation was particularly difficult for newly appointed practice nurses.

- Prior to the formation of the PCT, a Practice Nurse Forum had met on a regular basis to discuss issues affecting practice nursing. When attendance fell significantly, the Forum was disbanded. Since the PCT had been established practice nurses, alongside other community nurses, were invited to attend a trust wide Nursing Forum. Whereas district nurses were able to exert a degree of flexibility in managing their caseload in order that they could attend the Forum, practice nurses encountered greater difficulty due to clinic commitments and part-time sessional contracts.

chapter four

the public health agenda

Many community nurses, by virtue of the particular role they occupy, engage in public health activities. District nurses, for example, frequently undertake health education with individual patients and support carers; practice nurses, through involvement in women's health, travel clinics and chronic disease management play an important role in promoting the health of practice populations; health visitors attend to the health and well-being of families with young children and school nurses play an active part in promoting the health of school aged children. Rather than merely confirm the public health 'givens' in respect of the roles and responsibilities of community nurses, the focus group discussions considered the current public health challenges highlighted in 'Report 1, The national policy objectives and their evidence-base'. These challenges are expressed in terms of the responsibilities of health authorities and PCTs collectively and in collaboration with other agencies, to address health inequalities, and a call for community nurses to engage more actively in public health work.

The key public health issues identified that impacted upon district nursing and practice nursing are summarised below.

- Public health innovation, whilst clearly in evidence, was not necessarily widespread. and was seen to be driven by the motivation and enthusiasm of the individuals concerned. At the time of undertaking the consultation, there was no comprehensive picture of the range and extent of public health initiatives being undertaken by community nurses in the PCT, although the review did not incorporate health visiting.

- Examples were provided of public health initiatives linked to the government's priorities in which community nurses were taking a lead or actively participating, for example smoking cessation clinics in respect coronary heart disease; other developments were in response to local needs identified by community nurses themselves. However, there was considerable scope to extend public health initiatives linked to the National Service Frameworks. Moreover, community nurses did not appear to have undertaken a health needs assessment of their practice populations or local communities in order to prioritise public health activities. In view of the resource constraints under which community nurses are reported to be working, such tailoring of initiatives to identified need is crucial in order to maximise the impact of public health initiatives on health gain.

- The large number of single-handed practices in Doncaster West presents particular challenges in terms of taking forward the public health agenda. The district nursing resource is spread thinly across single-handed practices and hinders the capacity of district nurses to develop their public health role in relation to practice populations. Practice nurses employed by single-handed practices generally work in isolation with limited capacity to develop take forward public health innovation. Collaborative working across single-handed practices could provide a means of enabling community nurses make a more effective contribution to the public health agenda.

- Health visitors have a major role in responding to the public health agenda. Whereas health

visitors were reported to undertake community profiles there was little evidence of health visitors working collaboratively with practice nurses and district nurses to identify the health needs of practice populations.

- The current public health role of community nurses was seen to receive low priority because of the pressures to deliver core services. Capacity to extend this role was seen to be limited due to resource constraints and inequalities in the allocation of the nursing resource. Although measures were underway to address these problems, the demands placed on community nurses are set to increase with the implementation of the broader modernisation agenda for health and social care. In order for community nurses to extend their public health role within the constraints of the existing workforce, it may be that the different groups of community nurses need to clarify the nature of the particular service they provide and refocus as deemed appropriate.

- Delivering on the public health agenda was seen to require multi-agency working with community nurses establishing new partners, for example, with housing, employment and education. These are not the agencies that community nurses have worked with traditionally, and although some examples were provided of this type of partnership starting to get of the ground, it did not appear to be commonplace. In rolling out the public health agenda the skills and confidence of community nurses in interagency working will need developing.

chapter five

the nursing workforce

recruitment and retention

Reference has been made in 'Report 1 The national policy objectives and their evidence-base', to national concerns regarding the recruitment and retention of nurses. The community nursing workforce was seen to be relatively stable with little movement amongst senior clinical nurses. However, although the PCT currently encountered little difficulty in filling vacancies, it was recognised that recruitment may become more difficult in the future. A number of issues were identified regarding recruitment and retention.

- The proportion of the nursing workforce who will be approaching retirement age in the next 5-10 years is cause for concern as significant numbers of district nurses and practice nurses reported to fall within this group. The loss of so many experienced practitioners over the next decade carries implications for the development of community nursing services unless appropriately qualified replacement staff can be recruited. The need to develop effective strategies for workforce planning and succession planning across Doncaster was highlighted.

- Particular difficulties were reported in recruiting practice nurses of a suitable calibre and with appropriate experience. This related to the idiosyncratic nature of practice nursing, the lack of a clear career framework and inconsistencies in the terms of and conditions of employment of practice nurses. Many nurses applying for practice nurse posts have little prior experience of working in general practice. Given the diversity of the practice nurse role and the specialised knowledge and skills required the situation is problematic and is compounded by the lack of a formalised induction programme for newly appointed practice nurses. The appointment of a practice nurse facilitator to assist newly appointed practice nurses develop their skills and confidence was seen as a potential way forward.

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

education and training

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

- There appeared to be considerable CPD opportunities for district nurses including the proportion with degree level qualifications. Releasing staff from clinical duties in-order to

undertake training, however, was often very difficult.

- There appeared to be well developed appraisal and PDPs for district nurses. However, it was not clear how the individual education needs identified in the PDPs were integrated into an overall education and training strategy for community nursing.

- The ongoing professional development of practice nurses was variable and depended upon the support of GP and practice managers. Although many practice nurses had undertaken short clinical courses relevant to their role, for example cervical cytology, asthma management and diabetes care, very few had gained a specialist practitioner qualification or were undertaking relevant diploma or degree programmes. This was attributed largely to difficulties in practice nurses securing funding and study leave to support continuing professional development. Additionally, practice nurses perceived that GPs were often reluctant to support them undertaking degree programmes as they could see little immediate direct benefit to the practice. Consequently, those practice nurses pursuing higher education programmes generally did so at their own expense and in their own time. However, more practice nurses need to be encouraged and supported to undertake relevant academic courses since it will empower them to develop and improve practice and to contribute more effectively to the development of primary care services. It is also an important consideration in regard to the development of specialist roles in general practice, for example, nurse practitioners and nurse consultants. A significant number of District Nurses had been supported in their attempts to obtain higher education, although finding replacements to cover study leave was a constant source of difficulties.

- Very few practices nurses reported that they participated in an annual appraisal and had personal development plans linked to the needs of the practice. This is an important deficit to be addressed in order to ensure that practice nurses are enabled to maximise their contribution to the modernisation agenda through appropriate education and training.

- All practice nurses participated in TARGET initiatives in general practice. However, although they valued this opportunity it was felt that TARGET focused primarily on information dissemination rather than addressing the continuing professional education needs of practice nurses. The amount of time allocated to attend TARGET meetings meant that there was little opportunity for practice nurses to pursue other CPD opportunities within working hours. Elsewhere in the country, for example Leeds, a relief team of practice nurses has been established to backfill for study leave etc. in order to support the continuing professional development of practice nurses as well as helping in the recruitment to new posts and this may be something for the PCT to consider in the future.

- Practice nurses perceived that they were not presented with the same educational opportunities as other community nurses employed by the PCT and stressed the need for parity with district nursing and health visiting colleagues.

- References has already been made to the need to establish an induction programme and mentorship scheme for newly appointed practice nurses. The current situation, where it is left to the new appointee to plan their own induction is far from satisfactory especially for those working in single-handed practices where there is no peer group support readily available.

- Joint training initiatives involving district nursing and other agencies, e.g. social services for example in relation to intermediate care and the single assessment process required by the NSF for older people need to be considered.

improving working lives

One of the greatest strengths of the community nursing workforce was seen to be the motivation and commitment of many practitioners. Despite all the changes occurring in primary care, morale amongst community nurses was generally reported to be good. Nevertheless, a number of issues were raised in respect of improving the working lives of community nurses:

- Flexibility in working hours was seen as an import means of enhancing the working lives of staff. As a general policy, nurses were able to work flexibly in the event of a family crisis. However, practices nurses encountered particular difficulties in negotiating release due to clinic commitments. Whereas one practice nurse was currently employed to provide temporary cover for leave, it was agreed that the development of a more substantial practice

nurse bank was needed.

- There was considerable diversity reported in the terms and conditions of employment of practice nurses, for example in respect of salary/grading, study leave and annual leave entitlement. Practice nurses stressed the need for standardisation in their employment contracts and consistency in the terms and conditions of employment with other community nurses.

- The ageing community nursing workforce in Doncaster West was seen to present particular challenges in respect of maximising the contribution of these experienced nurses, for example, through providing new opportunities to challenge and stimulate them or for phased retirement. Additionally, it was recognised that an older workforce was more likely to have carer responsibilities for adult dependents and their support needs would be different from younger nurses with children.

chapter six

developing nursing services

enhancing the quality of care

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

- There appeared to be scant information on local audit of district nursing linked to First Assessment.

- Specific initiatives were underway linked to First Assessment, e.g. the role of the district nursing service, the development of referral criteria, caseload management etc.

- A programme of clinical supervision had been established for practice nurses with a choice of individual or group supervision depending on the preferences of individual practice nurses. Although practice nurses had welcomed this initiative, several nurses reported difficulty in attending sessions due to heavy workload commitments. Moreover, there was a lack of consistency in the support practice nurses received to participate in clinical supervision. Some practice nurses attended during normal working hours, others received additional payment to attend outside their contracted hours, however, some practice nurses were able only to attend clinical supervision in their own time and at their own expense. The uptake of clinical supervision by practice nurses was therefore variable.

- Audit activity within the different community nursing specialties was reported to be variable. The PCT agreed the annual audit priorities with the Health Authority, however, these were not always seen to have direct relevance to community nursing. Practice nurses were actively engaged in collating information required for standard audits in general practice but there was little evidence of audit in respect of specific clinical nursing activities in general practice. It was suggested that further consideration needed to be given to developing a more comprehensive approach to clinical audit.

- The Trust had yet to give proper consideration to the implementation of clinical benchmarking criteria identified in the recently published Department of Health 'Essence of Care' [2] although some preliminary discussions were taking place at the time that the interviews were undertaken. The benchmarks, which cover 8 fundamental aspects of nursing care, could provide a valuable means of improving standards of care in partnership with social services and the acute sector.

- Disseminating good practice was seen to be an important aspect of enhancing the quality of care. Whereas the nursing forum provided the opportunity for community nurses to network, as mentioned earlier, some practice nurses encountered difficulties in attending these meetings.

- Practice nurses were involved in developing clinical protocols in their individual practices and

this inevitably led to some duplication of effort and potential variation in standards across practices. Work was underway to start developing some patient group directives and protocols that would be applicable across practices.

- It was acknowledged that the clinical governance implications for practice nursing were considerable. Wide diversity in the roles and responsibilities of practice nurses arising from the idiosyncratic demands and expectations of different GPs, a lack of investment in the continuing professional development of practice nurses and the professional isolation of many practice nurses were major influences. The appointment of a practice nurse facilitator was seen to provide a means of taking forward the clinical governance agenda for practice nursing.

strengthening nursing leadership

Strengthening clinical leadership in community nursing is an important priority of the modernisation agenda. The group discussions suggested that the full potential of community nursing may not be being realised. Investment in clinical leadership at the level of nursing teams was seen to be essential to underpin the implementation of the modernisation agenda.

It was acknowledged that practice nurses have a central role to play in taking forward the modernisation agenda but concern was expressed that this contribution would not be realised without appropriate leadership. Practice nurses stressed the need for leadership provision at PCT level in order to provide direction for the development of practice nursing, empower practice nurses to move practice nursing forward and to address professional development needs. Investment needs also to be made in developing the clinical leadership skills of practice nurses. The appointment of facilitator posts in district nursing and practice nursing was seen as an important step in fostering clinical leadership and developing an empowered clinical workforce.

chapter seven

working in new ways

the scope of professional practice

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

- Practice nurses were generally satisfied with the interface between themselves and district nurses. Although there were no explicit referral criteria, practice nurses felt able to refer patients whom they considered would benefit from district nursing care.

- Practices nurses perceived a degree of failure on the part of some general practitioners and practice managers to recognise the value and complexity of the practice nurses' role. Support for practice nurses to undertake further education and training was not always forthcoming. In looking to the future, it is important that a balance is achieved between getting through the work of general practice and creating an environment that enables nurses to deliver high quality care in an informed manner and provides the opportunity for practice nurses to extend their scope of professional practice.

- Although district nurses were primarily involved in undertaking domiciliary visits some district nurses ran clinics at health centres or general practices. The decision as to whether to provide district nursing clinic was largely historical and based on GP preferences rather than client need.

- Practice nursing had developed considerably in recent years in response to new demands placed on general practice with practice nurses taking on increased responsibility for chronic disease management, health promotion and travellers health. It appeared that few, if any, practice nurses were currently involved in triage and minor illnesses clinics although this was a potential area for diversification and role development, possibly linked to the introduction of nurse practitioners. Practice nurses anticipated that their role would develop, especially in response to the proposed expansion of nurse prescribing.

workload management

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

skill mix

The demands on community nursing to extend the scope of professional practice in order to address the modernisation agenda contrasted with the historical under funding of the service highlighted the need to consider skill mix through out community nursing in order to ensure a cost-effective service.

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

- Although skill mix was well established in district nursing concern was expressed that the skills of different grades of staff were not necessarily being used to best effect. G grade nurses were often tied up with routine care delivery that prevented them from fulfilling key aspects of the G grade role. Most surprisingly District Nurses were either G/H grade or D grade. There were no opportunities in between. The criteria which determined the grade of the post was simply the possession of post-registration training in District Nursing. In contrast a suitably experienced nurse, without a district Nursing qualification could be graded anywhere from D grade to H grade in practice nursing. It is understood that this issue is currently being addressed.

- Opportunities for skill mix review arose when a vacancy occurred within a particular team. In the absence of systematic workforce planning data decisions about skill mix were based on professional judgement and experience of the caseload characteristics.

- The majority of practice nurses were employed at F and G grade although there were a number of E grade nurses in post. Practice nurses generally felt that there was little differentiation between the roles and responsibilities of practice nurses employed at different grades. The particular grade that a practice nurse occupied was seen in many instances to reflect the preferences of the GP / Practice Manager and the funding available rather than the responsibilities of the post. It was reported that work was currently underway to examine the job descriptions of different grades of practice nurse in order to establish some clarity.

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

referral criteria

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

- The district nurses felt that most referrals to the district nursing service were deemed appropriate although there appeared to be no formal mechanism for screening referrals for appropriateness. Cases deemed to be straightforward and of limited duration were assessed by D grades all others were assessed by the G grade.

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

- District nurses considered that both hospital staff and GPs, the two sources for the majority of district nursing referrals, did not fully understand the role of the district nursing service. The situation in the hospital had been improved significantly through the use of experienced liaison nurses. Some referrals to the district nursing service were perceived to be made because there was no other easily identifiable health or social care professional to whom the patient could be referred.

caseload management

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

- G grade community nurses were responsible for caseload management within their particular specialism. The general perception of the District Nurses was that this worked well, although there appeared to be no clear systematic mechanism in place for the proactive approach to managing community nursing caseloads. Similarly there was no systematic approach to caseload profiling across district nursing teams within a locality that could then be used to inform workforce planning. Concern was expressed that current data collected on caseload activity was concerned with basic contact details and did not capture the complexity of district nursing interventions with patients/carers and therefore did not provide an accurate account of district nursing activity.

new nursing roles

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

- Nurse consultant posts are a new development and little is known about the actual contribution such posts might make to primary care. However, with the government's intention to steadily increase the number of nurse consultants in post by 2004 [3] the initiative is a significant one that merits consideration in the context of the development of community nursing services in Doncaster West

- Nurse practitioner appointments in general practice were a very new development with only one such appointment currently being developed. It was not clear if the PCT had developed a strategy for the further expansion of nurse practitioner posts.

integrating community nursing

The need for community nurses to adopt more flexible, integrative and collaborative approaches to providing nursing services in primary care has been emphasised in a number of recent policy documents [3, 4] and had formed the basis of specific guidance from the Department of Health [5]. Although there are different models of integrated working amongst community nurses, the notion of integrated community nursing teams in which district nurses, health visitors and practice nurses attached to a particular general practice work collaboratively in responding to the health needs of the practice population has been advocated by the Audit Commission [1]. Such teams are normally self-managing and carry responsibility for budgetary management [6].

- Although there were some practices where district nurses, health visitors and practice nurses work collaboratively together, they did not function fully as an integrated team in terms of self-managing status and budgetary control for all streams of nursing. District nurses and health visitors being based in the practice premises facilitated collaborative working.

- It was recognised that integrated community nursing teams would be difficult to establish in areas where there were a large number of single-handed practices or where community nursing staff were based some distance from the practice. Moreover, differences in the employment status of various community nurses could pose problems. Although those interviewed were generally receptive to the idea of integrated community nursing teams, it was felt that a mixed economy approach would be most appropriate, possibly with integrated working occurring in some instances at the level of the primary health care team and in others at a 'patch' level amongst a group of practices and possibly with a multi-agency focus.

- Whilst most community nurses expressed a need to provide greater clarity in respect of the roles and responsibilities of community nurses, including practice nurses, caution was voiced against being too prescriptive. Rather than rigidly demarcate the roles and responsibilities of different community nursing practitioners, emphasis should be placed on identifying the

Necessary competencies required to achieve health gain. A health needs assessment of the local community/practice population could be used as a basis for identifying the competencies of different practitioners needed to fulfil the health needs. Whilst not advocating a generic community nurse, there was the potential to breakdown professional boundaries in order to provide a more integrated patient focused-service.

chapter eight

service organisation and delivery

There were clear examples across the PCT of community nursing innovation in service delivery linked to the modernisation agenda. It was not the purpose of the review to appraise the extent to these initiatives, but it was noted that the modernisation agenda would place additional expectations on community nursing to consider new models of service delivery.

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

inter-agency and inter-professional working

The need to enhance and further develop inter-professional and inter-agency working has been identified as an important priority of the modernisation agenda. However, such collaboration may not be easy to achieve because of differences in culture. Joint training between professional groups can be a useful means of breaking down such barriers although there was little evidence of this to date.

- Practice nurses participated with other members of the general practice team in TARGET initiatives and were actively involved in primary health care team meetings. Whereas some district nurses attended practice meetings it was difficult for district nurses attached to several single-handed practices to be actively involved in the PHCT.

- Integration between district nurses and social care seemed patchy. Interagency collaboration amongst front line staff was often dependent on the motivation and commitment of individual practitioners.

- Although there were examples of good practice across the PCT, it was also recognised that there was a need to extend inter-agency collaboration in order to deliver a modernised health and social care service. There was a need to move beyond networking across agencies (which community nurses were seen to be relatively successful at) to actually working collaboratively to address health need.

primary-secondary care interface

Inter-professional collaboration between different health care sectors was also seen to be important.

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

although communication difficulties still arose.

im&t developments

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

- The IM & T infra-structure was in the process of being rolled out across the Trust. At the time of undertaking the interviews, very few practitioners had ready access to evidence-based information via the Internet or an intranet to inform their practice.

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

conclusion

In concluding, it is not the intention to reiterate the issues that have already been identified in the earlier sections of this report but rather to summarise what appear from the focus group discussions to be key priorities in modernising community nursing services in Doncaster West.

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

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

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

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

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

vi. The apparent variation on the allocation of the community nursing resource to different general practices presents particular challenges in taking forward community nursing. In addition to seeking to working towards a more equitable distribution, there is scope to increase efficiency and effectiveness by matching staffing levels more closely to need and to workload, managing caseloads more effectively, and maximising skill mix opportunities. To this end, a more strategic approach could be taken to determining skill mix across community nursing as a whole.

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

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

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

ix. The requirements of clinical governance make it imperative that there are systems in place to ensure a consistently high standard of patient care across community nursing services in the PCT. Considerable progress is being made in respect of policy and protocol development, staff appraisal and personal development plans, continuing professional development, and clinical supervision. However, further consideration needs to be given to monitoring the performance of individuals and teams, clinical audit and benchmarking.

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

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

xi. Key priorities specific to practice nursing include:

- Establishing equity in the terms and conditions of service and grading of practice nurses across the Trust.
- Providing parity in the education and training opportunities across practice nursing and with other community nurses employed by the PCT.
- The development of an induction programme and mentorship scheme for newly appointed practice nurses.
- The appointment of a practice nurses facilitator to support newly appointed practice nurses, facilitate networking and the dissemination of good practice amongst practice nurses.

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Resource Allocation in Community Nursing across Doncaster West PCT

A compilation of research based reports
to inform the modernisation of community nursing services
in Doncaster West PCT

report 3

Contents

Introduction

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

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

   - An estimate of the reported levels of District Nursing and Health Visiting resource for each PCT population

   - A mechanism for the distribution of District Nursing and Health Visiting resources locally between GP practices, or groupings of practices using localised measurements of need and other demand.

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

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

4. In addition to Doncaster West, two other (control) Primary Care Trust areas have been analysed to provide a context against which the Doncaster West results can be judged. The three areas are relatively deprived areas as measured by any of the public health deprivation indicators. However the areas are structured differently to deliver Community Nursing to their local populations. Doncaster West PCT currently provides with Community Nursing services itself as does Control PCT (S). Control PCT (D), however received community nursing services from a combined Acute Hospital and Community NHS Trust until April this year.

chapter one
methodology

resource allocation formulae in the nhs

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

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

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

the national allocation formula

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

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

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

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

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

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

special allocations

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

unified allocations

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

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

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

12. The formula now has three components, reflecting HCHS, GMSCL and prescribing. Each component of the formula is used to produce a weighted population for each Health Authority.

    These are then combined, proportional to the national expenditure on each component for the latest available year, into unified weighted populations. A single distance from target is calculated for each HA and a single pace of change policy is applied.

hospital and community health care services (hchs)

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

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

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

general medical services cash limited (gmscl)

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

prescribing

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

allocations to pcgs

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

hospital and community health services component

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

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

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

age related need - purpose of the age weighting

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

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

inpatient and daycases

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

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

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

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

community health services

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

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

outpatients and daycare

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

other programmes

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

deriving the age / cost curve

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

additional need

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

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

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

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

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

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

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

Acute need index variables

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

Psychiatric need index variables

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

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

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

Community Health Services (CHS) need indices

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

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

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

Community psychiatric need variables

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

overall need weighting

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

36. The next section includes details of the allocation formula and specifically how it derives a figure for community health care services that include elements for Health Visiting and District Nursing.

district nursing and health visiting

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

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

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

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

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

approach adopted for calculation of target allocations

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

41. Next in determining the target shares of the allocation it was necessary to take account of those areas of health care spending which fall outside the description of health services used in the formula for hospital and community health care services (HCHS). These areas are Prescribing and Primary Care. For the purposes of this study the percentages offset for these two areas have been taken directly form the NHS Allocation Exposition book[6] and are standard percentages of 15.238% and 2.924% respectively.

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

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

establishing the actual spending

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

    a) Apply a pro rated share to each PCT based on weighted capitation.

    b) Carry out a thorough audit to identify all cost centers and costs incurred

    c) Base the local expenditure on a workload measure.

45. Option 'c' was the preferred option originally. It would provide more detail than option 'a' but did not involve the volume of work associated with option 'b'. When it came to the collection of workload data from the Community Nursing Services, however, it became apparent that there was a significant lack of faith in the data in all three Trusts. We therefore fell back on the use of option a) whereby we apportioned the reported spend on Community Nursing and Health Authority level on a capitation formulae basis The work will be enhqanced by the production of a locally verified figure for Community Nursing split by District Nursing and Health Visiting headings in the future but at this critically early stage their development Primary Care Organisations cannot take on this task.

establishing resource use at gp practice level

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

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

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

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

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

50. It would be possible to examine resource distribution using other indicators. Jarman under privileged area scores[11] are indicators of deprivation based upon GP workload. However they are a mathematical calculation and are not relevant to absolute deprivation between different population groups. Another possible method for resource sharing would be to apply Limiting

Long Term Illness indicators that are also derived from Census data.

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

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

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

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

chapter two
findings

target resources - national

53. The total national resources are taken from the 2001/02 NHS Allocation Exposition Book[6]. The national resource is allocated to Health Authorities using the National Formula

target resources - doncaster health authority
Control Health Authority (D) and Control Health Authority (S) level

54. Of the total allocation to Doncaster Health Authority and Control Health Authorities (D) and (S) resources should be divided as follows:

Table 1 Resources by Health Authority see Appendix A

	Weightings	Control HA (D) £ '000	Doncasterl HA £ '000	Control HA (S) £ '000
Overall Allocation		438,275	234,962	367,733
Adjustment for admin		- 10,080	- 5,404	- 8,458
Adjustment for prescribing		- 66,784	- 35,803	- 56,035
Adjustment for FHS		- 12,815	- 6,870	- 10,752
Adjustment Total		348,596	186,885	292,488
Community Total	0,1118	38,973	20,894	32,700
Health Visiting	0,1451	5,655	3,032	4,745
District Nursing	0,4970	19,370	10,384	16,252
Chiropody	0,0473	1,843	988	1,547
Community Maternity	0,1060	4,131	2,215	3,466
Other Community	0,2045	7,970	4,273	6,687

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

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

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

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

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

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

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

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

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

actual resources - doncaster west pct, Control PCT (D) and Control PCT (S)

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

Table 3 Actual Expenditure at HA level - Community Health Services

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

NB figures taken from CIPFA[8]

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

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

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

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

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

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

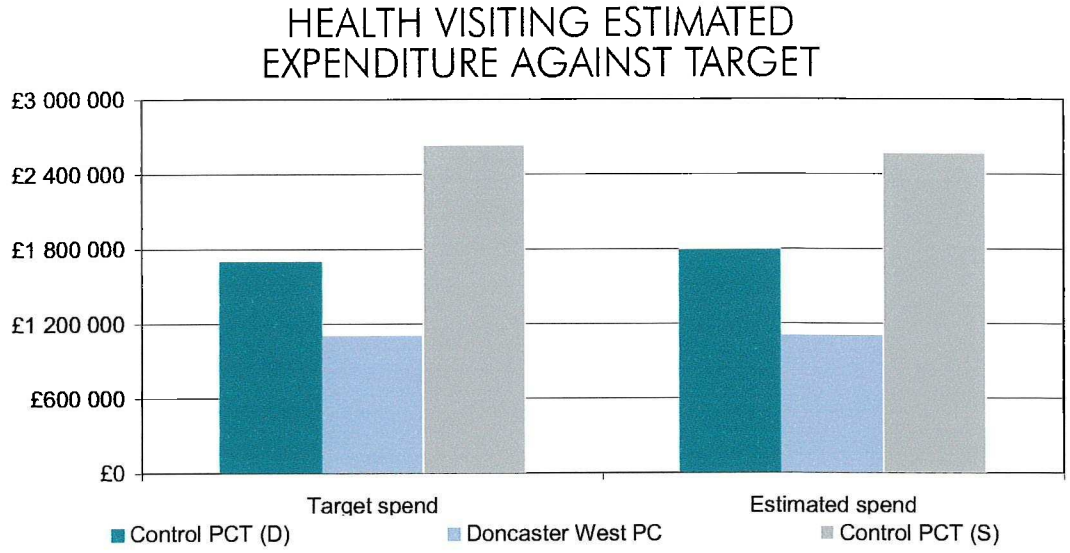
This derives an estimated expenditure for Health Visiting Nursing of:
£1,798,000 Control PCT (D)
£1,105,000 Doncaster West PCT
£2,568,000 Control PCT (S) at the Primary Care Trust levels

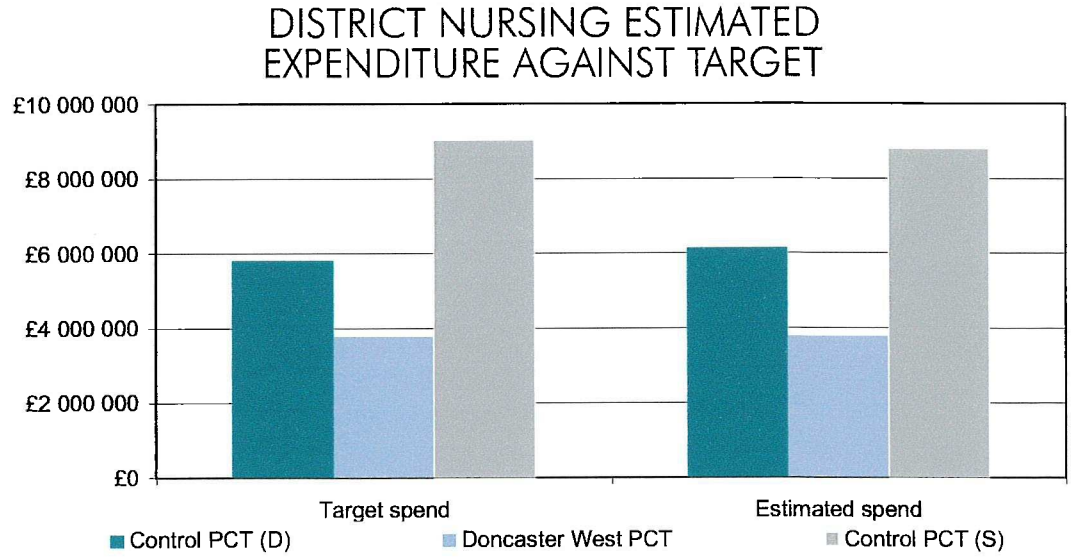
Table 5 The difference between target spend and actual spend

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

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

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





NB The calculation of actual for Community Health care 2001/02 for the Districts is based on Outturn 1999/2000 CIPFAdatabase HAA..

This shows what the Health Authority has spent on Community Services. We have uplifted the figure for inflation estimated at 4% to estimate expenditure at 2001/02 levels. We have then calculated the split of expenditure between the trusts using the 36.48% population split. We have further assumed the split of Doncaster West expenditure between District Nursing Health Visiting etc is the same as the national formulae. Although it is unlikely that the split for expenditure will exactly match the national formula shares it is necessary to use these figures in the absence of any detailed local information i.e. (budgets including apportioment of all on-costs). The actual figures can be inserted once the PCT has had time to undertake a detailed analysis of the Community Nursing budget.

the results - part two

59. The next part of the findings shows the process used to share the target allocation at GP Practice levels. As discussed earlier there is no right or wrong answer to this question. Nor is there a gold standard for resource allocation at this level. As discussed at the beginning of this paper the Townsend deprivation measure would have been selected as the most appropriate means of setting practice based targets. Unfortunately this data was not available at GP Practice level.

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

61. The measurement of resources in this part of the work is by reference to finance. This is the most straightforward comparison. The options of measurement by whole time equivalent staff numbers or by numbers of community nursing contacts are less robust as the outcomes are subject to local nuances about the grading mix for the nurses and also the measurement of nursing contacts needs to be on a consistent basis. We have been unable to clearly identify staff budget allocations at or below locality level for the two control PCTs at this stage although Doncaster West were able to produce this data without any problem whatsover .

analysis by gp practice

62. It should be noted that the target budgets for each GP practice, set out in part one, are gross costs for Community Nursing. That is they take account of any and all necessary running costs, administration and establishment overheads incurred by an organisation providing Community Nursing services. They also include centralized services such as night services or nursing banks. It is suggested that the PCT should calculate these overheads and indirect costs into the whole time equivalent nursing costs. This would help to identify efficient services by allowing comparison between different Primary care Organisation areas and would highlight those areas that incur higher overheads than others.

63. The following charts were developed from data provided by the PCT showing Nursing budgets at practice level. The first group of charts show the percentage of the total population cared for by each practice alongside the percentage of the Health Visiting, District Nursing and combined Health Visiting / District Nursing budget assigned to each practice.

64. Chart 1 below shows the share of identified community nursing resources that would be allocated to each practice in an ideal world based purely on capitation. Weighting of the allocation for deprivation would make a difference but our experience with the control PCTs is that this difference, at this level is normally very small i.e. less than 1%.

Practice	No of Pts	Share of target resources	% Share of Resource
Dr Agarwal	7,139	713,900	6.33%
Dr Anim Addo	6,657	665,700	5.90%
Dr Baig	5,853	585,300	5.19%
Dr Boon	2,392	239,200	2.12%
Dr Burton	10,940	1,094,000	9.70%
Dr Connor	1,426	142,600	1.26%
Dr Fitton	2,141	214,100	1.90%
Dr Gilbert	2,025	202,500	1.80%
Dr Goni	2,495	249,500	2.21%
Dr Haq	3,385	338,500	3.00%
Dr Inman	6,772	677,200	6.00%
Dr Islam	1,709	170,900	1.52%
Dr Khan	2,216	221,600	1.96%

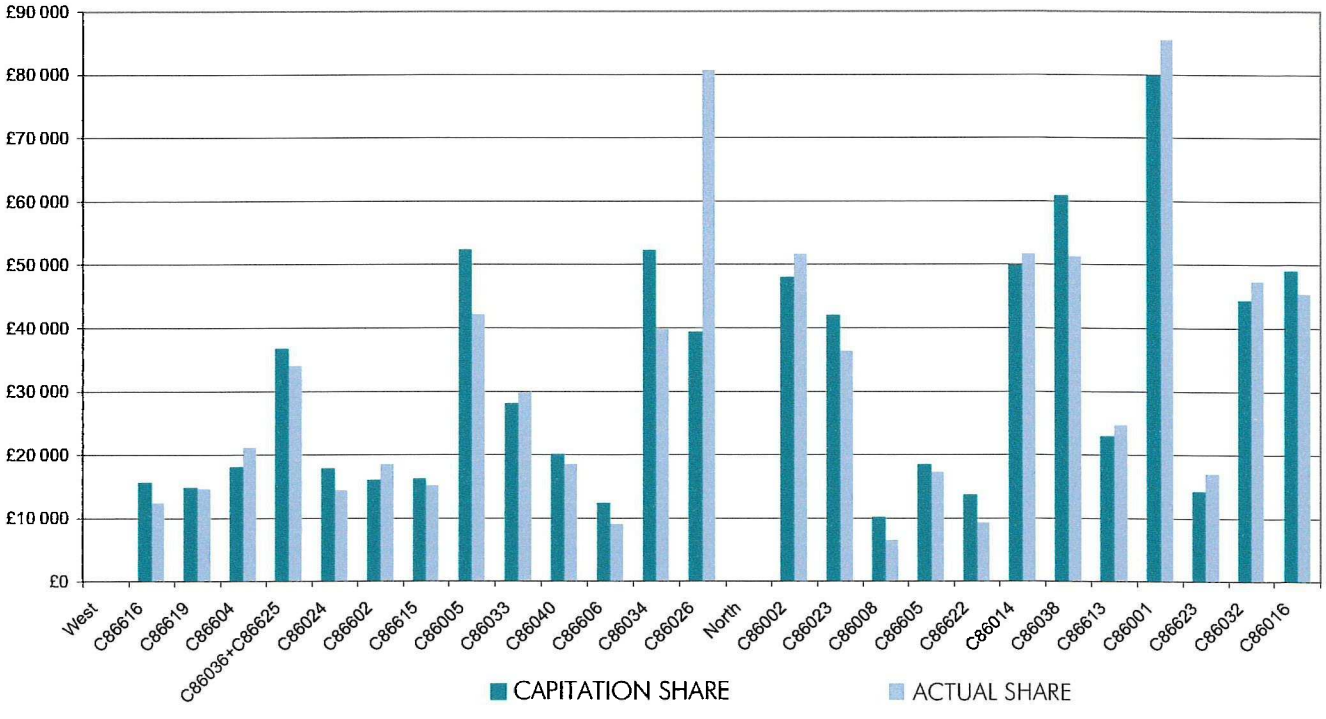
Practice	No of Pts	Share of target resources	% Share of Resource
Dr Kirkpatrick	2,562	256,200	2.27%
Dr Kassam NN	3,435	343,478	3.05%
Dr Kouchouk	1,845	184,500	1.64%
Dr Krishnatheson	2,198	219,800	1.95%
Dr McKenna	8,471	847,100	7.51%
Dr Nagpal	2,746	274,600	2.43%
Dr Nayar	3,894	389,400	3.45%
Dr Nelson	3,191	319,100	2.83%
Dr Rogers	1,715	171,500	1.52%
Dr Sheihk	1,980	198,000	1.76%
Dr Srivastava	7,270	727,000	6.45%
Dr Syed	6,114	611,400	5.42%
Dr Taylor	6,778	677,800	6.01%
Dr Zaidi	5,430	543,000	4,81%

65. Some practices have more than their fair share of the resource on a capitation basis others slightly less. If the calculation were used to inform investment priorities the practices furthest below target would be advantaged in the debate. For some reason the Zadie practice shows up as a massive outlier in both Health Visiting and District Nursing. It is not clear at this stage if this is a data error.

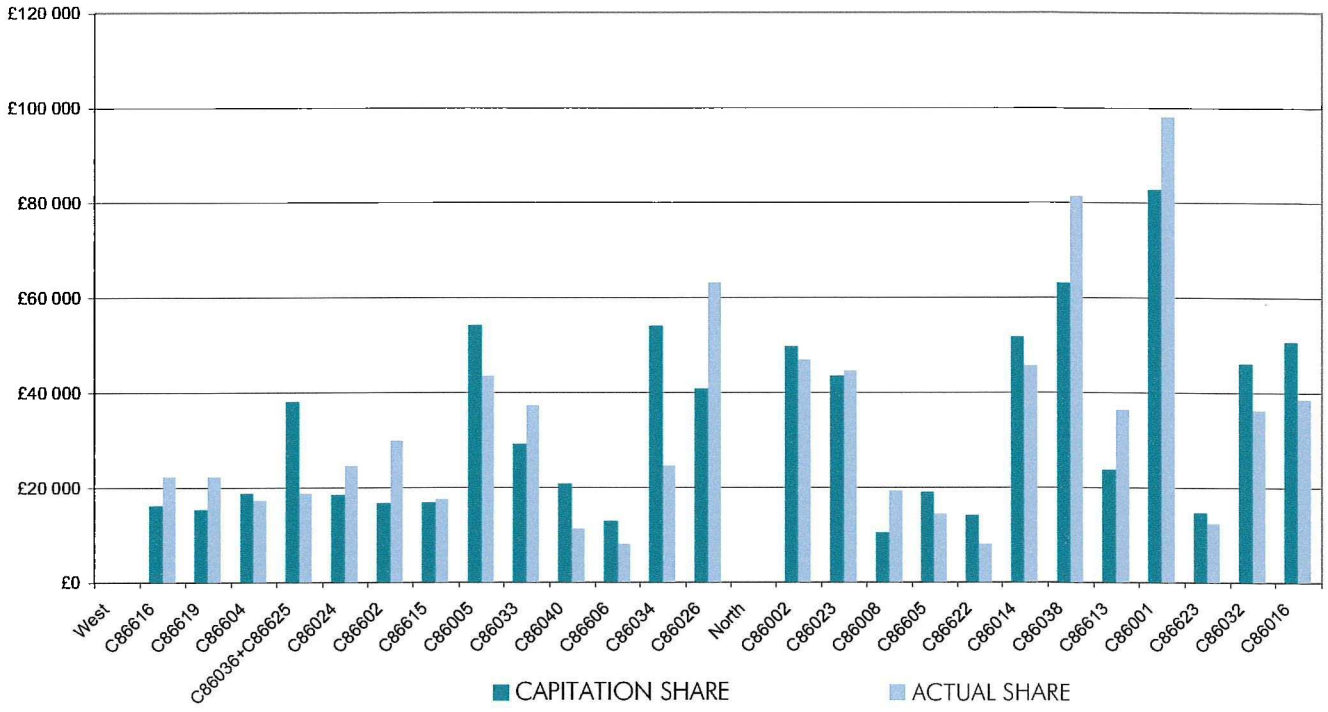
66. The following graphs were calculated by dividing the actual budgets for District Nursing and Health Visiting by the capitation based "fair share" to indicate the proportion you would expect to be allocated to a practice then comparing this with the amount actually allocated.

67. It is acknowledged that practice nurse resources will have skewed allocation of District Nurse time particularly over time. Unfortunately the Trust were unable, at the time, to provide equivalent information for Practice Nurses.

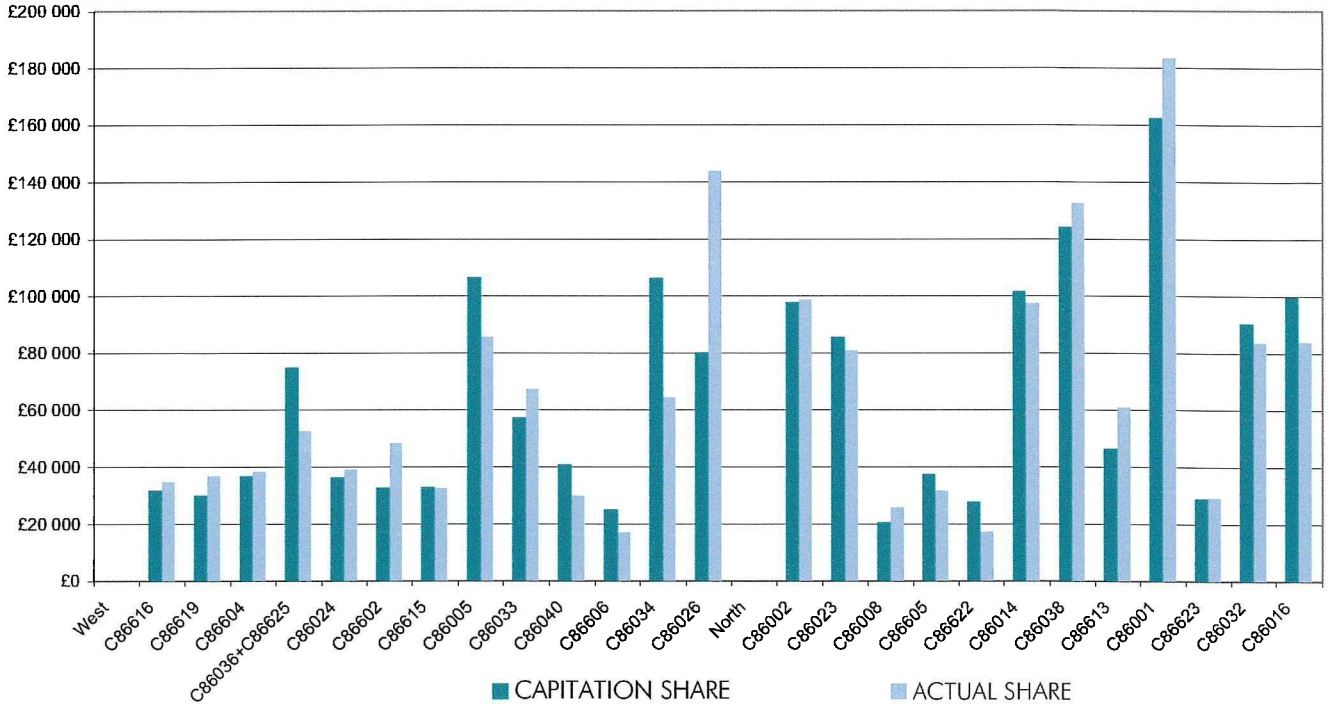
COMPARISON OF CAPITATION SHARE AND ACTUAL SHARE OF HEALTH VISITING RESOURCE



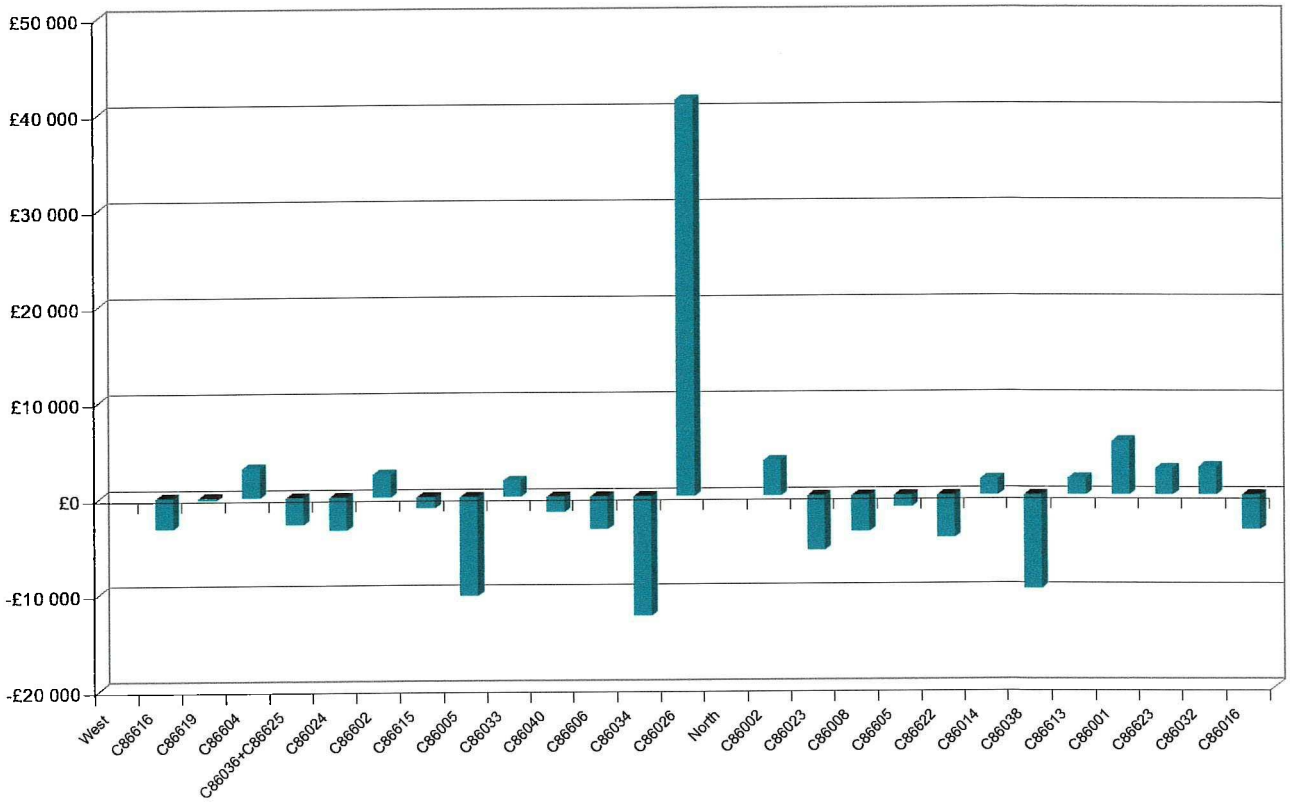
COMPARISON OF CAPITATION SHARE AND ACTUAL SHARE OF DISTRICT NURSING RESOURCE



COMPARISON OF CAPITATION SHARE AND ACTUAL SHARE OF COMMUNITY NURSING RESOURCE

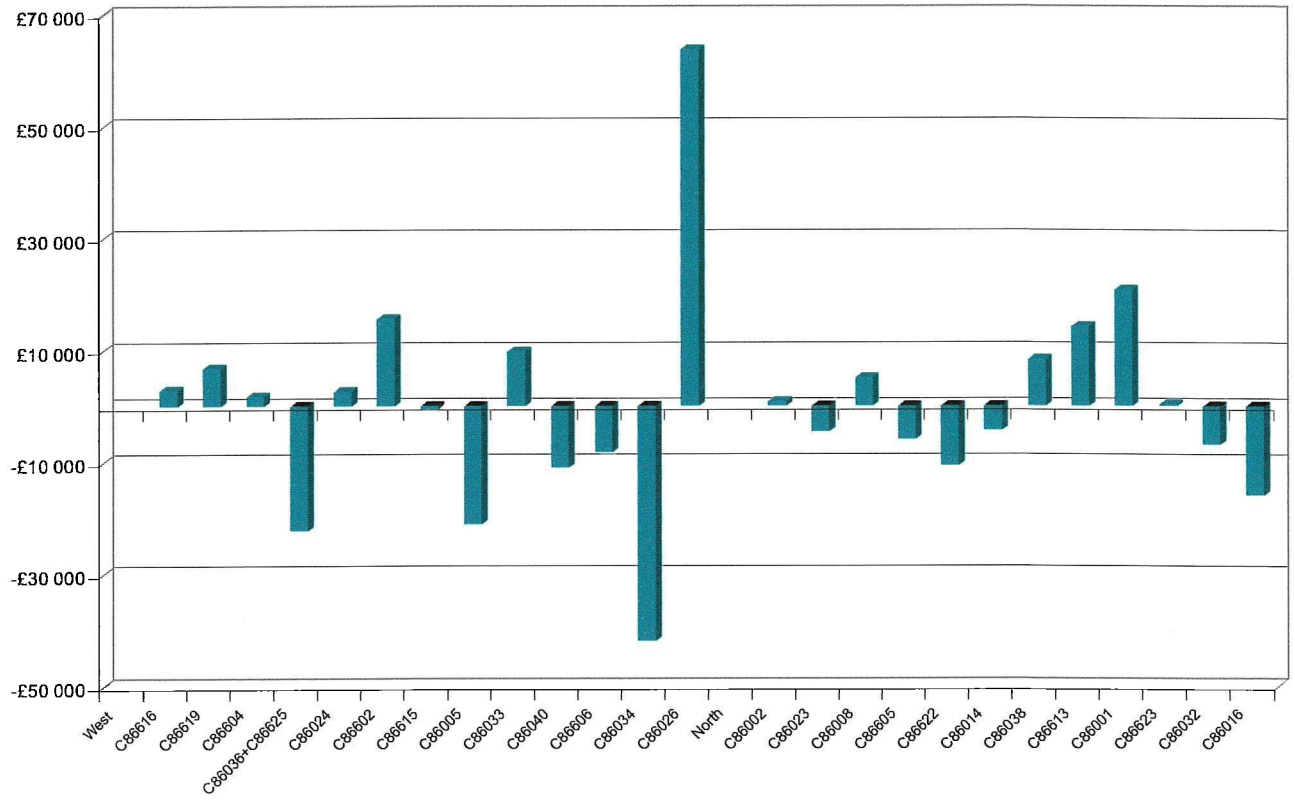


VARIANCE BETWEEN ACTUAL BUDGET AND CAPITATION SHARE HEALTH VISITING

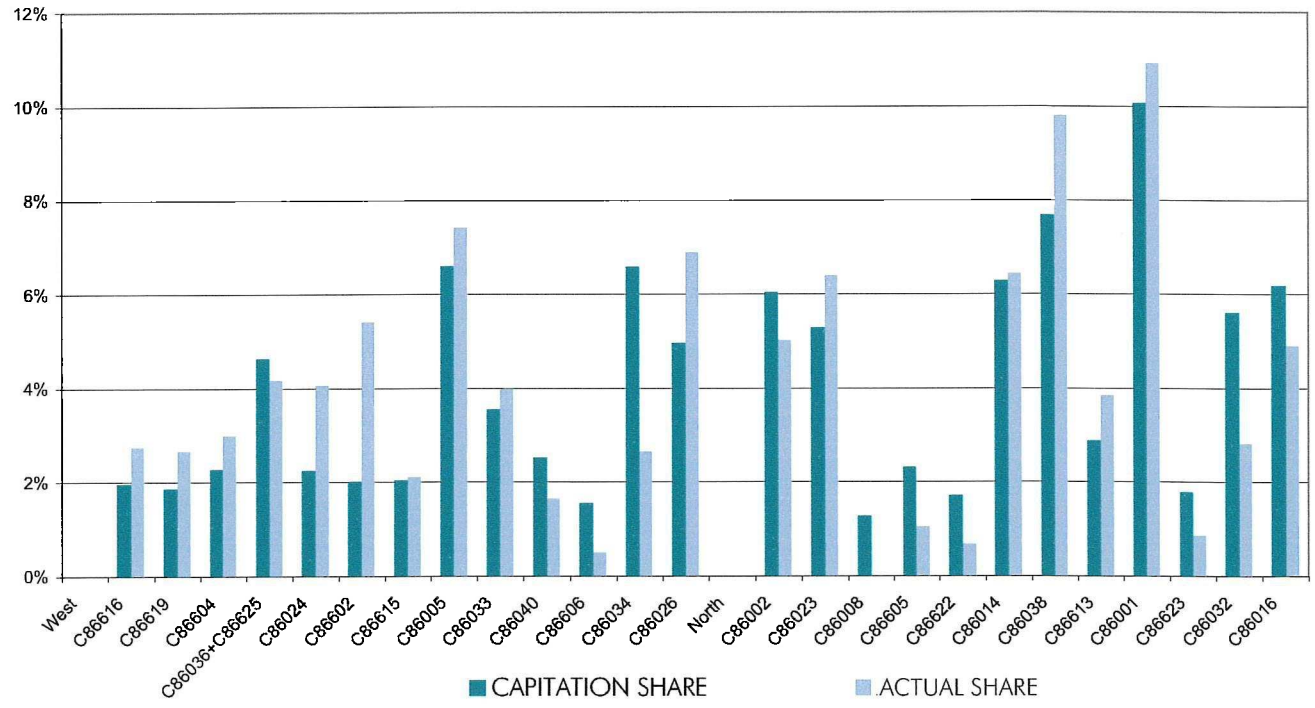


VARIANCE BETWEEN ACTUAL BUDGET AND CAPITATION SHARE DISTRICT NURSING

VARIANCE BETWEEN ACTUAL BUDGET AND CAPITATION SHARE COMMUNITY NURSING

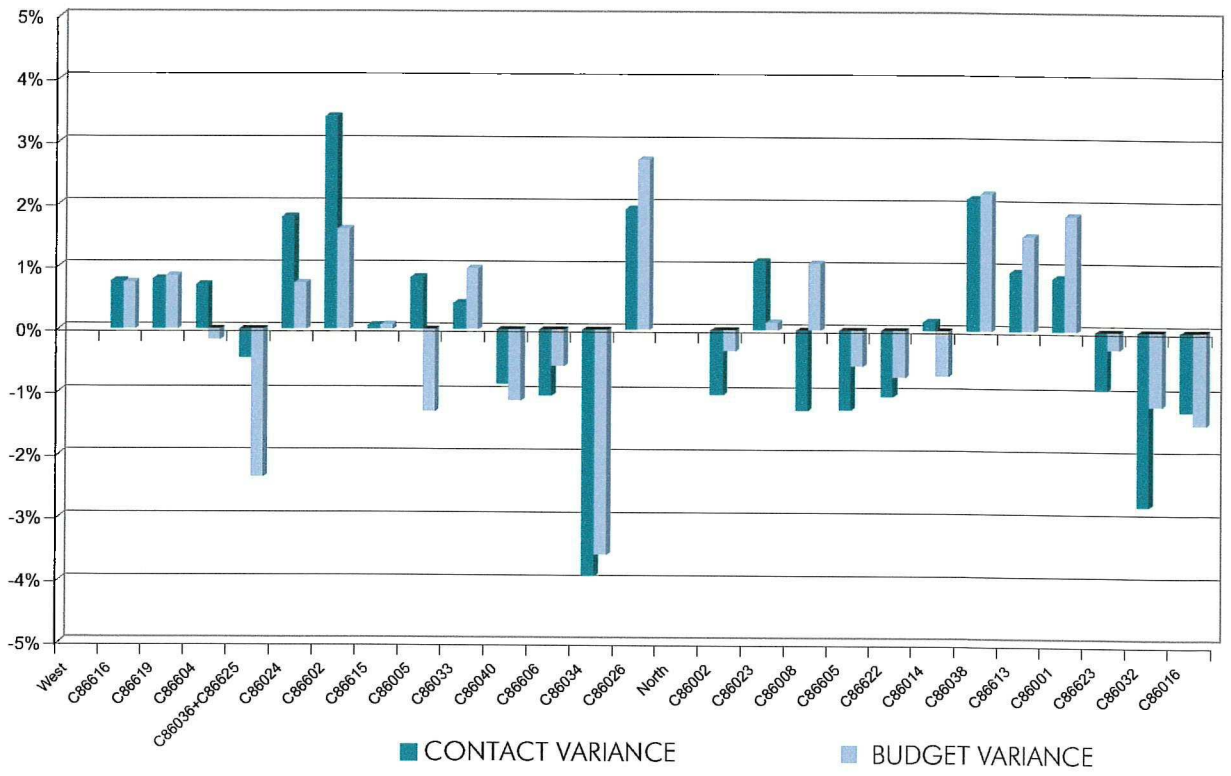


COMPARISON OF CAPITATION SHARE AND ACTUAL SHARE OF DISTRICT NURSING CONTACTS



VARIANCE BETWEEN ACTUAL CONTACTS AND CAPITATION SHARE
DISTRICT NURSING CONTACTS

CORRELATION BETWEEN CONTACT VARIANCE AND BUDGET VARIANCE
DISTRICT NURSING



chapter three

discussion and conclusion

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

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

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

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

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

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

Budget	Target	Actual	Variance	% Variance
CONTROL PCT (D)	£'000	£'000	£'000	
Health Visiting	1,704	1,798	94	5.49
District Nursing	5,838	6,159	321	5.50

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

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

70. This suggests that spending on Community Nursing is currently marginally below the target in Doncaster West, 2.6% below the target in Control PCT (S) and over target in Control PCT (D). This assumes that the calculation of the existing target is correct. The Finance Department will be able to insert actual figures for Doncaster West and adjust the tables accordingly.

appendix a

community health care 'targets' based on needs formula

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

HA	Weightings Allocation	Adj for amin Exp see analysis	Adj for presc Exp see analysis	Adj for FHS Exp see analysis	Adjusted Health Care Exp see analysis	Main Comm Weight 0,1118	Health Visiting 0,1451	District Nursing 0,497	Chiropy 0,0473	Community Maternity 0,106	Other Community 0,2045
Bradford	373 007	10 080	56 839	10 907	295 181	33 001	4 788	16 402	1 561	3 498	6 749
Calderdale and Kirklees	**438 275**	**10 080**	**66 784**	**12 815**	348 595	**38 973**	**5 655**	**19 370**	1 843	**4 131**	**7 970**
County Durham	493 021	11 339	75 127	14 416	392 139	43 841	6 361	21 789	2 074	4 647	8 966
East Riding	427 341	9 829	65 118	12 495	339 899	38 001	5 514	18 886	1 797	4 028	7 771
Gateshead and South Tyneside	300 845	6 919	45 843	8 797	239 286	26 752	3 882	13 296	1 265	2 836	5 471
Leeds	559 240	12 863	85 217	16 352	444 808	49 730	7 216	24 716	2 352	5 271	10 170
Newcastle and North Tyneside	395 871	9 105	60 323	11 576	314 868	35 202	5 108	17 496	1 665	3 731	7 199
North Cumbria	235 539	5 417	35 891	6 887	187 343	20 945	3 039	10 410	991	2 220	4 283
North Yorkshire	512 685	11 792	78 123	14 991	407 780	45 590	6 615	22 658	2 156	4 833	9 323
Northumberland	233 523	5 371	35 584	6 828	185 739	20 766	3 013	10 321	982	2 201	4 247
Sunderland	238 153	5 478	36 290	6 964	189 422	21 177	3 073	10 525	1 002	2 245	4 331
Tees	440 871	10 140	67 180	12 891	350 660	39 204	5 688	19 484	1 854	4 156	8 017
Wakefield	251 077	5 775	38 259	7 341	199 701	22 327	3 240	11 096	1 056	2 367	4 566
Barnsley	186 289	4 285	28 387	5 447	148 171	16 565	2 404	8 233	784	1 756	3 388
Doncaster	234 962	5 404	35 804	6 870	186 884	20 894	3 032	10 384	988	2 215	4 273
Leicestershire	615 919	14 166	93 854	18 009	489 890	54 770	7 947	27 221	2 591	5 806	11 200
Lincolnshire	469 403	10 796	71 528	13 725	373 354	41 741	6 057	20 745	1 974	4 425	8 536
North Derbyshire	270 974	6 232	41 291	7 923	215 527	24 096	3 496	11 976	1 140	2 554	4 928
North Nottinghamshire	283 454	6 519	43 193	8 288	225 453	25 206	3 657	12 527	1 192	2 672	5 155
Nottingham	465 499	10 706	70 933	13 611	370 249	41 394	6 006	20 573	1 958	4 388	8 465
Rotherham	189 182	4 351	28 828	5 532	150 472	16 823	2 441	8 361	796	1 783	3 440
Sheffield	432 940	9 958	65 971	12 659	344 352	38 499	5 586	19 134	1 821	4 081	7 873
South Derbyshire	406 562	9 351	61 952	11 888	323 372	36 153	5 246	17 968	1 710	3 832	7 393
South Humber	234 702	5 398	35 764	6 863	186 677	20 871	3 028	10 373	987	2 212	4 268
Bedfordshire	370 744	8 527	56 494	10 841	294 882	32 968	4 784	16 385	1 559	3 495	6 742
Cambridgeshire	472 551	10 869	72 007	13 817	375 857	42 021	6 097	20 884	1 988	4 454	8 593
East and North Hertfordshire	348 992	8 027	53 179	10 206	277 581	31 034	4 503	15 424	1 468	3 290	6 346
Norfolk	551 633	12 688	84 058	16 130	438 758	49 053	7 118	24 379	2 320	5 200	10 031
North Essex	597 643	13 746	91 069	17 475	475 353	53 144	7 711	26 413	2 514	5 633	10 868
South Essex	502 311	11 553	76 542	14 688	399 528	44 667	6 481	22 200	2 113	4 735	9 134
Suffolk	470 284	10 817	71 662	13 751	374 055	41 819	6 068	20 784	1 978	4 433	8 552
West Hertfordshire	374 913	8 623	57 129	10 962	298 199	33 339	4 837	16 569	1 577	3 534	6 818
Barking and Havering	305 009	7 015	46 477	8 918	242 598	27 122	3 935	13 480	1 283	2 875	5 547
Barnet	248 445	5 714	37 858	7 265	197 608	22 093	3 206	10 980	1 045	2 342	4 518
Bexley and Greenwich	345 432	7 945	52 637	10 100	274 749	30 717	4 457	15 266	1 453	3 256	6 282
Brent and Harrow	371 479	8 544	56 606	10 862	295 467	33 033	4 793	16 417	1 562	3 502	6 755
Bromley	218 662	5 029	33 320	6 394	173 919	19 444	2 821	9 664	920	2 061	3 976
Camden and Islington	396 403	9 117	60 404	11 591	315 291	35 250	5 115	17 519	1 667	3 736	7 209
Croydon	242 431	5 576	36 942	7 089	192 824	21 558	3 128	10 714	1 020	2 285	4 409
Ealing, Hammersmith and Hounslow	581 735	13 380	88 645	17 010	462 700	51 730	7 506	25 710	2 447	5 483	10 579
East London and the City	598 866	13 774	91 255	17 511	476 326	53 253	7 727	26 467	2 519	5 645	10 890
Enfield and Haringey	387 770	8 919	59 088	11 338	308 425	34 482	5 003	17 137	1 631	3 655	7 052
Hillingdon	184 100	4 234	28 053	5 383	146 430	16 371	2 375	8 136	774	1 735	3 348
Kensington, Chelsea and Westminster	361 234	8 308	55 045	10 562	287 318	32 122	4 661	15 965	1 519	3 405	6 569
Kingston and Richmond	256 722	5 905	39 119	7 507	204 191	22 829	3 312	11 346	1 080	2 420	4 668
Lambeth, Southwark and Lewisham	695 407	15 994	105 966	20 334	553 113	61 838	8 973	30 733	2 925	6 555	12 646
Merton, Sutton and Wandsworth	498 646	11 469	75 984	14 580	396 613	44 341	6 434	22 038	2 097	4 700	9 068
Redbridge and Waltham Forest	351 329	8 081	53 536	10 273	279 440	31 241	4 533	15 527	1 478	3 312	6 389
Berkshire	527 723	12 138	80 414	15 431	419 740	46 927	6 809	23 323	2 220	4 974	9 597
Buckinghamshire	443 321	10 196	67 553	12 963	352 608	39 422	5 720	19 593	1 865	4 179	8 062
East Kent	469 623	10 801	71 561	13 732	373 629	41 761	6 059	20 755	1 975	4 427	8 540
East Surrey	289 301	6 654	44 084	8 459	230 104	25 726	3 733	12 786	1 217	2 727	5 261
East Sussex, Brighton and Hove	596 697	13 724	90 925	17 447	474 600	53 060	7 699	26 371	2 510	5 624	10 851
Isle of Wight	108 678	2 500	16 560	3 178	86 440	9 664	1 402	4 803	457	1 024	1 976
North and Mid Hampshire	346 725	7 975	52 834	10 138	275 778	30 832	4 474	15 324	1 458	3 268	6 305
Northamptonshire	386 889	8 898	58 954	11 313	307 724	34 404	4 992	17 099	1 627	3 647	7 036
Oxfordshire	396 426	9 118	60 407	11 591	315 309	35 252	5 115	17 520	1 667	3 737	7 209
Portsmouth and South East Hampshire	397 591	9 145	60 585	11 626	316 236	35 355	5 130	17 572	1 672	3 748	7 230
Southampton and South West Hampshire	390 001	8 970	59 428	11 404	310 199	34 680	5 032	17 236	1 640	3 676	7 092
West Kent	667 819	15 360	101 762	19 527	531 170	59 385	8 617	29 514	2 809	6 295	12 144
West Surrey	434 136	9 985	66 154	12 694	345 303	38 605	5 602	19 187	1 826	4 092	7 895
West Sussex	557 695	12 827	84 982	16 307	443 580	49 592	7 196	24 647	2 346	5 257	10 142
Avon	700 442	16 110	106 733	20 481	557 118	62 286	9 038	30 956	2 946	6 602	12 737
Cornwall and Isles of Scilly	373 576	8 592	56 926	10 923	297 135	33 220	4 820	16 510	1 571	3 521	6 793

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

HA	Weightings Allocation	Adj for amin Exp see analysis	Adj for presc Exp see analysis	Adj for FHS Exp see analysis	Adjusted Health Care Exp see analysis	Main Comm Weight 0,1118	Health Visiting 0,1451	District Nursing 0,497	Chiropy 0,0473	Community Maternity 0,106	Other Community 0,2045
Dorset	526 399	12 107	80 213	15 392	418 687	46 809	6 792	23 264	2 214	4 962	9 572
Gloucestershire	393 675	9 055	59 988	11 511	313 121	35 007	5 080	17 398	1 656	3 711	7 159
North and East Devon	355 185	8 169	54 123	10 386	282 507	31 584	4 583	15 697	1 494	3 348	6 459
Somerset	344 794	7 930	52 540	10 082	274 242	30 660	4 449	15 238	1 450	3 250	6 270
South and West Devon	452 705	10 412	68 983	13 237	360 072	40 256	5 841	20 007	1 904	4 267	8 232
Willshire	410 000	9 430	62 476	11 988	326 106	36 459	5 290	18 120	1 724	3 865	7 456
Birmingham	811 468	18 664	123 652	23 727	645 426	72 159	10 470	35 863	3 413	7 649	14 756
Coventry	242 177	5 570	36 903	7 081	192 623	21 535	3 125	10 703	1 019	2 283	4 404
Dudley	218 770	5 032	33 336	6 397	174 006	19 454	2 823	9 669	920	2 062	3 978
Herefordshire	118 231	2 719	18 016	3 457	94 038	10 513	1 526	5 225	497	1 114	2 150
North Staffordshire	363 668	8 364	55 416	10 634	289 255	32 339	4 692	16 072	1 530	3 428	6 613
Sandwell	243 582	5 602	37 117	7 122	193 740	21 660	3 143	10 765	1 025	2 296	4 430
Shropshire	295 252	6 791	44 991	8 633	234 838	26 255	3 810	13 049	1 242	2 783	5 369
Solihull	144 421	3 322	22 007	4 223	114 870	12 842	1 863	6 383	607	1 361	2 626
South Staffordshire	381 115	8 766	58 074	11 144	303 131	33 890	4 917	16 843	1 603	3 592	6 931
Walsall	194 613	4 476	29 655	5 690	154 791	17 306	2 511	8 601	819	1 834	3 539
Warwickshire	346 213	7 963	52 756	10 123	275 371	30 786	4 467	15 301	1 456	3 263	6 296
Wolverhampton	190 822	4 389	29 077	5 580	151 776	16 969	2 462	8 433	803	1 799	3 470
Worcestershire	355 751	8 182	54 209	10 402	282 957	31 635	4 590	15 722	1 496	3 353	6 469
Bury and Rochdale	298 897	6 875	45 546	8 740	237 737	26 579	3 857	13 210	1 257	2 817	5 435
East Lancashire	416 738	9 585	63 502	12 185	331 465	37 058	5 377	18 418	1 753	3 928	7 578
Liverpool	410 236	9 435	62 512	11 995	326 293	36 480	5 293	18 130	1 725	3 867	7 460
Manchester	412 322	9 483	62 830	12 056	327 953	36 665	5 320	18 223	1 734	3 886	7 498
Morecambe Bay	242 955	5 588	37 022	7 104	193 242	21 604	3 135	10 737	1 022	2 290	4 418
North Cheshire	236 528	5 440	36 042	6 916	188 130	21 033	3 052	10 453	995	2 229	4 301
North West Lancashire	382 876	8 806	58 343	11 195	304 532	34 047	4 940	16 921	1 610	3 609	6 963
Salford and Trafford	367 733	8 458	56 035	10 753	292 488	32 700	4 745	16 252	1 547	3 466	6 687
Sefton	230 009	5 290	35 049	6 725	182 945	20 453	2 968	10 165	967	2 168	4 183
South Cheshire	480 505	11 052	73 219	14 050	382 184	42 728	6 200	21 236	2 021	4 529	8 738
South Lancashire	223 342	5 137	34 033	6 531	177 642	19 860	2 882	9 871	939	2 105	4 061
St Helen's and Knowsley	279 857	6 437	42 645	8 183	222 592	24 886	3 611	12 368	1 177	2 638	5 089
Stockport	209 028	4 808	31 852	6 112	166 257	18 587	2 697	9 238	879	1 970	3 801
West Pennine	353 596	8 133	53 881	10 339	281 243	31 443	4 562	15 627	1 487	3 333	6 430
Wigan and Bolton	446 516	10 270	68 040	13 056	355 150	39 706	5 761	19 734	1 878	4 209	8 120
Wirral	268 682	6 180	40 942	7 856	213 704	23 892	3 467	11 874	1 130	2 533	4 886
England total	**11 648 662**	**267 919**	**1 775 023**	**340 607**	**9 265 113**	**1 035 840**	**150 300**	**514 812**	**48 995**	**109 799**	**211 829**

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School of health and related research
School of nursing &
University of Sheffield

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

A compilation of research based reports
to inform the modernisation of community nursing services
in Doncaster West PCT

report 4

Contents

Introduction

This report covers one of the objectives of the review

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

This report seeks to do the following

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

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

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

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

chapter one

issues to consider in collecting and analysing data

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

what is the question that you wish to answer?

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

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

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

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

2) To understand their views about the proposed changes

3) To monitor the changes over an agreed timescale

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

what will the data be used for?

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

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

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

at what level do you wish to involve respondents?

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

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

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

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

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

can lessons be learnt from experience elsewhere?

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

are sufficient resources available?

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

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

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

what happens to the results?

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

chapter two
choice of methods

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

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

focus groups

Definition

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

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

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

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

Strengths and weaknesses

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

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

3) They can be very intimidating for individuals.

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

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

in depth interviews

Definition

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

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

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

Strengths and weaknesses

1) Good for discussing sensitive topics

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

3) Produces a lot of rich data

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

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

6) Interview skills needed to carry these out effectively

health panels, citizens' panels

Definition

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

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

Strengths and weaknesses

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

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

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

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

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

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

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

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

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

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

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

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

open surgery

Definition

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

Strengths and weaknesses

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

2) Continuous dialogue can be established

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

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

5) It may be perceived to be for complaints only

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

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

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

rapid appraisal

Definition

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

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

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

Strengths and weaknesses

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

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

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

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

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

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

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

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

9) A multi agency team can aid collaboration between agencies

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

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

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

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

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

15) It is open to unrepresentative sampling of key informants

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

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

questionnaire based survey

Definition

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

2) The questionnaire can be distributed by mail or post

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

Strengths and weaknesses

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

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

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

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

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

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

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

deliberative polling / referenda / ballots

Definition

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

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

Strengths and weaknesses

1) Provides clear results in a statistical form

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

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

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

5) There may be a poor response rate

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

conjoint analysis

Definition

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

2) The following steps are taken

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

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

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

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

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

Strengths and weaknesses

1) Measures the strength of preference rather than simply preference

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

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

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

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

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

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

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

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

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

11) It needs specialist health economics skills and analysis packages

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

willingness to pay

Definition

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

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

3) There are four main techniques

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

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

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

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

Strengths and weaknesses

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

2) Firmly rooted in economic theory

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

4) Behaves as might be expected!

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

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

7) Politically sensitive for use in the NHS where it could be seen as attempting to privatise the NHS.

8) Users can respond with protests bids because they object to being asked to pay even in theory.

9) Retired people may not think the technique applies to them because they do not pay taxes. Those on lower incomes may have different views on their willingness to pay from those on higher incomes.

10) Unclear whether willingness to pay increases as the benefit increases or whether people are just willing to pay for a good cause.

11) The technique is sensitive to the starting point used for bidding, the range used in bidding in the payment scale method and the allocation of individuals to each level if bids in the close-ended technique.

12) It needs specialist health economics skills.

consensus methods

Definition

1) The aim of these techniques is to obtain general agreement through a formal process

2) There are three main methods

   a *Delphi method*; where expert individuals are contacted using mailed questionnaires. They do not meet face to face or interact directly, instead they are asked to give their views on items suggested by themselves and other participants. They make decisions privately. The findings are summarised and fed back formally to individuals who can revise their judgements in the light of this feedback. This process can be repeated. Views are aggregated using statistical techniques, sometimes weighting views by expertise.

   b *Nominal Group Technique,* aims to structure interaction within a group of experts. There is face-to-face contact, where each person contributes an idea in turn until all ideas are listed. A facilitator runs the group, records the ideas and ensures that idea is discussed by the group. Individuals privately record their judgements or vote for options. Further discussion and voting may take place. Judgements are aggregated statistically to derive the group judgement.

   c *Consensus development conference,* brings together a selected group of about ten people to reach a consensus on an issue. The meeting is open, operating as a public forum for discussion. Experts or interest groups, who are not members of the decision-making group, present evidence. Implicit aggregation of views takes place by the group retiring to make a decision.

Strengths and weaknesses

These are listed by technique; with the more general ones listed under consensus development conferences

1) *Delphi method*

   a) Gives numerical estimates of participants' views

   b) Allows the exchange of information at low cost

   c) No face-to-face interaction to determine reasons for disagreements, although sometimes participants are allowed to meet once.

2) *Nominal Group Technique*

   a) Allows all members to express their ideas

   b) Allows articulation and discussion of all ideas

   c) Reduces the dominance of some members

   d) It has been likened to focus groups, but is undertaken with a single goal in mind rather than to generate a range of ideas

   e) No weaknesses listed

3) *Consensus development conference and general issues*

   a) No specific strengths or weaknesses identified in the literature, although like the other two techniques the way that information is presented affects the decisions that are made.

   b) Like the other techniques, its use has been confined to professional groups and not used with patients or carers. It is known that users and carers have different views on health care. An example being patients who had suffered a stroke generated different items for communication issues for quality of life measures than a group of clinicians.

c) The choice and balance of groups will affect the conclusions they draw. An example was a study of consensus views on medical education about end of life care in intensive care. The group included three specialists in critical care, six in palliative care, seven in medical ethics, three in medical education, one in communication and one consumer advocate. This power in balance between experts, in particular health professionals and patients, needs to be addressed.

citizens juries

Definition

1) A citizens' jury brings together a group of between 12 to 16 randomly chosen citizens, to deliberate on a question or set of questions. They are enabled to make an informed decision through the provision of written information and through hearing from expert witnesses.

2) Over a number of days, typically 2-4, participants are exposed to information about the issue and hear a wide range of views from witnesses, who are selected on the basis of their expertise or on the grounds that they represent affected interests.

3) With the help of trained moderators the jurors can cross examine the witnesses and call for more information.

4) Following the deliberation the jurors produce a decision or provide a report of citizens' recommendations.

Strengths and weaknesses

1) People participate as citizens not patients or carers and so should provide an objective view.

2) Can be a way of achieving organized public participation.

3) Participants can be chosen to broadly reflect the characteristics of the wider population.

4) Citizens' juries are considered to play a part in democratising decision making processes and enabling a more active form of citizenship.

5) They can enable people to become more competent in decisions and develop a habit of participation.

6) Their greatest strength is the opportunity for informed deliberation jurors can call in other people: professionals, patients, etc to give evidence so they are able to get a rounded understanding.

7) They can be used as a method for priority setting where the subject is emotive, and controversial and depends on value or moral judgements

8) The process is not rushed, so jurors can think carefully and discuss things over with fellow jurors.

9) As a relatively small group, the jurors view may not represent the views of the wider population.

10) Jurors may be introverted and unable to make their views known.

11) There may be a range of issues requiring decisions and it can be difficult to narrow them down so that they can realistically handled by the jury in the time given.

13) The value of the jury can depend on the precise phrasing of the question.

14) Organisation of a jury can be costly and take months.

15) A consensus may not be reached.

16) Little work done to address public acceptability of this method.

17) Not suitable for all issues.

use of the internet to elicit user views

Definition

Most proposed applications of the Internet merely seek to reproduce established methodologies in a way that is facilitated but not extended by the technology for example

a) A questionnaire is translated into an online questionnaire, distributed by email or as an email attachment

b) An interview is conducted over time by email or live via an audio or video link

c) A focus group is run over time by a mailing list discussion group or live via a chat room or virtual meting room

d) A Delphi process can be achieved through successive rounds of staged email messages.

Strengths and weaknesses

1) Research has shown that postal surveys achieve better response rates, although costs are higher

2) Email interviewing, either one to one or via an electronic focus group reduces the problem of the interviewer effect. It can also reduce problems caused by dominant or shy participants. However the richness of the data obtained is not comparable to that of face-to-face interviewing.

3) There are a number of specific data collection problems such as the problem posed by multiple email addresses, difficulties in identifying respondents and verifying their identities.

4) Although access to the Internet is improving it is still selective and some staff, user and care groups are much more likely to have access to the Internet than others. Thus coverage by the group to study is an important issue to address.

chapter three

recommendations for work in doncaster west pct

Collecting and analysing data reflecting the views of patients, carers and staff is an important part of the work of a Primary Care Trust. It helps to ensure that the decisions the PCT makes take account of the views and needs of the staff and the population it serves. It can also be very rewarding not only in understanding and valuing their contributions but also in framing appropriate policy.

The first consideration before collecting data should be the formulation of a clear research question and the aims and objectives that follow from this. It is important to establish what change is possible as a result of the data collection. If it is unlikely that any change is possible than there needs to be a clear reason why data is being collected. Support of key stakeholders within and where appropriate outside the PCT is crucial from the start.

It is also important to establish what other work has been done in the field locally and in many cases nationally. Liaison with other agencies is important to ensure that the project does not duplicate their efforts.

Once the aims and objectives are clear the choice of methods(s) of data collection can be made. This also needs careful thought and there are many occasions when more than one of the methods described can be used. A key issue here is the availability of time and skills to carry out the work. Some of the methods described need specialist input. All forms of data collection and analysis take time and use up resources, often more than was originally anticipated. In some cases data collection may take place over a long period of time or may be part of a continuing dialogue with a group or community.

From the analysis of the data should come conclusions and recommendations for future action; this must be the ultimate purpose of the exercise. These need to be fed back not only to the sponsors of the work but also to the participants.

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appendix 1

an example of a research protocol

This is adapted from the one currently in use in North Derbyshire Health Authority.

TITLE OF PROJECT:

AIM OF PROPOSED RESEARCH:

OBJECTIVES:

1.

2.

3.

OUTCOMES OF RESEARCH:

START DATE: **FINISH DATE:**

LEADER OF THE PROJECT:

Name: JobTitle:

Location and address:

Tel: Ext:

If there are other people involved please list them below.

METHODOLOGY:

Please describe what you intend to use, i.e. Questionnaires or interviews. You should also include information about the target population, how you will sample them, etc.

HAVE YOU DONE A LITERATURE RESEARCH AND WHAT ARE THE KEY CONCLUSIONS FROM THIS?

You will need to show why local research is necessary, if national research exists.

ON WHICH AREAS DO YOU NEED SUPPORT? PLEASE TICK

Drawing up the proposal	☐	Choice of research methods	☐
Sampling	☐	Collecting research data	☐
Analysis of research data	☐	Report writing	☐
Making recommendations	☐	Other (please specify)	☐

.....

WHAT COSTS ARE INVOLVED IN THE PROJECT AND HAVE YOU IDENTIFIED A SOURCE OF FUNDING?

WHAT ARRANGEMENTS HAVE YOU MADE TO DISCUSS THE PROJECT, PARTICULARLY THE RESULTS, WITH PARTICIPANTS?

HOW DO YOU INTEND TO CIRCULATE THE RESULTS?

Please state the group(s) you will be reports in back to and who will be responsible for any follow up action.

You may wish to enclose additional information in support of the application. Please feel free to do so.

Criteria for acceptance of your research proposal

The form attached asks you a number of questions about your proposal. There are a number of issues your replies should answer and these are listed below. These issues will form the basis of decisions on the priority to be given to supporting your project.

1) How the proposed research will answer current health service concerns within the PCT area?
2) Has a comprehensive and literature review been carried out?
3) If similar work has been done elsewhere, what are the reasons for repeating it locally?
4) Should this research be done locally or in conjunction with other health authorities?
5) What is the question that the research is trying to answer?
6) Do the methods proposed appear to be the most appropriate to obtain the data?
7) Does the research incorporate the views of users of the service?
8) What are the resource implications of doing the research?
9) How it is proposed to disseminate the results to the sponsors and participants?
10) How action will be taken to follow up the results of the research?
11) Does the research have (or need) approval by the Ethics Committee?

appendix 2

arnstein's ladder

The levels in Arnstein's ladder of involvement are described below.

1) *Manipulation* level of non-participation where citizens are placed on bodies for 'educational purposes' or to engineer their support

2) *Therapy* another level of non-participation where citizens are involved in some form of group activity to 'cure ' them of their 'pathology'

3) *Informing* - where citizens are informed of the proposal and decisions of officials, often at a late stage where they can have little opportunity to change things

4) *Consultation* - where citizens are asked for their opinions, but without any assurance that their views will be taken into account.

5) *Placation* where citizens begin to have some degree of influence, but this is still tokenistic. Possible example being where they have representatives on a group but this has an inbuilt majority of staff.

6) *Partnership* where power is in fact redistributed through negotiation between citizens and stakeholders. They agree to share planning and decision making responsibilities

7) *Delegated power* where citizens are given dominant decision making authority over a particular plan or programme area

8) *Citizen control* where citizens are given control of a programme through a neighbourhood group