

**THE MOVE TO GEOGRAPHICAL WORKING
FOR HEALTH VISITORS AND NURSERY NURSES
IN DONCASTER**

**A CONCURRENT HEALTH IMPACT ASSESSMENT
OF THE FIRST SIX MONTHS**

Doncaster HIA Steering Group, January 2004

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Copies of the report can be downloaded from:

<http://www.doncasterhealth.co.uk/phiu/pdfs/hvhia.pdf>.

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List of abbreviations

CD	Community Development
CRESR	Centre for Regional Economic and Social Research (Sheffield Hallam University)
DMBC	Doncaster Metropolitan Borough Council
HFAC4	Health For All Children (See references)
HIA	Health Impact Assessment
HV	Health Visitor
LMC	Local Medical Committee
PCT	Primary Care Team
PEC	Professional Executive Committee
PHAAR	Public Health Approach A Reality (see references)
WTE	Whole Time Equivalent

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1 Summary

1.1 Background

In April 2003 the three Primary Care Trusts (PCTs) in Doncaster changed the organisation of health visiting and nursery nurse services from the previous system of practice attachments to one based on geographical teams. The change was proposed following two years work by an innovation group of health visitors and aimed to increase public health and community development ways of working. When the proposals were discussed at the PCT Professional Executive Committees (PECs) local general practitioners in particular had concerns and the PECs decided that the impacts of the changes should be evaluated.

The Public Health Directorate of Doncaster Central PCT was asked to lead the evaluation and the method chosen was a concurrent Health Impact Assessment.

The Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University provided expert facilitation of the work. Their involvement was funded by the Yorkshire and Humber Regional Health Impact Assessment Steering Group.

1.2 Methods

This report discusses evidence of the health impact of the first six months of the change. The report's authors were the members of a steering group who considered evidence from the following sources.

- Review of policy guidance
- Review of evidence base
- Previous public and patient consultations in Doncaster
- Views of Central PCT residents panel
- Analysis of resources in comparison with census deprivation variables before and after the change
- Immunisation coverage data
- Health visitor mileage claims as a proxy for time spent travelling
- An email questionnaire of practice managers
- Evidence from Health visitor team portfolios
- Views expressed at a stakeholder event

Emerging findings were checked at a stakeholder event and the Steering Group then acted as an expert group to weight and assess the evidence for positive and negative health impacts at six months.

1.3 Results

Six months after the change the Steering Group considered that there was evidence of a positive health impact in five areas:

- Health visitors have more knowledge about their neighbourhoods
- Resources are now distributed more transparently and equitably
- Health visitors are providing increased support for families in need
- Health visitors are now using a more community development way of working
- Health visitors now spend around 20% less time travelling

There was evidence of a negative health impact in two areas:

- In general links with primary care teams work less well
- Communication between HVs and GPs is less effective and takes up more time

In three potentially important areas the evidence suggested there had been no overall positive or negative health impact at six months:

- An impact on the effectiveness of child protection
- An impact on immunisation rates
- An impact on the attractiveness of Doncaster as a location for health visitors to work

In one area the Steering Group felt there was insufficient information to reach a conclusion:

- Whether health visitors are feeding back more information on needs to organisations such as PCTs and Doncaster Metropolitan Borough Council (DMBC).

1.4 Conclusions

The overall health impact of the change has been positive.

The overall score given to the impacts by the Steering Group was considerably less than the maximum possible positive score. This emphasises the importance of the recommendations given in the next section to minimise negative impacts and to ensure that all potential positive impacts do occur.

There are two important limitations to the conclusions:

- The conclusions are provisional because it is only six months since the change was introduced; some aspects of the changes were phased in and some substantial impacts (both positive and negative) would not be expected to be apparent this soon after the change.
- The process of introducing and communicating about the change could have been managed better. This makes it difficult to assess whether some of the criticisms expressed refer mainly to the change management process or to the new system itself.

1.5 Recommendations

A summary of the five recommendations made by the Steering Group is given below. More detail can be found in Section 10.7

- I) On current evidence geographical working should continue**
- II) The PCTs should clarify the overall objectives and the distribution of resources within the health visiting services**
 - i) Give guidance on the extent to which resources should be weighted in favour of more deprived areas*
 - ii) Give guidance on the extent to which it is reasonable to expect health visitors to offer substantial services to needful groups other than families within current resource limits*
 - iii) When the work of the local HFAC4 review group is completed (by April 2004). The aims and broad objectives of the health visitor service should be communicated to all stakeholders.*
- III) The PCTs should act to minimise the negative impacts of the changes**
 - i) Reduce negative impacts on primary care*
 - ii) Reduce other negative impacts*
 - iii) Provide resources to facilitate team building for health visiting teams*
- IV) The PCTs should maximise the potential benefits of geographical working**
 - i) Ensure health visitor teams continue to receive training in community development and public health ways of working*
 - ii) Enable and encourage health profiling*
 - iii) Develop a mechanism to enable Health Visitors to feed back health needs information to PCTs.*
- V) The PCTs should use routine systems to evaluate the ongoing impacts of the change**
 - i) Ongoing analysis of significant events*
 - ii) Monitoring of quarterly immunisation cover statistics with comparison with other districts if rates fall*
 - iii) Ascertain the views of PCT resident panels and of service users as recorded in health visitor team portfolios*
 - iv) Health visitor managers to monitor recruitment and retention of health visitor staff*

2 The change to geographical working

This section describes the change from practice based to geographical working, briefly summarises the reasons for the change and describes the methods used in the health impact assessment to produce an interim report on the impact of the first six months of the change.

2.1 Introduction

Doncaster has three PCTs serving a population of 299,000. In April 2003 the organisation of health visitors and nursery nurses in all three PCTs changed so that teams became responsible for geographical areas. Prior to this health visitors were attached to General Practices and had caseloads based on practice lists. In this previous arrangement the amount of HV resource allocated to practices was largely historical with no explicit relationship to need. Individual health visitors, like GPs, had clients spread over a wide geographical area.

In the new configuration there are 62 whole time equivalent (WTE) health visitors in 23 teams. Health visitor teams were involved in the process of deciding their precise geographical areas; in many cases the location of teams' bases remained the same but teams are now responsible for defined areas. The size of the zones was varied according to the size of the team and the perceived level of socio-economic deprivation in the area, in an attempt to adjust for caseload. The areas are described in more detail in Section 5.

In areas where patients had comparatively little choice of general practice (such as some rural locations) relatively few patients will be directly affected by the change. In areas served by many different general practices (such as Doncaster town centre) a higher proportion of patients will be affected by the changes and families will have health visitors who are not based at the same GP surgery the family are registered with.

Although the stated date of the change was April 1 2003, some teams chose to phase some aspects of the change (such as the handing over of caseloads) over time, to minimise the disruption to individual clients.

2.2 Reasons for the change

The change to geographical working was the result of two years work by an Innovation Group of health visitors and nursery nurses. The work of the Innovation Group has been described in a separate paper (Gater and Fitzakerley 2003), and so is only briefly summarised here.

The aims of the Innovation Group were:

- To develop a family centred, public health role for health visitors and nursery nurses working with local communities at a range of levels
- To change from screening to parental support and education
- To change to a service that promotes equity of outcome rather than equity of input
- To change to a skills based approach rather than a role based approach

- To change from a prescriptive to a facilitative approach to health promotion

These aims were strongly influenced by a number of recent policy initiatives affecting the NHS generally and health visitor services in particular. The most important of these are summarised in Box 2.1.

Box 2.1 Key influences on the change to geographical working

- **The Health visitor practice development resource pack (Department of Health 2001)** - This sets out a family centred, public health model for health visiting with the concept of a continuum for public health practice in health visiting, from working with individuals and families, through group work and community development, to the development of public health programs at community level.
- **Liberating the talents (Department of Health 2002) and a specific version of Liberating the talents for community practitioners and health visitors (Department of Health 2003)** - This sets out new roles and opportunities for nurses and health visitors in the context of the changes in the NHS Plan, Shifting The Balance of Power and the modernisation agenda. In particular there is an emphasis on opportunities for health visitors to expand their roles in public and patient participation and feeding back information on health needs to PCTs.
- **Health For All Children 4th Edition (Hall and Elliman 2003)** - This sets out an evidenced-based, health-promoting program for children. There is less emphasis on routine visits and screening for existing problems with increased emphasis on addressing issues in the local environment and building on the strength of communities.
- **Sure Start** - Local and national experience with Sure Start has given practical demonstration of new ways of working, including community development approaches, targeting to areas of specific need and innovative approaches to skill mix.

The Innovation Group took the view that changing the organisational structure to geographical working was necessary to achieve their objectives. Papers setting out this proposal to the three PCT Professional Executive Committees (PECs) gave a long list of potential advantages of geographical working. These lists formed the basis of the positive impacts part of Table 2.2 in the next section.

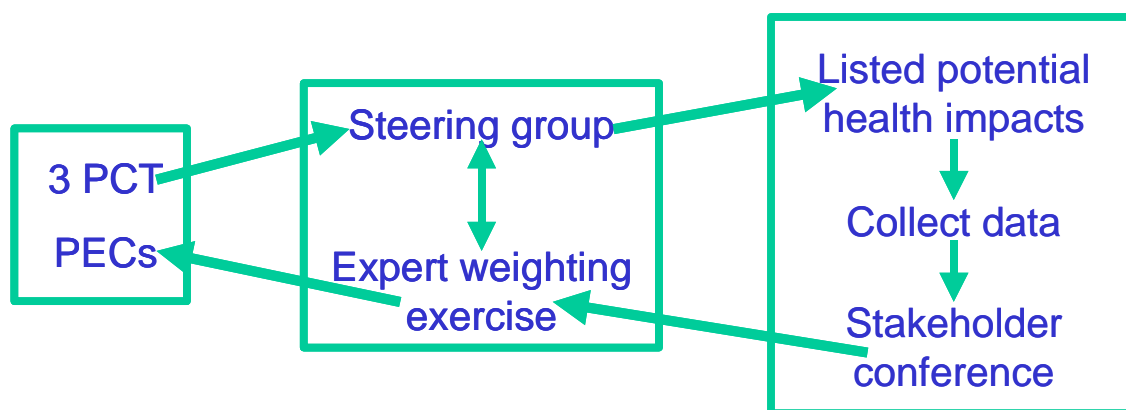
Discussion of the change at the PCT PECs and at the Local Medical Committee showed there was significant opposition to the changes among some GPs who were concerned about the impact on primary care teams. The eventual decision of the PECs was to agree to the changes going ahead but with the proviso that the impact of the change was evaluated.

2.3 Description of the Health impact assessment

Doncaster Central PCT's Public Health Directorate was asked to co-ordinate the evaluation. It was decided to use the methodology of Health Impact Assessment (HIA) to gather information and summarise potential positive and negative impacts of the change. Sue Whittle of The Centre for Regional Economic and Social Research at Sheffield Hallam University (CRESR) provided expert support for the work.

The overall process of the HIA is summarised in Figure 2.1.

Figure 2.1The overall process of the HIA



A HIA steering group was set up (see Table 2.1 for membership) and produced a list of potential positive and negative health impacts (Table 2.2).

Table 2.1Membership of the HIA steering group and additional professional attendees at the Stakeholder event

Membership of the HIA steering group	Additional professional attending stakeholder conference
Health visitor facilitator from each PCT	Health visitors and nursery nurses (19)
3 PCT Public Health Directorates	Local Authority and New Deal for Community, Community Development workers (8)
Health Visitor manager from each PCT	Other PCT managers and health promotion staff (3)
GP (representing the LMC)	GPs and practice manager (3)
Child Health	Child Health (2)
Public Health Intelligence Unit Sheffield Hallam University	Child Protection Advisor
	Community midwife

Table 2.2 Potential health impacts initially identified by the HIA steering group

Health Impact	Category	Sub-category
Potential Benefits	Increased Public Health way of working	Increased support for families
		Increased skills in Community Development work
	Increased efficiency	Less time spent travelling by HVs
	Better use of information	HVs have more knowledge of services available in their neighbourhood
		HV have better information about needs in their neighbourhood
		HVs feed back to PCT more information about their neighbourhood
Opportunity to address inequalities		
Potential Risks	Risk to child protection	
	Risk to immunisation coverage	
	Risk of disruption of primary care teams	Lost opportunities and additional time taken by GPs and HVs in communicating with each other
		Loss of opportunity to integrate HV and primary care records

Various types of information were collected (summarised in Box 2.2) to find out whether the potential health impacts identified had in fact occurred.

Box 2.2 Types of information used to inform expert weighting exercise in addition to own experience and opinion

- | |
|--|
| <ul style="list-style-type: none"> • Review of literature on evidence (Section 3) • Public and service user views from HV portfolios, views of Central PCT Residents panel and from previous consultation exercises (Section 4) • Census information on deprivation scores in relation to number of health visitor numbers (Section 5) • Immunisation coverage rates (Section 6) • Mileage claims (as a proxy for time spent travelling) (Section 6) • Critical incidents and information from emailed questionnaire of GP practice managers (Section 7) • Evidence on changed ways of working from health visitor teams portfolios (Section 8) • Views expressed at stakeholder event (Section 9) |
|--|

The information was presented to a stakeholder event of around 50 Stakeholders. In addition to members of the Steering Group other professionals attended the event as listed in Table 2.1 above.

The aim of the event was partially formative (to contribute to the process of explaining and developing neighbourhood working) but mainly to check stakeholders’ views on the emerging findings and to obtain the views of stakeholders from small group discussion and ‘post it’ boards

Following the event the HIA Steering Group was used as an “expert group” to identify and weight the various impacts the change to geographical working has had in its first six months of operation. The Steering Group recognises that evidence for many important potential impacts (both positive and

negative) would not be expected to have occurred within the first six months of the change, this is reflected in the interim nature of the conclusions and the recommendation that future impacts continue are reported.

Sections 3 to 8 describe the various sources of information used to inform the expert group. Section 9 describes the views expressed at the stakeholder conference and Section 10 reports the results of the weighting exercise by the HIA steering group.

3 The evidence base for the change

3.1 Introduction

This section considers published evidence relevant to the decision on whether or not to move to geographically based working. Policy documents have been briefly considered in Section 2. This review considers evidence in four areas:

- Specific evidence on geographical working
- Evidence for and against conventional ways of working
- Evidence for and against public health ways of working
- Evidence to inform resource allocation for health visitors

There was insufficient time to carry out a systematic review so the literature was approached primarily from published reviews, in particular the 4th Edition of Health for all Children and its associated website (Hall and Elliman 2003, subsequently referred to as HFAC4). Other useful reviews were those on public health nursing (Elliott and others 2001), home visiting by health visitors (Elkan and others 2000), and a review of health visiting and school nursing in Wales (Clark and others 2000). In addition searches were carried out combining terms such as health visitor, neighbourhood, resource allocation, community development, public health and effectiveness in Medline, CINAHL and EMBASE.

In this review the term 'conventional working' is used to refer to the provision of health visitor services to children and their families often through home visits and with an emphasis on the early detection of health problems.

There are several problems in using the literature to make judgments on the relative effectiveness of geographical compared to other ways of working for health visitors.

- **There is a shortage of UK evidence on the effectiveness of conventional ways of health visiting and also a shortage of evidence on the effects of NHS service restructuring generally.**

There are few UK based studies on the effectiveness of routine health visiting. In some ways this is not surprising, as NHS research tends to concentrate on the effects of specific technologies or drugs rather than on the generic effects of professional groups. Malone and others (2003) have pointed out that Elkan and others' review (2000) was the first government funded review of an entire occupational group. In a similar way there has been a general lack of studies on the consequences of mainstream health service reconfigurations when compared to the amount of research into new innovations.

- **Lack of clarity on the objectives and target groups for health visitor services**

Doncaster does not have an up-to-date statement of the objectives of its Health Visitor Service. This lack of clarity is mirrored nationally; although the Community Practitioners and Health Visitor Association (2003)

stresses that health visitors aim to promote the health of the whole community, the House of Commons Select Committee (2001) was concerned that in practice 'Health visitors currently limit their work to mothers and the under fives.' (The Select Committee did believe that the health visitor role should be developed 'to work with the elderly or other needy groups').

- **Difficulties in using conventional ways of assessing evidence on the effectiveness of public health and community development ways of working**

There is a considerable volume of literature that emphasises the methodological difficulties of obtaining evidence of effectiveness for health programs that aim to improve the health of communities compared to studying interventions delivered to individuals (for example Gilles 1998).

- **Lack of evidence on which professional group should deliver public health and community based approaches**

Many of the studies that have demonstrated effective public health working (for example those in the review by Elliot and others discussed later) contain little information on what level of training and skills are necessary for health workers to repeat the findings in another setting (Malloy and Caraher 2000). In a similar way although HFAC4 makes evidenced based recommendations about which health-promoting programs should be made available to children and families it is careful not to make recommendations about which professional groups (or combination of skill mix) are necessary to deliver the programs.

3.2 Specific evidence on geographical working

There is an extremely limited literature that specifically addresses the evidence for and against geographical working for health visitors; Broklehurst and others (2003) state that they are not aware of any robust studies in the area. They quote two case studies of changes in opposite directions, that both apparently led to improved working relationships. One from practice based attachments to geographical teams in Derby in 2003, the other from geographical working to practice attachment in Hackney in 1987.

The process of change in Derby has also been written up in more detail (PHAAR Development Team 2003). This report is extremely useful for any health community that has already made the decision to change to geographical working; it sets out the necessary steps for successful change and identifies likely barriers. The PHAAR report however has only limited information to help communities decide whether to make the change to geographical working. The project was able to demonstrate an improvement in health visitors' self-reported competencies in three areas: addressing inequalities, strategic skills for delivering health gain and involving communities. There was also evidence that most teams had carried out some local health needs assessment. The PHAAR report however contains little evidence of direct health gain as a consequence of the change to geographical working.

There is a larger literature on corporate working (the sharing of HV tasks within teams, for example Houston and Clifton 2001) and on integrated

nursing teams (sharing of nursing and health promotion tasks between professionals with differing skill mixes, for example Bailef 2000). This literature has not been reviewed in detail because although the change to geographical working in Doncaster may result in more teams choosing to work corporately this was not seen as an inevitable consequence of the change. Similarly although the change involves integration between health visitors and nursery nurses, at the moment health visitors in Doncaster are not integrated into teams with practice nurses, school nurses, district nurses and midwives.

There are a considerable number of opinion based papers (for example Billingham and Hall 1997, Billingham and Perkins 1997, Plews and others 2000, Malone and others 2003) on the future of health visiting and public health nursing written since the arguments for geographical working were first set out in the Cumberlege report (1986). These have not been reviewed in detail because they are not evidenced based but a few comments may be relevant.

- The Cumberlege report with its vision of a geographically based, integrated nursing teams, with statements of service aims and priorities for each client group, neighbourhood user involvement, and using the knowledge of neighbourhood nurses to inform wider health service planning still contains much that is relevant (but not implemented) today.
- The reasons why the Cumberlege report was not implemented may also still be relevant. These were presumably because the report started from the perspective of designing an ideal nursing service rather than analysing how a nursing service could be integrated into the NHS as it was then configured. The report's emphasis was on rational planning rather than on choice between primary care teams, in retrospect it seems the authors underestimated the influence of general practice on decision making at that time. Similar points have been made recently for example Malone and others have warned of the strategic risks for health visitors if they become separated from primary care at a time when primary care is central to Department of Health's agenda.
- Several authors point out changes other than geographical working that are necessary to bring about public health nursing. Billingham and Hall point out that if public health nursing is really to happen it requires explicit dedicated time rather than being viewed as an 'add on' to services for individuals. Clark and others (2000), and Plews and others (2000), emphasise the importance of getting the right educational infrastructure for community nurses so that the required culture change can be delivered.
- The size of the culture change required is emphasised by authors such as Malone and others, who criticise the Department of Health's concept of a continuum from individual level to community services (see Section 2) as over-simplistic. The PHARR report in Derby found a 'dissonance' between the Department of Health's recommendation for community based initiatives and the fact that traditional health visiting and primary care approaches are dominated by individual and family perspectives.'

3.3 Evidence for and against conventional ways of working

The evidenced based recommendations in successive editions of Health for all Children (Hall and Elliman 1989, 1992, 1996 and 2003) have shown a progressive shift of emphasis from a 'defect-detecting' model of child health surveillance to child health promoting programs in which secondary prevention (the identification of existing problems) plays a much less prominent part than other aspects of health promoting activity.

HFAC4 (2003) does still recommend a program of universal contact with all pre-school children. There are three underlying reasons for this: to provide some evidenced based screening, to deliver other health promoting activities, and to identify families with complex needs who require more intensive support.

HFAC4 states there is good evidence for health promoting activities to encourage immunisation, reduce sudden infant death, support breastfeeding, encourage better dental care and advise parents about accidental injury. In addition obesity is identified as a major public health problem that needs an evidenced based solution.

Formal screening programs for pre-school children have been rationalised by the National Screening Committee (summarised on page 351 of HFAC4). Some activities that were previously carried out by health visitors are no longer recommended. It is now recognised that speech delay and developmental delay are best identified by professionals responding to parental concerns rather than by formal checks. The distraction hearing test, which was a major rationale for the eight month health visitor visit, will be phased out when all eight month olds have received neonatal screening (during 2005 in Doncaster). Partly as a consequence of this HFAC4 recommends that face-to-face contact between health visitors and children between four months and pre-school entry should now be negotiated with parents, rather than simply occurring routinely at three standard times.

Elkan and others (2000), and Kendrick and others (2000), report the results of a systematic review of the effectiveness of domiciliary health visiting to children and the elderly. The review found a very small UK evidence base. There are high quality, randomised, American studies showing improvements in parenting skills and the home environment measured by validated scores (Kendrick and others 2000). However the reviewers overall conclusions on the effectiveness of home visiting made when including less methodologically robust UK studies is that 'expectations of home visiting by health visitors should be realistic. Home visiting by itself can be insufficient to bring about radical improvement in health and social outcomes.'

Elkan and others did find evidence to support the use of professional judgement for decisions about where to target resources, making the content, duration and intensity of visiting sensitive to the needs of clients, and making the content of visits broadly based to address multiple needs of individuals and families. Robust studies on visits to the elderly were also mainly American. There was evidence of decreased mortality and decreased hospital

admissions among frail, at risk, elderly clients but only weak evidence for other outcomes studied because the majority of studies lacked sufficient power (Elkan and others 2000).

Whittaker and Cowley, and Malone and others, have taken a more positive view of the strength of the evidence for home visiting by health visitors particularly as a method for delivering parental support. Whittaker and Cowley make three points: firstly, there is strong epidemiological evidence that 'parental behaviour is the most immediate, powerful and potentially alterable influence on the early years of a child's life'; secondly, there is some UK evidence that parental behaviour can be positively influenced (such as the Bristol Child Development Program); and finally, the reason there are no UK randomised studies of home visiting is that, because there is already a universal service, it is difficult to identify controls.

3.4 Evidence for and against public health ways of working

HFAC4 points out that there is compelling evidence that communities, relationships and environments are important determinants of health. There is however an extensive literature on the methodological difficulties of adding empirical evidence to the strong theoretical justifications for the themes that underlie many current policies such as, multi-agency working (e.g. Gillies 1998), community development (e.g. Swinder 2002), and interventions to improve social capital (e.g. Hawe and Shiell 2000).

HFAC4 contains a chapter summarising the reasons for focussing on parents in child health promotion (seeing the child as a member of the family and the family as a member of a community) and a chapter on promoting child health, which concludes there is growing evidence for interventions to improve language skills, pre literacy skills and behaviour patterns. Much of the published evidence for the effectiveness of targeted interventions in this area is American but the UK Sure Start program is providing a focus of experience of innovatory practice in this area and is currently being evaluated (Sure Start 2003).

The overall conclusion in HFAC4 on public health ways of working is: '*there is persuasive (although indirect) evidence that activities that address issues in the local environment and build on strength of communities are at least as likely to improve health as traditional health care approaches*'.

The literature on public health nursing has been summarised in a review of systematic reviews, which is arranged by themes (Elliott and others 2001). This assembles a considerable volume of evidence of effective public health interventions that could potentially be delivered by nurses (700 studies, 300 reviews). There were several general conclusions:

- Behavioural change is more likely to occur when education or counselling is combined with environmental modification (such as providing safety equipment, changing school meals or distributing condoms)
- Effective strategies are usually based on theoretical models of behaviour change and included skills training for practitioners
- Multi-agency strategies are more likely to succeed

- Interventions targeted at high-risk groups are often more successful than interventions delivered to the general population
- Many behaviour changes require long-term interventions to sustain and reinforce results

Specific evidence of effectiveness in the area of child and adolescent health that appear particularly applicable to health visitors includes encouraging and prolonging breast feeding and accident prevention.

Although Elliot and others' review provides strong support for the recent policy emphasis on public health working for nurses they also point out there are many studies of public health initiatives that show either no benefit or only a weak benefit. This emphasises the importance of adhering to the evidence-base in areas where there is robust evidence, but also the fact that there are some areas of major public health importance, such as the prevention of obesity and teenage pregnancy, where there is limited evidence for effective interventions.

3.5 Evidence to inform resource allocation for health visitors

HFAC4 points out that decisions have to be taken at a managerial level to decide the overall amount and the distribution of resources for health visiting services. Decisions also have to be taken at a professional level by teams and individuals to decide how they prioritise their activities between clients and between health priorities. Although HFAC4 advocates a minimum universal service, it also acknowledges there are wide variations in need, that the distribution of health visitors across the UK has little correlation to deprivation levels and that there is good evidence that the inverse care law operates for preventative health.

There is evidence that public health nursing interventions are more effective when targeted at those at high risk (Elliott 2002). Billingham and Hall (1998) and Hawksley and others (2003) have suggested that targeting high-risk communities is less stigmatising than targeting high-risk individuals. However there is a marked shortage of evidence to inform any decision of how to target health visitor resources to areas with more health problems.

The overall funding each PCT receives is adjusted according to need (and other factors such as the cost of providing services). Different services receive different adjustments and in theory the allocation formulae used to adjust resources at a PCT level could be used to inform resource allocation to geographical areas within the PCT. Allocation formulae are based on small area variations in health service activity. This is based on the assumption that variations in recorded activity are related to need once supply side variations are adjusted for. Some previous health service resource allocations have contained adjustments based on differences in recorded activity by health visitors (University of Kent and Plymouth 1996). However the 2003 resource allocation process (Department of Health 2003) was "unable to produce a well specified formula" to describe variations in activity by community health services (which include health visitors). This means that in practice the

amount of notional funding for health visitors allocated to PCTs is adjusted according to formulae derived from variations in other health service activity (specifically hospital and maternity service activities).

The difficulties of deriving an evidenced based needs formula for community health services have received considerable discussion (University of York 1996, Buckingham and Freeman 1997). The difficulties relate to the absence of a national dataset, variations in the completeness of recording of activity and a flaw in the assumption that existing activity by a predominantly preventative service will be correlated with need. The background analysis for the 2003 formula did recommend that if health visitor resources were to be weighted according to need the two variable to be used should be the Index of Multiple Deprivation Housing Domain and the proportion of children of low birth weight (Sutton and others 2002). However even this background analysis did not give recommendations on the amount of weighting recommended to adjust for the needs of deprived areas.

Two studies have looked at how much variation in health visitor activity can be predicted by case mix. Crofts and others (2000) in Sheffield used a case mix scoring system applied to each individual client. Reading and Allen (1998) in East Anglia estimated case mix by using direct unemployment and social class data. The Sheffield study showed that health visitors did make more contacts with individuals with higher case mix scores and that the configuration of the Sheffield service did reflect this because teams in deprived areas looked after fewer cases. The East Anglia study showed large differences in health visitor contact rates between areas but this variation was largely unexplained by differences in employment and social class.

There only appear to be two suggestions in the literature as to how much health visitor services should be weighted to adjust for need. Crofts and others report that health visitor caseloads in Sheffield are adjusted by 20% according to case mix (on the arbitrary basis that 20% represents one day per week). The PHAAR report (2003) describes the process of weighting used in Derby. Resources are allocated on the basis of the number of children aged under four weighted by a range of 1 to 2.5 depending on the Index of Multiple Deprivation (IMD) Score. This would imply a much steeper adjustment than in Sheffield.

Although HFAC4 recommends a universal service it also accepts that to achieve greater equity of outcome some families may need substantially more input than others. HFAC4 argues against the formal use of checklists and formulae to identify individual families at 'high risk' but states that there is a good case for allocating more resources to localities with greater needs. It supports community profiling – the building up of an information base of information on child health needs and local services, but points out that such an exercise is of limited value unless there is commitment to action on resource allocation. It also points out that health visitors need to be able to effectively influence wider health planning, otherwise there will be a reluctance to identify needs where no existing service exists.

3.6 Conclusions from the literature review

- There are no robust studies that specifically address the question of whether geographical working is more effective than other ways of configuring health visitor services
- There is evidence from the USA on the effectiveness of home visiting by health visitors but little high quality evidence from the UK
- HFAC4 gives less emphasis to screening for development and language delay and recommends that the distraction hearing test should be phased out and that visits between four months and pre-school should be negotiated rather than occur routinely. This should release some capacity for new initiatives.
- There is persuasive (although indirect) evidence that activities that address issues in the local environment and build on the strength of communities are at least as likely to improve health as traditional health care
- There is little evidence to inform decisions on the appropriate skill mix for health visiting teams
- Policy reviews have indicated the importance of considering how well health visitor teams are integrated with other nursing services and primary care teams as well as their own perspective
- There is evidence of considerable variation in need for child health promotion and HFAC4 supports the distribution of resources in proportion to need however there are no evidenced based examples of how to do this.

4 The views of service users and the public

Views on the changes to the health visitor service were obtained from three sources and fed into the health impact assessment (HIA) process.

- Evidence for service user involvement in specific changes at health visitor team level. This was identified from the health visitor team portfolios.
- Information available to the PCTs from earlier consultations about service users' expectations for Sure Start programs that is relevant to the overall population.
- Consultation with Central PCT's residents panel.

4.1 Evidence from health visitor team portfolios

The use and first analysis of information from health visitor team portfolios is described in Section 8. One of four dimensions of evidence collected by each team is of working with communities. On page 50 evidence of local service changes that have taken place with community involvement is described. The aggregation of themes from different teams' portfolios also offers the opportunity to respond to community initiatives and identified needs at a more strategic level.

4.2 Information from the Sure Start consultation exercises

The PCTs have had several consultation exercises to gather the public's views on the services they would like for specific Sure Start programs.

The results, such as those from the Intake Sure Start consultation that explored parents' priorities (Figures 4.1 to 4.4), were presented at the Health Visitor HIA stakeholder event.

Play facilities feature highly among the needs identified as well as increased contact with health visitors and midwives.

Figure 4.1 Overall priorities of parents in the Intake Sure Start program consultation

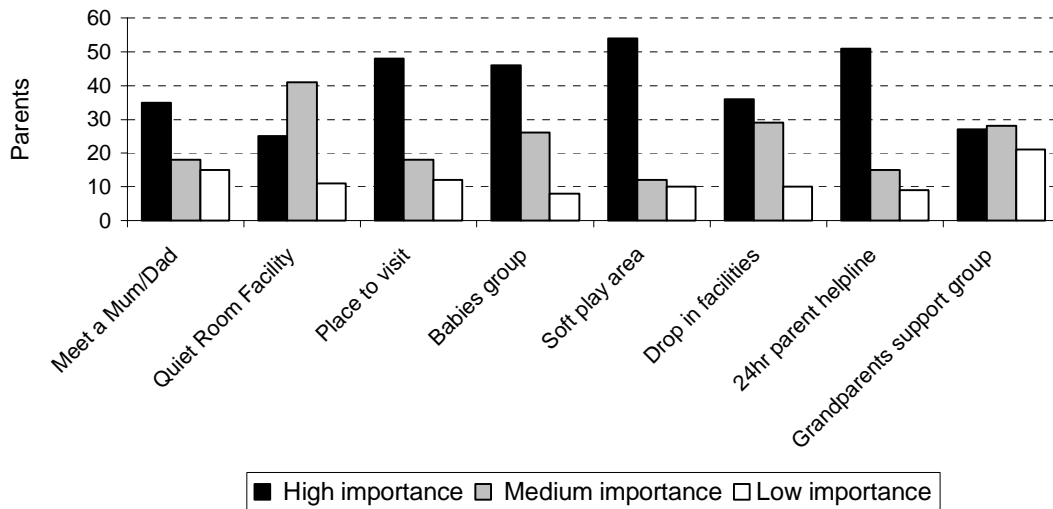


Figure 4.2 Parental priorities prior to birth in the Intake Sure Start program consultation

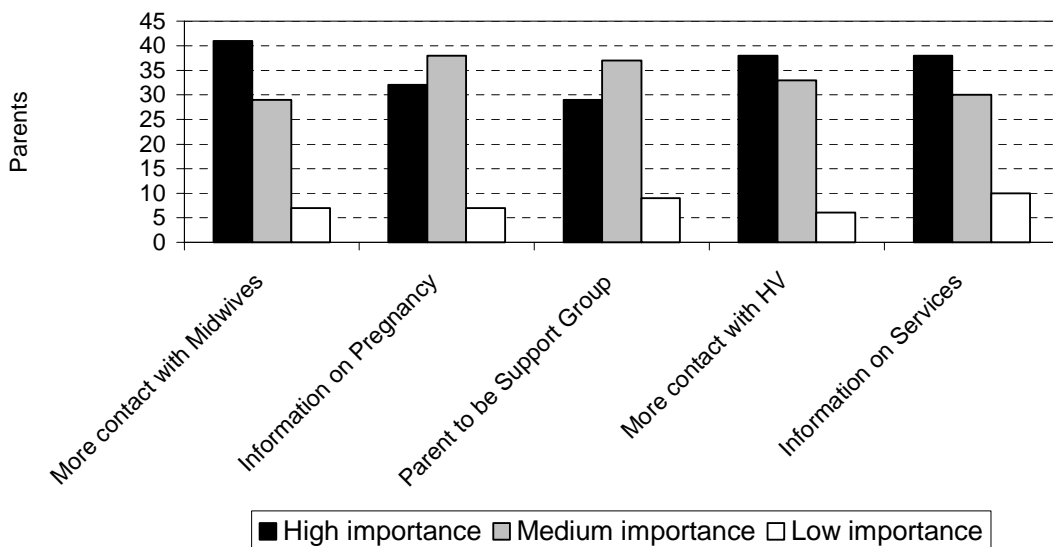


Figure 4.3 Parental priorities for one and two year olds in the Intake Sure Start program consultation

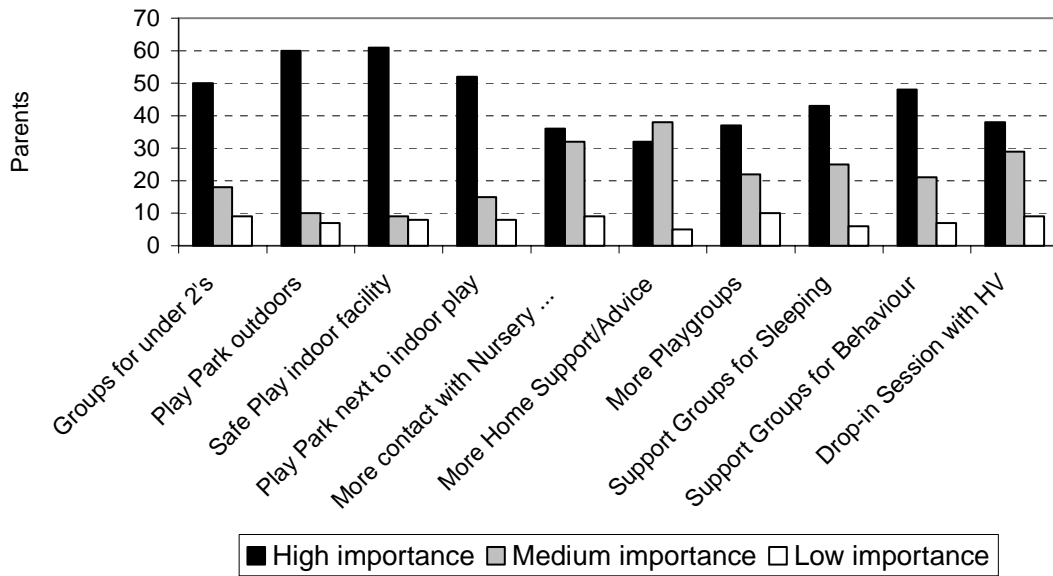
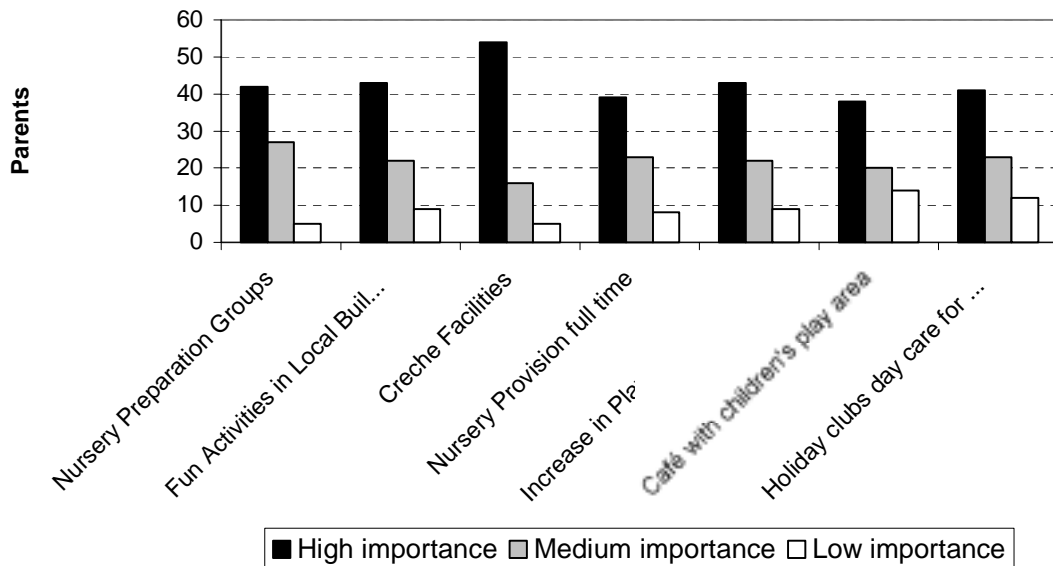


Figure 4.4 Parental priorities for two to four year olds in the Intake Sure Start program consultation



4.3 Views of Central PCT residents panel

The HIA Steering Group chose to use existing consultation structures to assess the public's views. One reason for this was the desire to make consultation on the health impact of service changes a routine, regular PCT activity rather than it depending on the initiative of specific project groups.

Central PCT covers Doncaster town centre and includes an area where nine GP surgeries are located in close proximity. It was therefore hypothesized that a high proportion of service users would be directly affected by the change to geographically based health visiting so Central PCT's residents panel was chosen for consultation.

The changes and underlying reasons for the changes were outlined to the seven residents present at a regular meeting. The panel members were asked to discuss with contacts and relatives in the community whether they had any comments or specific information on positive or negative impacts resulting from the change. The results of these discussions were reported back to the next routine meeting and are summarised below:

4.3.1 Specific impacts noticed by the residents panel

- The opening of a new community based 'mother and tots' clinic (at St Jude's) was reported as a specific positive impact. The clinic had health visitor support, which was felt to have been easier to arrange because of the change to a geographically based service
- No negative impacts were reported to the meeting

4.3.2 General views of the residents panel on the change

- The new system was felt to be preferable because it is more synchronised with the midwives who work geographically. However it was also pointed out that district nurses teams are organised by practice
 - *'Seems like common sense'*
- There was discussion around the fact that although geographical working might seem to be a sensible arrangement when the health visitor service is considered on its own, there could be detrimental effects on the relationships between health visitors and other services.
 - *"Should going geographical be for all services or none?"*
- The practice manager representative on the residents' panel brought up the issue of potential disruption to primary care teams. There was sympathy with this view from the residents. There was a discussion of the bigger picture;
 - *"Why are GP services not geographically based?"*However there was also the strongly expressed viewpoint that patients' must have choice.
- Questions were asked about whether there would be complications over medical records and computerised access to records.

- The residents raised the issue of child protection and the potential loss of informal 'corridor conversations' between GPs and health visitors.
- Residents were concerned about the size of teams, and stressed the importance of ensuring small teams, continuity of care and robust methods of identifying health professionals who turn up on their doorsteps.
- Residents were concerned about the total numbers of health visitors available. Was this sufficient? Are health visitors able to devote sufficient time to the elderly?

At a third meeting the overall findings and recommendations from the health impact assessment will be discussed with the panel.

5 Epidemiological information

5.1 Introduction

This section presents information from routine data sources. Four types of information are presented:

- Maps of health visitor team areas
- Maps of the distribution of deprived households from the 2001 census
- Tables comparing the distribution of health visitors with proxies for need
- Charts comparing the distribution of health visitors before and after the change to geographical working

The data have three potential uses:

- To inform the question for the HIA of whether health visitor resources are distributed more transparently and equitably since geographical working was introduced
- To provide information to individual health visitor teams to contribute to community profiling
- To provide information for health visitor managers to be used in combination with local knowledge when making decisions about resource allocation to teams

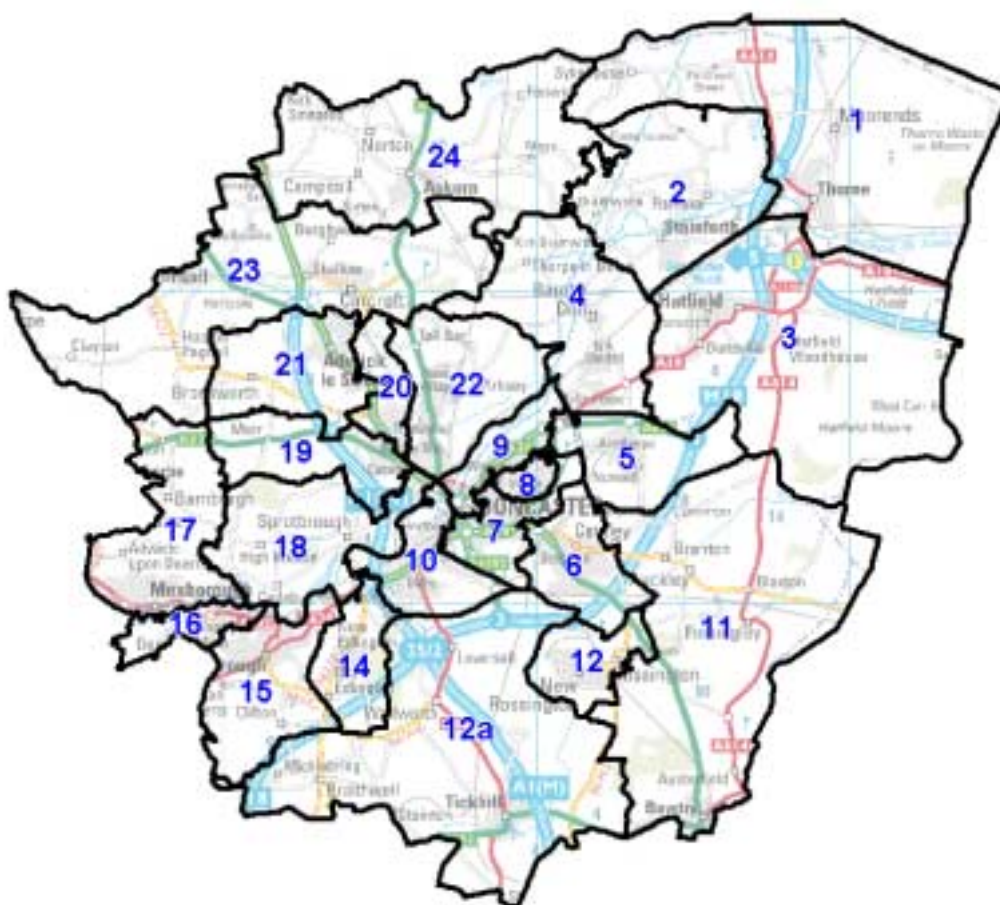
Quantitative data can never show the whole picture and some important limitations of the analysis are summarised in Section 5.3.2

5.2 Geography of the health visitor zones

The change to geographical working makes it easier to provide a greater range of information for the health visitor zones. For example, census data, mortality data, cancer registration data and others can more easily be analysed on a geographical basis than on a registered practice basis. Staff in the Public Health Intelligence Unit are in the process of developing an Internet based database of public health data sets, which will enable information to be accessed quickly for pre-defined geographies, including health visitor zones. A first version of this system is expected to be available before the end of 2004.

The starting point of the analysis was to map the new health visitor geographical zones into 2001 Census output areas (Map 5.1). These are small geographical areas, made up of around 125 households, for which 2001 Census information is released. These output areas formed the building blocks of the new health visitor zones, making it possible to obtain tailor-made data from the 2001 Census.

Map 5.1 Geography of health visitor zones



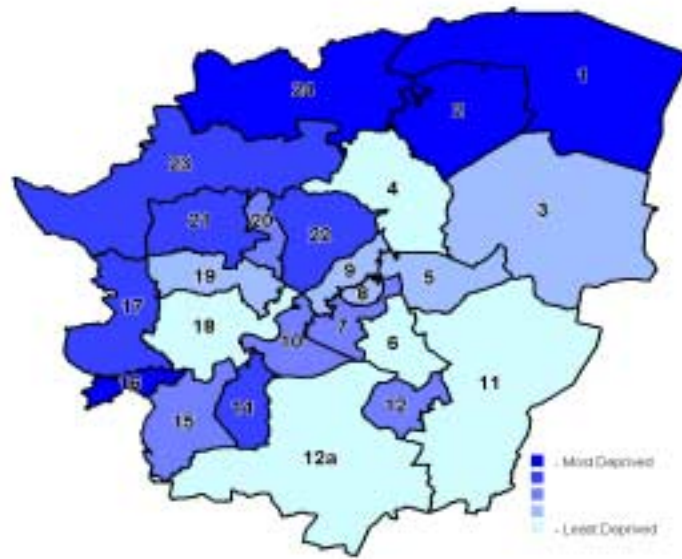
- | | | |
|------------------|-----------------|-----------------------|
| 1 - Thorne | 2 - Stainforth | 3 - Hatfield |
| 4 - Kirk Sandall | 5 - Armthorpe | 6 - Bessacarr |
| 7 - Hyde Park | 8 - Town Centre | 9 - Wheatley |
| 10 - Balby | 11 - Bawtry | 12 - Rossington |
| 12a - Tickhill | 14 - Edlington | 15 - Conisbrough |
| 16 - Denaby | 17 - Mexborough | 18 - Sprotbrough |
| 19 - Scawsby | 20 - Scawthorpe | 21 - Adwick le Street |
| 22 - Bentley | 23 - Carcroft | 24 - Askern |

The boundaries were drawn in consultation with the health visitor managers, and have been made to match the teams' working boundaries as closely as the Census output areas will allow.

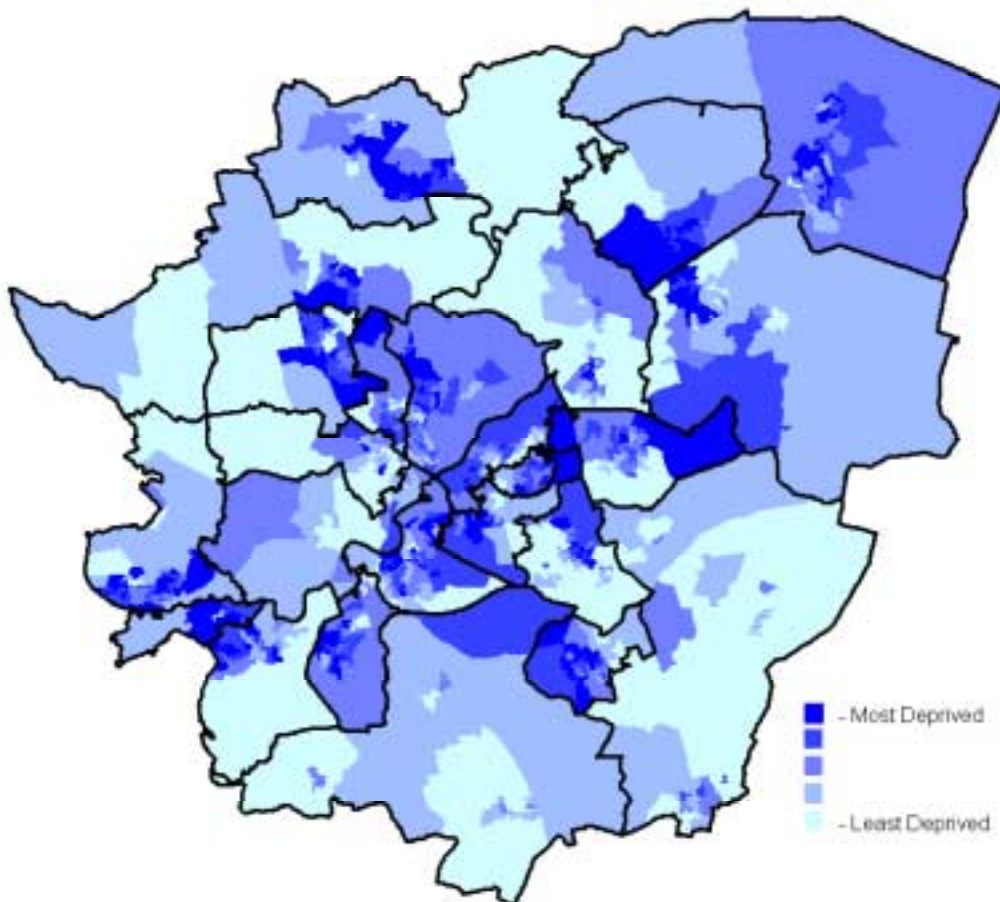
5.2.1 Levels of household deprivation in health visitor zones

The health visitor team maps can be populated with any health or social data that are available on a geographical basis. As an example the maps have been illustrated with data from the 2001 Census Classification of Household Deprivation (Map 5.2). This uses four domains: unemployment, education, health and disability.

Map 5.2 Quintiles of the Classification of Household Deprivation by Health Visitor Zone (2001 Census)



Map 5.3 Quintiles of the Classification of Household Deprivation by Census Output Area



Map 5.2 shows the average number of deprived domains by health visitor zone. To a certain extent the results are not surprising, with the lowest percentage of deprived domains in Bawtry (zone 11) and the highest level in Denaby (zone 16).

Map 5.3 shows the same data mapped to Census output areas with health visitor zone boundaries. The map highlights the variations in deprivation within zones and the fact that all the teams contain some relatively deprived areas.

5.3 Relationship between ‘need’ and resource

5.3.1 Relationship of health visitor numbers to 2001 Census information

The ‘quilt’ table (Table 5.1) shows selected population, health, and deprivation indicators from the 2001 Census. The fourth column shows each team’s establishment of G and H grade health visitors. This was used to calculate the columns labelled ‘Population’, which show the number of health visitors available for the populations of 0-4 year olds, and elderly people.

The indicators were ranked, and then grouped into four ‘quartiles’ (the inter-quartile ranges are shown at the bottom of Table 5.1). These quartiles are used to colour the ‘quilt’, and highlight any imbalance between resource and need. The columns labelled ‘Health’ and ‘Deprivation’ show potential indicators of need within the health visitor zones. The ‘Population’ columns are coloured from white to red, paler colours indicate a larger population per health visitor. The ‘Health’ and ‘Deprivation’ columns are also coloured, here paler colours indicate lower levels of deprivation; and those coloured red are in the most deprived quartile.

The table is based on the assumption that if workload and need are balanced then the population, health, and deprivation indicators will be the same colour. In general the balance seems to be about right, but there are exceptions, such as Denaby and Bentley where high levels of need do not appear to be matched with lower populations per WTE of health visitor. This is discussed further in Section 5.4.3. The data sources are detailed in Box 5.1

The data show that overall the number of 0-4 year olds per health visitor in Doncaster is slightly lower than the national average (274 compared with 295). This can be considered to be appropriate because the other columns show Doncaster to have higher deprivation and poorer health than the national average.

Table 5.1 Health visitor numbers with population, health, and deprivation indicators

ZONE	Team name	PCT	Health Visitors per Team WTEs	Population		Health		Deprivation
				0-4 year olds per WTE	75+ per WTE	People with limiting long-term illness as a percentage of total population	People with 'not good' self reported health as a percentage of total population	Classification of Household Deprivation. Average number of deprived households per zone (percentage)
12a	Tickhill	East	0.83	515.9	1207.6	19.8%	9.3%	26.0%
11	Bawtry	East	1.75	435.6	497.0	17.1%	8.3%	25.1%
18	Sprotbrough	West	1.00	418.8	615.3	17.3%	7.8%	25.7%
6	Cantley & Bessacarr	Central	2.50	348.6	849.4	20.5%	9.8%	27.9%
4	Kirk Sandall & Edenthorpe	Central	2.00	347.7	452.9	18.5%	9.4%	27.0%
22	Bentley	West	2.60	338.3	394.3	23.2%	12.5%	35.5%
16	Denaby	West	1.00	319.3	410.9	33.0%	21.4%	42.8%
24	Askern	West	2.00	311.6	374.8	25.0%	13.1%	36.1%
5	Arnthorpe	East	2.50	308.4	429.9	24.5%	13.0%	33.4%
19	Scawsby	West	1.50	291.4	388.0	19.9%	8.8%	28.9%
21	Woodlands	West	2.60	290.6	251.3	24.1%	12.2%	35.0%
12	Rossington	East	2.80	284.2	304.1	23.8%	12.5%	34.3%
10	Balby & Hexthorpe	Central	5.40	284.1	299.5	23.0%	12.1%	34.2%
3	Hatfield & Dunsville	East	3.00	271.8	345.5	21.6%	11.3%	31.6%
9	Wheatley & Town Centre	Central	3.60	258.9	352.5	22.5%	12.3%	33.4%
17	Mexborough	West	4.00	255.4	334.3	26.0%	14.1%	35.8%
1	Thorne & Moorends	East	4.18	247.8	311.0	25.1%	13.2%	36.7%
8	Intake	Central	3.00	235.7	290.6	22.2%	11.5%	33.9%
15	Conisbrough	West	2.80	228.0	282.5	24.5%	13.2%	34.6%
2	Stainforth	East	2.30	227.8	205.3	27.4%	15.1%	39.8%
20	Scawthorpe	West	1.50	224.3	372.3	23.9%	12.4%	34.0%
23	Carcroft	West	2.37	219.6	302.6	25.8%	13.6%	35.1%
14	Edlington & Warmsworth	West	3.00	216.0	237.2	23.9%	12.9%	35.2%
7	Hyde Park & Belle Vue	Central	4.00	138.1	165.5	24.5%	12.5%	34.8%
	Doncaster		62.23	288.9	376.2	22.9%	12.0%	33.0%
	England		9,912	295.2	373.8	17.9%	9.0%	31.5%

min	138.1	165.5	17.1%	7.8%	25.1%
quartile 1	233.8	297.3	21.3%	11.0%	30.9%
quartile 2	284.1	349.0	23.8%	12.5%	34.2%
quartile 3	324.0	415.7	24.6%	13.1%	35.3%
max	515.9	1207.6	33.0%	21.4%	42.8%

Box 5.1 Sources of information in Table 5.1

Health Visitors per Team: The number of whole time G & H grade health visitor establishment in each team. Does not include team members on other grades or health visitors and other workers attached to Sure Start programmes.

Data for England: Population, health and deprivation data are from the 2001 Census. Numbers of whole time equivalents from: NHS hospital and community health services non-medical staff in England: 1992-2002, Bulletin 2003/02, Table 2a, Department of Health (2002).

Population: The number of residents 0-4 and 75+, plus populations outside the Doncaster border registered with Doncaster practices (Exeter data) in each age group divided by the number of Health Visitor WTEs in the team.

Health: Limiting long-term illness (LLTI) and self reported health (SRH) from the 2001 census. For LLTI people were asked whether they have any long-term illness, health problem or disability that limits daily activities or the work they can do. This is expressed as a percentage of the total population. For SRH people were asked to classify whether their health had been good, fairly good, or not good over the last twelve months. The number of people with not good health is expressed as a percentage of the total zone population.

Deprivation: Classification of household deprivation (Census 2001, univariate Table UV67) – an index of deprivation composed of four domains: unemployment, education, health and disability, and housing. The indicator shows the average number of deprived domains per health visitor zone as a percentage.

5.3.2 Limitations and assumptions of data on resources and need

Details of the sources of data used are given in Box 5.1 however we emphasise there are several important limitations and assumptions involved with this type of analysis.

- **Limitations of the indicators of need**
 - Individual census variables such as the health variables selected and the household derivation index will never be able to capture all aspects of health need. The data should be regarded as proxies for some dimensions of need and should be interpreted in the context of local knowledge and qualitative data
- **Limitations of the indicators of resource**
 - The numbers of WTEs do not reflect the contributions of other grades of nurses in HV/nursery nurse teams
 - They also do not reflect other commitments carried out by team members, such as training and management roles, or the impact of vacant posts
 - The tables contain no information on other resources available to communities particularly through Sure Start programmes

5.4 Before and after comparisons

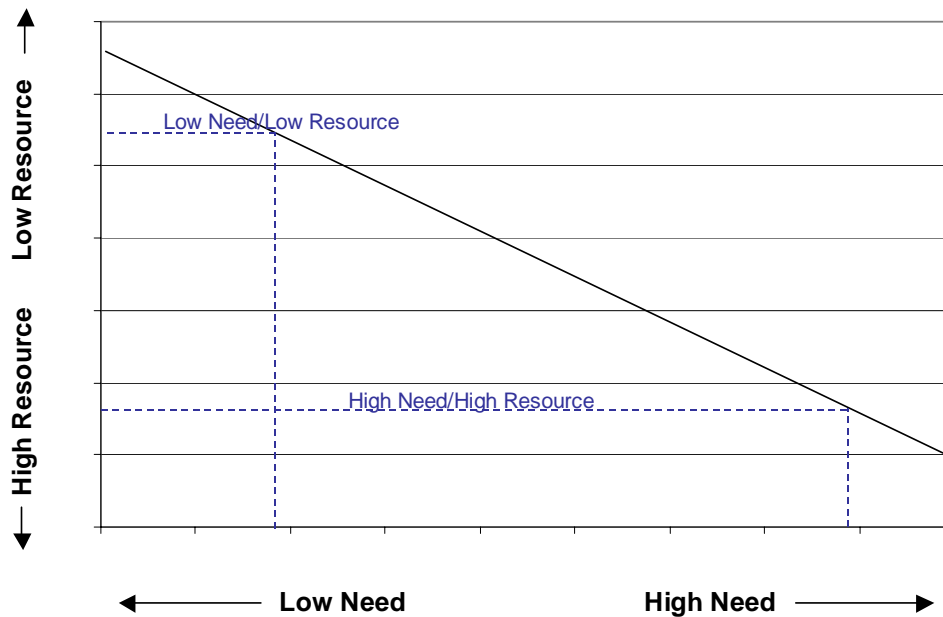
5.4.1 Methods and assumptions

Comparisons were made between the previous practice based method of working and the new geographical zones to see if there had been changes in the relationship between resources and need. The data for the new zones are from Table 5.1 and so the general limitations outlined in Section 5.3.2 still apply. The calculations utilised population data from the General Practitioner Patient Register (Exeter System); the population base was allocated to registered practice for the *before* picture, and to geographical areas to form the *after* zones. In both cases the population total was the same, and thus we are comparing like with like. Census data are not available by practice, so data have been attributed to practices based on their population distribution before the move to geographical working. This makes the additional assumption that a practice's patients resident in an output area will, on average have the same characteristics as the overall population of that output area.

5.4.2 Interpretation of Charts

Figures 5.1 to 5.11 show the relationships between health visitor resource and census variables as proxies for need. Although it is clearly appropriate for there to be greater resource in areas with higher need (Figure 5.1) the optimal form of this relationship is not clear: there is no particular reason why the relationship should be a straight line, and there is no clear evidence to inform the slope of the gradient (see Section 3.5).

Figure 5.1 Ideal Relationship Between Need and Resource



Three factors should be considered when looking at the figures

- **How close is the overall distribution to the trend line?**
Generally speaking if most points are close to the trend line, rather than widely scattered, this indicates that resources are more equitably distributed for the specific variables being illustrated. On mathematical grounds we could predict there might be less spread for the new zones (because the zones are, on average, larger than practices) but even so this would represent a more rational resource distribution.
- **How steep is the trend line?**
Given the assumption that the trend line should be linear, a steeper line indicates a stronger influence of the 'need' variable on health visitor resources. A horizontal line would indicate there is no adjustment in health visitor caseload for the variable concerned.
- **Individual 'outliers'**
Individual points well away from the trend line, show that resources for that zone do not have the same relationship as other zones for the variable considered. There may well be appropriate reasons for this and 'outliers' should be interpreted by teams and managers concerned in the context of full local information about need and resource for that zone.

5.4.3 Relationship between the numbers of children under 5 per health visitor and household deprivation and unemployment

Figures 5.2 to 5.7 all show the number of 0-4 year olds per WTE health visitor on the vertical axis. Figures 5.2 and 5.3 show before and after relationships

with the 2001 census household deprivation index. Figure 5.5 uses unemployment as an alternative proxy for deprivation and confirms that the results obtained from the analysis of the Classification of Deprivation are replicated when using simple unemployment.

In general the analysis reveals less scatter and a steeper gradient for the resources in geographical zones, compared with practice based teams. This can be illustrated by particular examples.

Figure 5.2 shows that health visitors in one of the practices in Conisbrough (orange), one in Rossington (sky blue) and one in Sprotbrough (yellow with a blue border) had far higher 0-4 populations per WTE than would be expected for the level of household deprivation. Figure 5.3 shows that this situation has been resolved with a more appropriate balance between need and resource in the Conisbrough, Rossington and Sprotbrough geographical zones. The zones are larger geographies than the practice catchment areas, more likely to encompass diverse populations with pockets of affluence and deprivation: this combined with the larger HV teams has a levelling effect on the balance between need and resource. The team covering Hatfield and Dunsville (black with a red border) has also moved closer to the trend line as a result of the change to a geographical zone.

Figure 5.2 also highlights a resource issue in the practices now covered by the Bawtry team (bright green). Both practices serve comparatively affluent populations, but the HV resource was inconsistent, with apparently too much resource for one practice, and too little for the other. Now these teams have been combined into the Bawtry zone, the imbalance is corrected, and the plot is much closer to the trend line (Figure 5.3).

Tickhill (bright pink) is also an outlier on Figure 5.2: the 0-4 population is higher than would be expected even though the practice covers a comparatively affluent area. This situation has not been improved by the change to geographical working, as Tickhill remains an outlier on Figure 5.3. (This issue is not confined to the 0-4 age group as Tickhill is also an outlier on plots using the over 75 age group - see Figures 5.6 and 5.7).

The move to geographical working highlights the needs of Denaby (red with blue border), the zone with the highest deprivation. The picture in Denaby is complicated by the Sure Start programme covering Denaby and Conisbrough, which does contribute to the health visitor provision. When Denaby and Conisbrough are combined (Figure 5.4), this brings the relationship between deprivation and health visitor cover back into line with the trend: it perhaps shows that there should be some redistribution of resource between the two zones. However this should not be considered before more detailed analysis of local considerations and input from health visitor teams.

Figure 5.2 Relationship between 0-4 population per health visitor WTE and classification of household deprivation

Before (practice based)

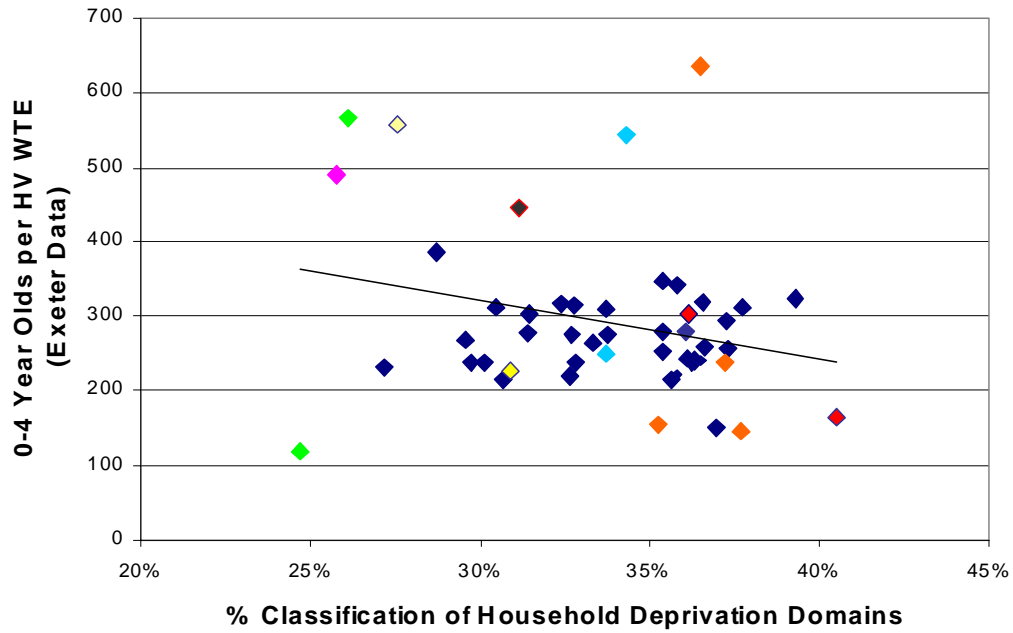


Figure 5.3 Relationship between 0-4 population per health visitor WTE and classification of household deprivation

After (geographical zones)

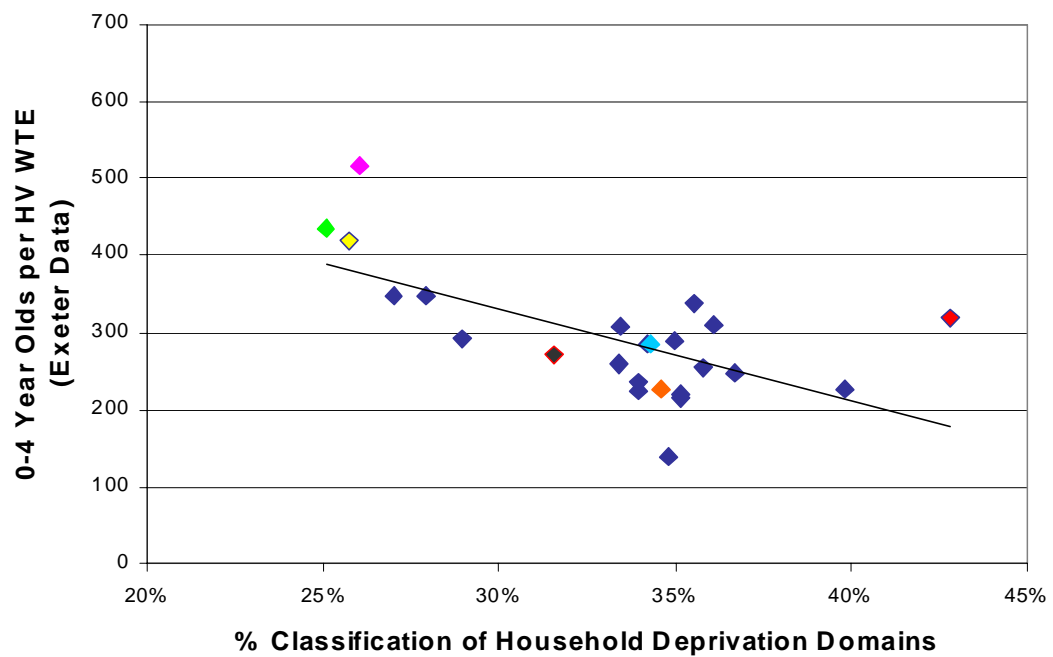


Figure 5.4 Relationship between 0-4 population per health visitor WTE and classification of household deprivation: result of combining data for Denaby and Conisbrough

After (geographical zones)

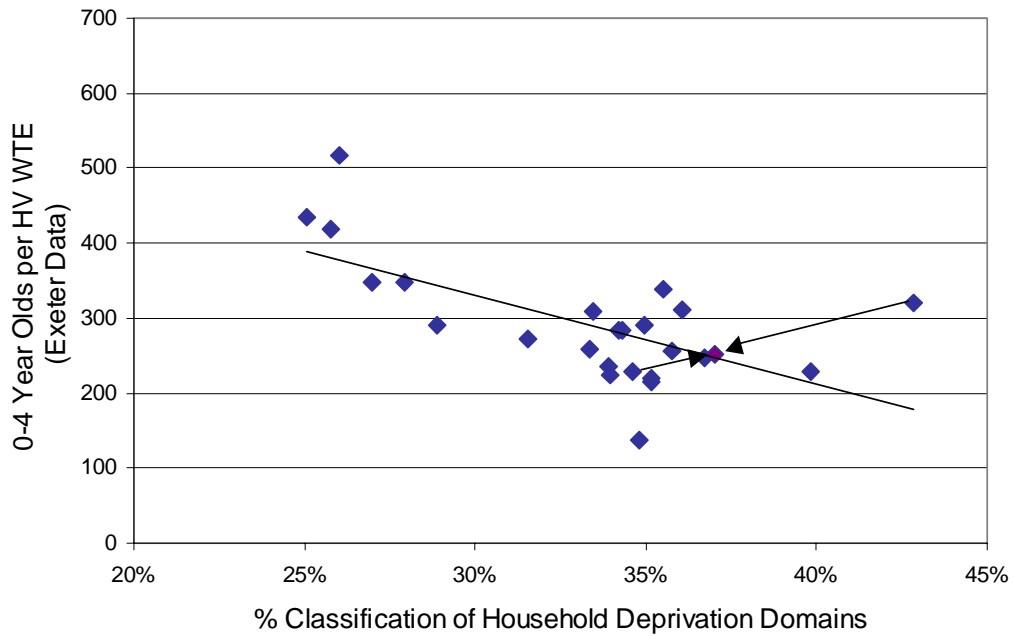


Figure 5.5 Relationship between 0-4 Population per Health Visitor WTE and Unemployment.

After (geographical zones)

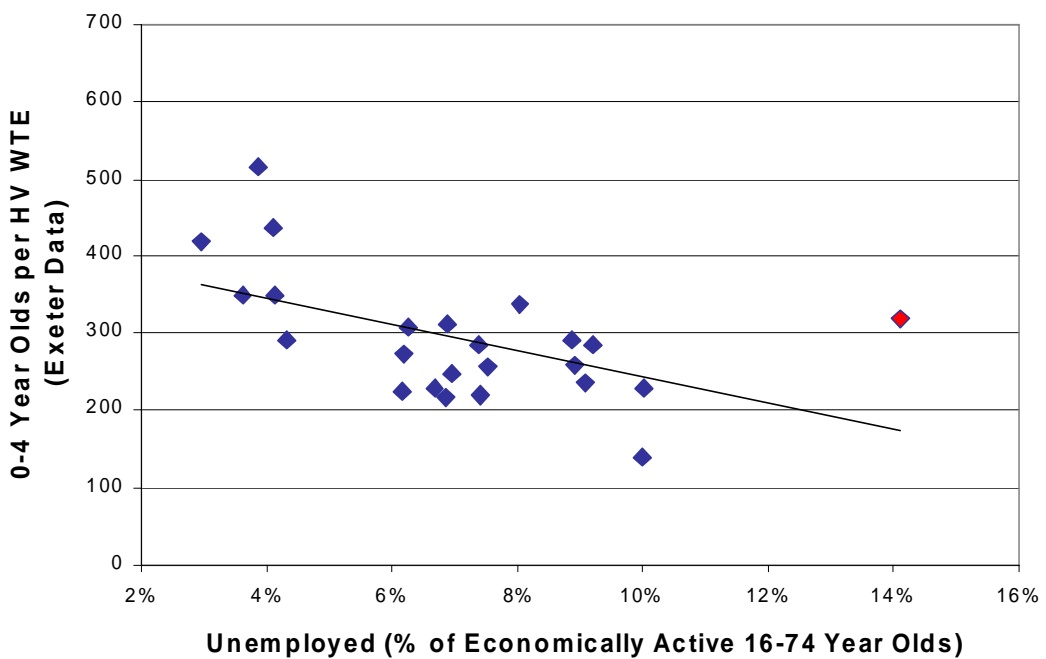


Figure 5.6 Relationship between 75+ Population per Health Visitor WTE and Classification of Household Deprivation

Before (practice based)

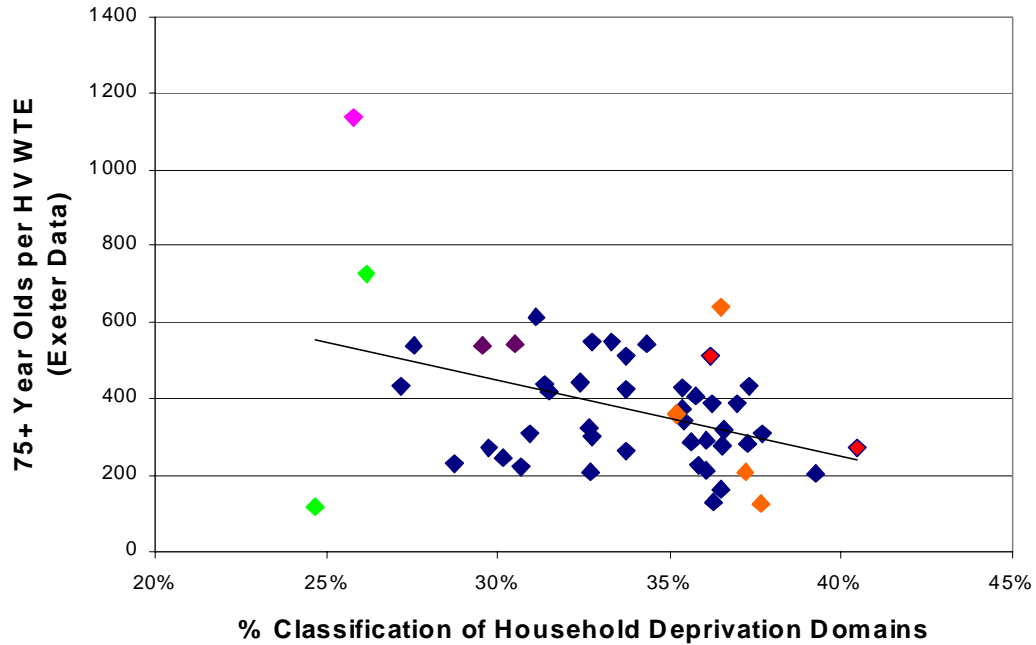
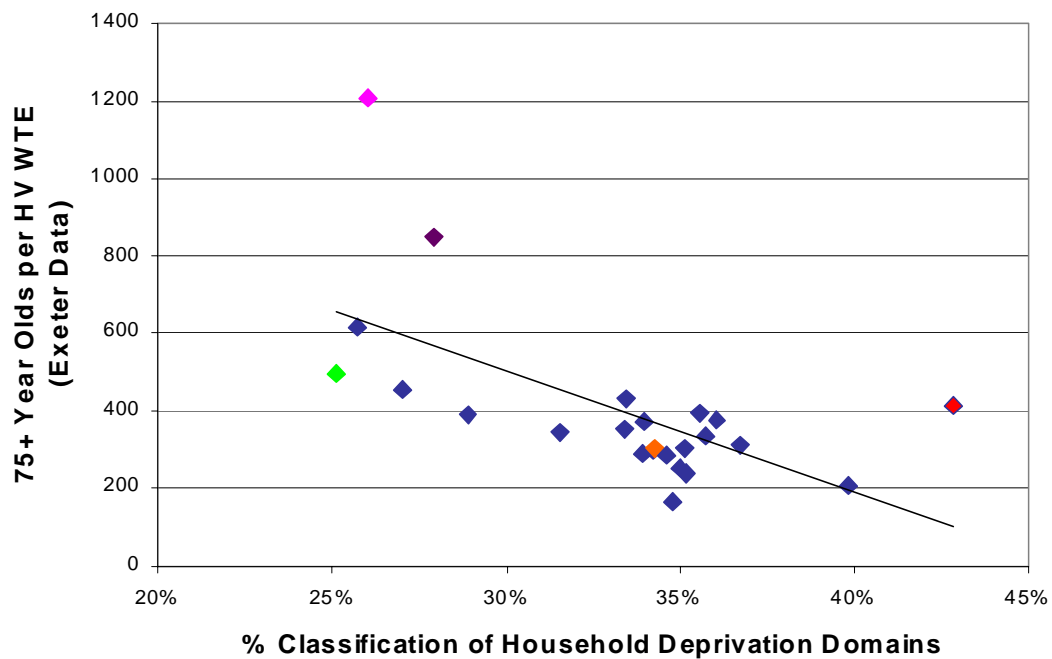


Figure 5.7 Relationship between 75+ population per health visitor WTE and classification of household deprivation

After (geographical zones)



5.4.4 Relationship between the number of over 75s per health visitor and deprivation indicators

One of the complications of allocating resources for health visitors is the lack of clarity about whether resources should be mainly distributed to where there are most 0-4 year olds in need or whether the distribution of resources should also be informed by other groups with need (see Section 3.1).

Figures 5.6 and 5.7 show the relationship between household deprivation and the number of over 75s per health visitor. The before and after comparison again shows a steeper gradient and less scatter around the trend line suggesting that in general resources for health visitor zones take more account of the number of over 75s in need.

Again there are outliers: Tickhill (pink) and Cantley & Bessacarr (purple) have an exceptionally high 75+ population per health visitor, even after taking into account the low levels of deprivation. Denaby (red with blue border), is again an outlier, as it was for the under 5 population analysis.

5.5 Conclusions

- All the data presented should be interpreted in the context of the limitations described in Section 5.3.2.
- In general resources are distributed more transparently and equitably to the new geographical zones.
- Synchronising health visitor zones with Census output areas gives potential for further use by teams for health profiling using data not presented here, such as ethnicity data.
- There are some apparent anomalies in resource distribution. These should be interpreted by teams and managers in the context of full local information.

6 Information on immunisation coverage and time spent travelling

6.1 Introduction

The stakeholder group identified a decrease in immunisation coverage as a potential risk of geographical working and shorter travelling time as a potential benefit. This section presents information relating to these potential impacts.

6.2 Immunisation coverage

If there is any impact on immunisation coverage this will only become apparent from routine statistics after a substantial time delay. The allocation of families to new zones was phased in over time after 1 April 2003, the timing of this varied between teams. Routine statistics are collected on cohorts of children each quarter: coverage for immunisations such as Meningitis C (scheduled at 2,3 and 4 months) is collected when the cohort reaches 12 months; coverage for Measles, Mumps and Rubella (MMR, scheduled at 11 months) is collected when the cohort reaches 24 months.

Baseline trends for immunisation coverage for Meningitis C and MMR comparing coverage in Doncaster with Barnsley and Rotherham are shown in Figures 6.1 and 6.2. If there were to be any impact on immunisation coverage it will not be detectable until the 3rd quarter of 2004.

Immunisation cover rates are reported to PCTs as part of routine performance monitoring. If there were any decline in Doncaster's coverage after the 3rd quarter of 2004 we suggest the first step would be to repeat the comparison with Barnsley and Rotherham, and if there is a difference for Doncaster to further investigate this.

Figure 6.1 Meningitis C at 12 months (Quarters April 01 to June 03)

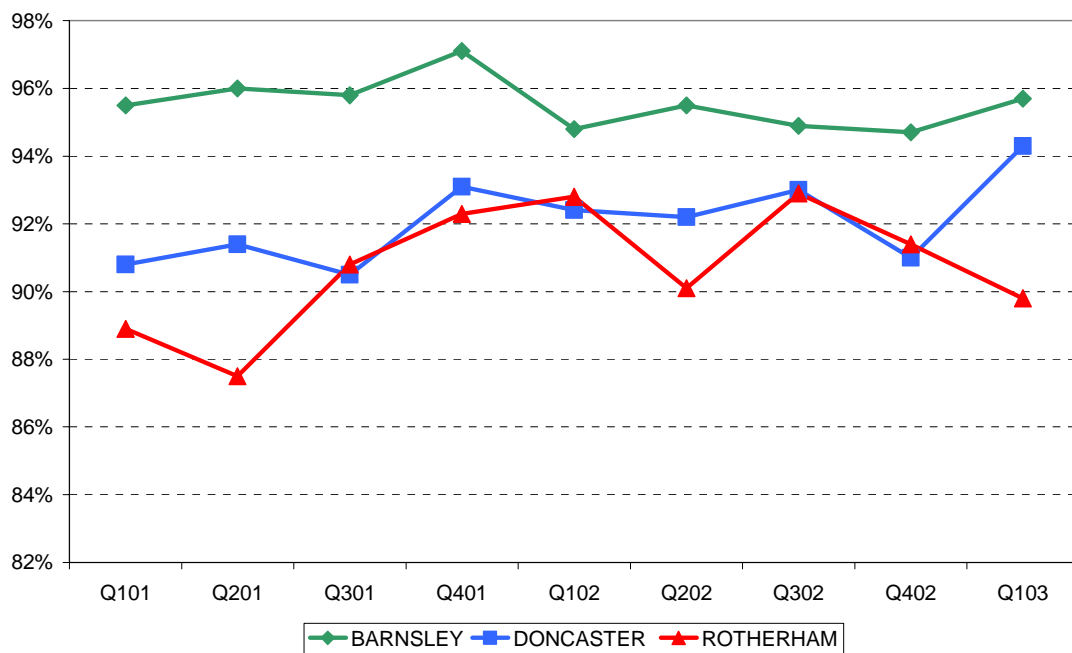
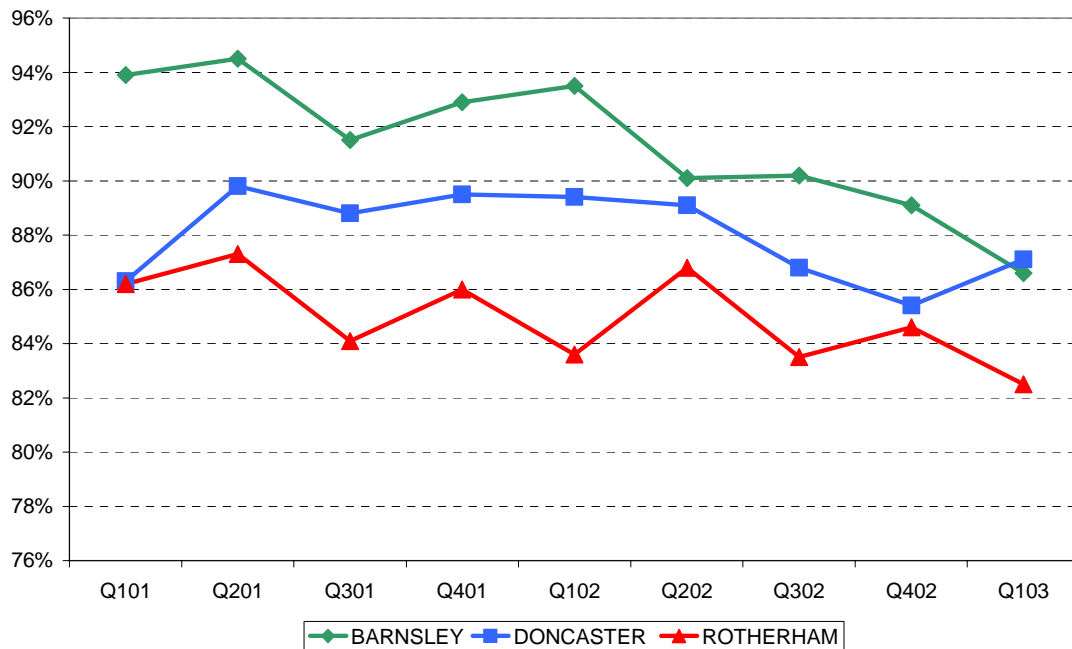


Figure 6.2 MMR at 24 months (Quarters April 01 to June 03)



6.3 Travel expense claims

A consequence of geographical working is that some health visitors should have case-loads of families that are closer together. This should decrease travelling time and so potentially increase the time available for clients.

This was investigated using mileage claims. Claims for May to July 2003 were compared to the corresponding period for the previous year. For the three PCTs combined the same number of claims were submitted in both three-month periods but there was a 19% reduction in the number of miles claimed in 2003 (Table 6.1).

There may well be some inaccuracy in individual claims. Health visitors might not claim for all the miles they travel and some claims might relate to travel before the date geographical working was introduced. Nevertheless taken overall the data do support the view that health visitors now spend less time travelling.

Table 6.1 Travel expense claim data

PCT	Claims	May to July 2002	May to July 2003	Percentage reduction
Central	Miles	10397	7615	27%
	Number of HVs (number of claims)	22 (58)	20 (55)	
East	Miles	11405	9716	15%
	Number of HVs (number of claims)	22 (62)	21 (65)	
West	Miles	8739	7542	14%
	Number of HVs (number of claims)	24 (60)	23 (60)	
Total	Miles	30541	24873	19%
	Number of HVs (number of claims)	68 (180)	64 (180)	

6.4 Conclusions

It is too early to tell if geographical working has had an impact on immunisation rates. If there is any impact it should be detectable using routine performance monitoring data.

There has been a 20% reduction in the number of miles health visitors travel since geographical working was introduced.

7 Views from general practice

7.1 Introduction

When the proposed change to geographical working was first discussed at the three PCT PECs and at the Local Medical Committee considerable reservations were expressed by GPs.

In view of this the Steering Group used two methods to assess general practitioners' views over the first six months of the change: critical incident reporting and an e-mail questionnaire survey of the practices

7.2 Critical incident reports

The first method was to encourage critical incidents to be reported to the Health Impact Assessment (HIA) Steering Group. An article asking for reports of any critical incidents thought to be related to the change was included in the LMC newsletter that is circulated to all Doncaster GPs.

This only resulted in two critical incident reports being made to the Steering Group:

- A report describing several incidents including problems due to lack of records when parents forgot to bring hand-held records, difficulties in contacting out-of-area health visitors and two patients with postnatal depression preferring the 'practice' rather than the 'area' health visitor.
- A report relating to a lack of consultation with a practice over a reduction in the length of an immunisation clinic.

It is hard to be sure whether the lack of reports from other practices was because there were few critical incidents or because general practitioners were resigned to the change and so felt that reporting incidents would not be worthwhile.

7.3 E-mail questionnaire survey of practices

7.3.1 Methods and response rate

The main method used to assess GPs' views was by e-mail questionnaire the results of which are summarised below. A more detailed report is available on request.

An email was sent using the practice manager e-mail circulation list for the three PCTs (this includes senior receptionists for small practices without managers). The email was sent on 9/9/03, that is five months after the change. The covering letter asked practice managers to co-ordinate one response per practice.

There were 22 responses (42% of all practices in Doncaster). In six cases the questionnaires were completed directly by GPs, in most cases the practice

manager filled in the questionnaires on behalf of their practice. The responses were analysed by PCT (Table 7.1). There were proportionally fewer responses from West PCT, which has smaller practices. Although the data were not specifically analysed by practice list size there appeared to be a higher response rate from larger practices suggesting that responses were probably received from practices covering considerably more than 42% of the population of Doncaster.

Table 7.1 Questionnaire response rates by PCT

PCT	Central	East	West	All
Number of practices	13	15	26	53 (100%)
Number (percentage) of responses to survey	7(54%)	10(67%)	5 (19%)	22(42%)

The following results relate to the 22 practices that responded.

7.3.2 Awareness of new services and improvements to existing services

Three respondents referred to improvements to health visitor services since April 2003. Similarly only a handful of practices responded that they had become aware of new or additional services since April 2003. These included services actually developed by health visitors and services provided by other organisations that the health visitors were able to inform the practices about.

Services mentioned were:

- A teenage pregnancy service at a local venue
- Sure Start
- A baby clinic in the community

7.3.3 Risks to baby clinics, immunisations and child protection

Three questions asked about any detrimental impact on baby clinics, child protection and immunisation (Table 7.2).

Table 7.2 Answers to questions on baby clinics, immunisation and child protection.

Survey question	No	Yes
Have you experienced problems running baby clinics?	9 (43%)	12 (57%)
Is there a likelihood of detrimental impact on immunisations?	16 (73%)	6 (27%)
Are you aware of a detrimental impact on child protection?	15 (75%)	5 (25%)

Problems with running baby clinics emerged from the survey as the area of health visitor-related work with which practices are experiencing most difficulties following the change to a geographically based structure.

The problems described fall into two categories. The actual comments made are shown in italics

- **Disruptions to working practices, clinic schedules, and roles and responsibilities.**
 - *‘Less staff to run baby clinic’*
 - *‘If the practice nurse is unavailable (sickness or holiday) there is a problem covering the immunisation clinic, as the health visitors are not required to do it’*
 - *‘Amalgamating the weighing and immunisation clinic causes overcrowding in the waiting room. Plans to reduce the length of the immunisation clinic due to "lack of demand" is disputed by the practice’*
 - *‘Health visitors’ clinic no longer synchronised with GP’s baby clinic’*
 - *‘Lack of communication: She did not tell us she was not available’*
 - *‘Practice nurse now doing baby vaccines’*
 - *‘Practice nurses are now vaccinating in the community so health visitors are not involved’*

- **Lack of fit between patient registrations and use of services.**
 - *‘Mums unaware of process of baby clinic due to not being visited by practice based HV’*
 - *‘Patients from other practices called to this baby clinic has resulted in two significant events, in which children not registered with this practice have been immunised’*
 - *‘Clients registered with different GPs attending this surgery’s baby clinic’*

7.3.4 Problems with contacting health visitors and communication difficulties

Two questions asked about any problems with contacting or communicating with health visitors (Table 7.3).

Table 7.3 Answers to questions on contact and communication

Survey question	No	Yes
Have you experienced any problems contacting a health visitor?	17 (81%)	4 (19%)
Have you experienced any problems communicating with a health visitor?	14 (67%)	7 (33%)

Whilst 19% of practices responding to the survey said they had experienced difficulties contacting health visitors (and 81% said they had not), a third reported communication difficulties.

- **Comments made about problems contacting health visitors were:**
 - *‘I just haven’t bothered to contact the health visitor out of area and neither has she contacted me’*

- *‘It is not always easy for health visitors covering our patients in other areas to contact GPs and vice versa’*
 - *‘Since health visitors relocated to a different building in June 2002, we have lost regular contact’*
 - *‘Several times not available at their station. Did not contact us as requested. Messages do not get passed on’*
 - *‘On about half a dozen occasions there has been no answer when trying to contact them’*
 - *‘Lack of communication. She did not tell us she was unavailable’*
- **Comments made about communication difficulties with health visitors were:**
 - *‘A Mum with six-week-old baby now attends a clinic in an adjacent village. Her older child is obese. I now have no informal contact with her health visitor – cannot exchange information of this sort’*
 - *‘They have recently taken the decision to shorten the baby clinic without discussing with the practice first’*
 - *‘Rarely see a health visitor’*

Clearly, there is the feeling in some practices of loss, frustration, and anxiety about the impact on patient care and well-being. Unfortunately, there is no base-line with which to compare these reported experiences making it impossible to assess whether existing problems have been improved, are unaffected, or have worsened. In addition, data are not available to assess the impact on health that problems with contacting health visitors or communication problems might give rise to.

7.3.5 Views on how the changes were introduced

The practices were asked whether they had any comments on the process of how the changes were introduced (Table 7.4).

Table 7.4 Answers to questions on the process of the change

Type of comment made	Number
Comments that identify problems with the process	10
Comments that identify good practice	1
Other comments	2
No response to question	9

Over a third of the questionnaires (9) had no response to this question. Of the 13 responses made:

- One referred to a senior health visitor giving “direct information” to a regular meeting of the practice
- Two indicated that they had been little affected by the introduction of the changes:
 - *‘Reorganisation has not had a significant impact on (us). We still have the same health visitor’*

- *‘Health visitors have been understaffed and overworked. We have had no complaints’*
- Ten identified problems they had with the process by which changes were introduced. The views expressed were largely summarised in one response, which described the process in terms of its *‘lack of involvement, lack of discussion, lack of choice’*

A significant minority of those practices responding to the questionnaire seem to feel that the changes were introduced at short notice, with inadequate consultation and as non-negotiable.

Comments were also made about:

- Whether the timing of the introduction of the changes is appropriate *‘when child protection is being highlighted’*
- Whether the changes were driven by concerns about efficiency rather than effectiveness
- The extent to which the changes were introduced *‘without having been fully thought through’*

7.3.6 Practices’ overall views on the changes

The practices were asked to choose the statement that most reflected their overall view of the changes (Table 7.5), although some respondents highlighted that even within practices individual GPs and professionals held different views.

Table 7.5 practices views on the changes

Questionnaire statement	Number of respondents
I am even more convinced that the changes have had a negative health impact	7
I still have reservations about the changes but less than before the changes were introduced	5
I am neutral about whether the changes have been beneficial or harmful	6
On the whole I think the changes have had a positive health impact	1

7.3.7 Analysis of the results by PCT

It was hypothesised that the change to neighbourhood working would possibly involve more practical disruption in Central PCT than in the other two PCTs because prior to the change families in the town centre were registered with many different practices. However analysis of the data did not show a substantial difference in patterns of response between PCTs. Slightly more Central PCT practices responding to the survey reported problems with running baby clinics but this impression is based on small numbers and may be due to chance. Of the seven practices choosing the most negative statement to represent their views on the changes (‘I am even more

convinced that the changes have had a negative health impact'), four were in East PCT, two in Central PCT and one in West PCT.

7.4 Conclusions

7.4.1 Methodological points

- The 42% response rate was understandable considering current demands on practices time. It is not clear what the level of concern or support for the changes is in practices that did not respond.
- Some of the critical comments appear to relate to on-going issues, for example the amount of overall resource given to health visiting and pre-existing issues between GPs and health visitors. Separating out these views from the specific impacts of the changes made in April is difficult without baseline information.
- It could be anticipated there would be some criticism of the process of change as it involves re-defining relationships. It is difficult to separate out criticisms of the way the change was introduced from comparisons on the relative health impacts of practice or geographical attachments. The fact that five practices commented that they are now less concerned than when the change was first proposed suggests some practices have modified their view as time has elapsed.

7.4.2 Summary

- Just over half of the practices that responded felt that overall the changes had a negative health impact (12 out of 21 responses from 53 practices)
- Just under half of the practices that responded (10 practices) had specific criticisms of the way the change was introduced
- The most frequent criticisms of neighbourhood working were, disruption to the previous arrangements for baby clinics (12 practices) and communication difficulties between GPs and health visitors (7 practices)
- Six practices felt there was a likelihood of a detrimental impact on immunisation and five practices were aware of detrimental impacts on child protection.
- Three practices were aware of specific improvements to health visitor services since the change with 7 out of 21 respondents reporting that the overall impact of the changes was either neutral or beneficial

8 Evidence from Health Visitor Team Portfolios

8.1 Introduction

When geographical working was introduced each health visitor team was encouraged to develop an evidence portfolio. Portfolios consist of a variety of documentary materials providing evidence of team activities and are intended both to stimulate discussion and to facilitate the evaluation of geographical working.

Each team was assigned a support facilitator who made themselves available to teams or individual team members for help or advice relating to contributing to the Portfolio. It was suggested that each team divide material into the same four sections to aid the evaluation process but the collection and selection of material was left to the discretion of each team to allow for the individuality of each team and the diversity of needs within their geographical area.

The four sections were:

- Working with the teams
- Working with clients
- Working with other teams/agencies
- Working with the community

8.2 Method of summarising the portfolios for the HIA

To provide a snap shot of changes that had occurred in the first five months of geographical working a clinical manager from each of the three PCTs collected data from two portfolios from their own PCT. All three managers were part of the Evaluation Steering Group and were also health visitors themselves, so they had insight into the context of the data.

Data on changed activity were categorised into the following areas:

- Family support
- Community development skills
- Knowledge of neighbourhood services
- Information on needs
- Addressed inequalities

In addition the data were categorised as:

- New activities
- Changed positive activities
- Changed negative activities

8.3 Results

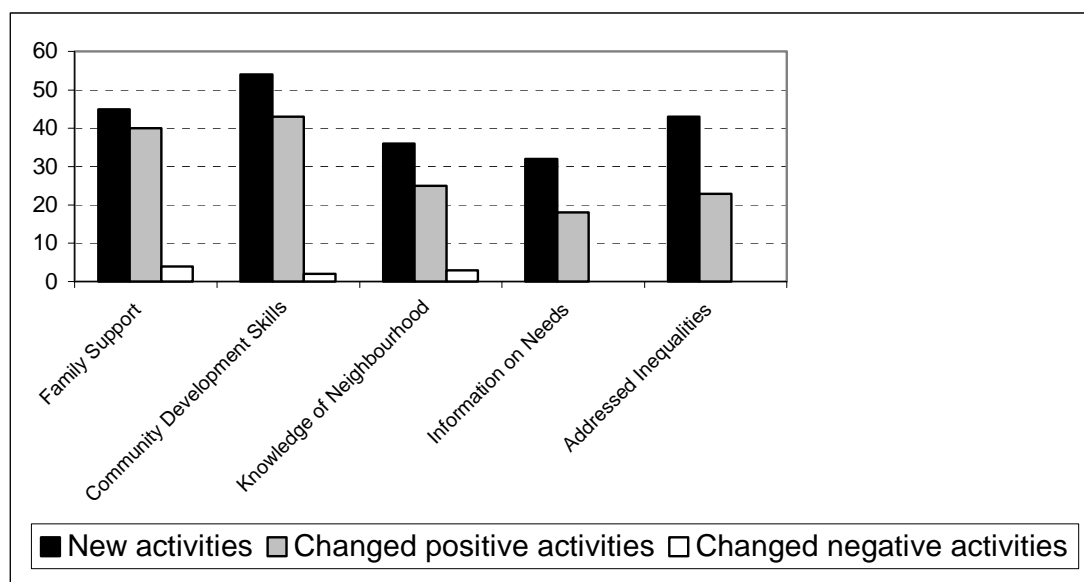
The quantitative and qualitative results of the analyses of the portfolios are presented separately

8.3.1 Numerical results

368 pieces of data were collected from the six teams. The majority of the data recorded new activities (58%), a further 40% recorded positive changes and only 2% recorded negative changes. The new activity could indicate that new needs are being addressed or that previously identified needs are being addressed in new ways. The very small number of negative records may suggest that the portfolio is not an effective method of capturing negative impacts.

The most common category of data recorded was the acquisition of community development skills. There were fewer records concerning knowledge of the neighbourhood and gathering information on needs. This was expected because the analysis was carried out soon after the change and a logical first step was to concentrate on acquiring skills.

Figure 8.1 Number of pieces of evidence from six sample portfolios indicating new and changed health visiting activities



8.3.2 Qualitative results

Evidence from the six portfolios has been analysed and is summarized in Boxes 8.1 to 8.4. This is followed by the reflections on the use of portfolios by the health visitor facilitators in Section 8.4.

Box 8.1 Portfolio evidence of working as teams

Not surprisingly a substantial part of the portfolio evidence was dialogue on aspects of team working. This reflects both the consequences of practitioners being moved into new teams and hopefully the beginnings of a sustainable process to support staff in the future.

- Questions were addressed such as why do we want team meetings? What are the benefits to the service and us? Team members recognised that the expansion of the teams required effort to build relationships, respect, trust and honesty. There was evidence of agreements being reached and teams being motivated to arrange regular meeting but also acknowledgement of the difficulty of finding the time.
- Evidence of team learning by sharing information on training events, identifying members to attend future events and feedback. Evidence of inviting speakers to explain their roles and give updates on service provision.
- Evidence of team working in the process of producing portfolios such as identifying practitioners to lead different components of the work to complete evidence.
- Evidence that the impact of change on those providing administrative support was being discussed within teams including the sharing ideas to reduce the stress that changes were making on administrative staff.
- Discussions on new ways of working for example identified contact times and rota systems intended to increase family access and allow practitioner research time.
- Discussions concerning prioritisation: how to meet clients needs in the context of overall workload demand. Some teams have decided to move to corporate caseloads.

Box 8.2 Portfolio evidence of working with clients

- The establishment of a new community group for parents with children under one. This arose from a health visitor team identifying gaps in the previous service which was felt to be held in an environment that was not conducive for peer support, lacked a family friendly play area and concentrated on weighing babies which raised parental anxieties. A new venue was identified in partnership with local parents, the local church and Sure Start, after using focus groups to review the service. The new group aims to provide peer support and social contact. Evidence of this has been recorded for example: *“Two mums observed to be laughing about their lack of sleep, said they felt less tense about the disturbed nights, not alone, not their fault, not seeking solutions but stating they felt less pressured.”* The confidence of parents involved in setting up the group has increased leading to further involvement. Some parents are now active Sure Start Board members and some parents are now employed. This project acknowledges parents’ capacity and potential to provide community support.
- A team working with pregnant women identified a wider community need within a developing housing estate. Young couples were distanced from their families and from their previous social contacts at a time they were taking on new roles as parents. The team invited parents-to-be to meet and discuss future service provision. Meetings were informal with the parents setting the agenda based on what they already knew and what they wished to find out. A postnatal group was established to provide time for parents to meet, form friendships and local networks. Peer support evolved as 'baby sitting circles', swimming sessions and a quiz night at the local pub.
- A team identified an opportunity to offer a baby massage course to parents in an area with a high incidence of postnatal depression and low parental self-esteem. There is research evidence for this relatively new concept. A rolling programme of courses has been established and the service has expanded to include families in a nearby community. There are now four practising massage instructors who meet regularly to review the service, share ideas and future planning.
- Teams have identified ways of improving the process of transferring families between teams. This includes individual welcome letters with contact information and information on services within their communities. Link Health Visitor Forms were designed to exchange information and joint visits encouraged arranged for families with more complex needs.

Box 8.3 Portfolio evidence of working with other agencies

- A team met with a local family centre to review service provision and offer health input. Issues discussed included: first contacts with 'hard to reach families' and the low numbers of non-middle class families utilising the existing baby clinic. There was agreement for 'baby clinic services' to be added to the family centre's 'Play Time' and to increase liaison about who is best suited and family preferences for first contact with 'hard to reach families'.
- Information recorded on services for local parents such as after-school and holiday activities. Evidence of links with local childminders and linked initiatives such as making training courses available to parents and staff, provision of toy library and sharing criteria for nursery places.
- Evidence of speakers being invited to team meetings such as 'Cancer Support Workers' and smoking cessation teams and evidence of plans to invite voluntary services and young peoples drug support team to future meetings.
- Joint working with the local drug support service and with the police leading to the use of shared information cards on service provision and local family support.

Box 8.4 Portfolio evidence of working with Communities

- A team worked with a local community forum to produce a needs profile. The community wished for a local surgery and a local service for benefit and housing advice. The team participated in a 'community event day' sharing information on local services with the public, networking with other services and revisiting the community's needs. The team learnt that promoting the event from fliers was insufficient and that personal communication was essential. Residents expressed their wish for school holiday play schemes and asked for help with stopping smoking. Links were established with the smoking cessation service (this was in an area where 57% of the population smoked).
- A team worked together with several agencies to hold a community event on a Saturday within the local school to encourage family awareness of drug related problems and local support services. Local children were involved with a play and songs to build self-esteem and positive images. The community made contacts with the agencies working to address these issues and was encouraged to become actively involved.
- A team reviewed their communities identified needs and existing services. Team members divided up the tasks of obtaining information from existing resources such as the local family centre, toddler groups, community centres, New Deal House, wardens and community link workers. Community link workers were invited to team meeting. In response to local wishes the team have set up new community clinics to provide an accessible service with an opportunity to respond directly to community needs. The clinic service was set up in the areas of highest need linked and is available to all age groups.

8.4 Reflections on the use of the portfolios from the health visitor facilitators

The portfolios provide an opportunity for front-line staff to record their work in a format that provides evidence of learning and good practice to influence future working. The portfolios are based on the reality of the work of front-line practice and encourage public involvement, team working and partnership working.

As facilitators, we emphasised the acceptance of differences within the portfolios, but encouraged a common format to support analysis of the content of each portfolio. Teamwork also has to be balanced by recognition of the responsibility and accountability of individual health visitors. Previously health visitors were previously responsible for a designated practice caseload with few resources or skill mix. Larger teams and support from our nursery nurse colleagues gives the opportunity to develop new approaches to meet communities' health needs.

Portfolios reflect the increased time that has been spent in communicating with each other. We acknowledge that for some teams this dialogue has been more difficult than for others and for some the change has led to additional stress and anxiety, however the change has provided the opportunity for problems that existed previously to be addressed. Portfolios are one way to encourage a creative approach to team working and share approaches that have been successful. Providing on going support for further team development is essential if all the potential benefits from the change are to be realised.

The portfolios contain evidence that health visitor teams are developing skills and starting to progress their work from an individual level to a population level, working to influence the root causes of ill health and increase access and choice for hard to reach families. There is evidence of new ways of working in initiatives such as the new Community Clinics and the links with New Deal for Communities to provide funding enabling the baby massage project to be extended to a wider client group.

8.5 Methodological issues from the analysis of portfolios

- The analysis was made only five months after the change it was therefore to be expected that much of the evidence would relate to establishing teams, acquiring skills and making contacts rather than initiating substantive projects.
- Health visitors were requested not to include any 'unchanged activities' in the portfolios so they will only contain evidence on what health visitors perceive has changed.
- The fact that only 2% of data concerned negative changes suggests that the portfolios may be severely limited in collecting data about perceived negative impacts. Health visitor teams are likely to be influenced by what

they perceive health visitor facilitators expect and could potentially feel constrained about openly recording negative data that are available to their managers.

- Health visitor managers who were already aware of the initiatives and issues being described made the interpretation of the data. This will be reflected in their interpretation of the data.
- The analysis was a sample of only six out of 23 health visitor teams so it is not possible to draw conclusions about the degree to which changed working has spread across all the teams.
- It is not possible to say how many of the initiatives recorded would have occurred if geographical working had not been introduced

8.6 Conclusions

There was agreement among the health visitor managers that the portfolios demonstrate evidence from the first five months of geographical working of changes in the following areas:

- There is some evidence of a change of focus in health visitor work activity away from the individual client towards the work based on the client as 'family' within a larger community.
- There has been a greater acknowledgement of working with other age groups as well as the under fives.
- There has been a perceived removal of administrative-governed (rather than need-governed) decision-making relating to the activities health visitors undertake.
- The use of evidence portfolios should be encouraged and supported. Portfolios are useful for analysis of the teams development needs. From the teams' perspective they are potentially useful for induction, training, personal development and team development. For the PCTs' perspective they have the potential to contribute to training needs analysis, analysis of skills mix or gaps in team skills and also for contributing to wider health needs assessment by the PCT.

9 Views expressed at a stakeholder event

9.1 Design and Structure of the Stakeholder Event.

On the 6th November 2003, a representative from each of Doncaster's health visitor teams and each GP practice, with community development workers and other stakeholders, such as midwives, were invited to participate in a briefing and discussion event at a local hotel as part of a planned set of activities to assess the health impacts of changes to the organisation of health visiting in Doncaster.

The event was designed:

- To report back to stakeholders on information gathered so far by the Health Impact Assessment Group
- To test out the credibility and implications of that information from a range of professional perspectives and working contexts
- To explore any unanticipated, and/or novel, and/or disconfirming data

The half-day was structured around:

A number of short presentations that aimed to

- i) Explain the policy and practice reasons behind the changes
- ii) Examine the current match between need and health visitor service provision by drawing on the 2001 Census
- iii) Report on work carried out by members of the HIA group on GP and health visitor experiences of the changes to date.

Plans of how to access patient views were presented and there was opportunity to discuss the presentations, to network, and to post individual's views and comments on flip charts.

Mixed group discussions focusing on

- (i) Whether intended benefits are being realised
- (ii) Whether potential risks are being avoided
- (iii) What should happen next?

The event program is shown in Box 9.1. In total, 51 people representing a range of professions and working contexts signed up for the event and 48 actually participated. During the break, individual views could be posted on a series of notice boards (reported in Section 9.2). Scribes working with facilitators captured reported experiences and opinions expressed in discussion groups. In addition, "group perspectives" were sought on the three issues listed above (Section 9.3).

Box 9.1 Changes to Health Visitor Working, Stakeholder Event Program
6 November 2003 9:00am - 12:00 noon

Session	Time
Introduction and Presentations	
<ul style="list-style-type: none"> • Reasons for the change and community development ways of working • Numerical information including 2001 Census data • Patient and public involvement • General practice perspective and results of practice questionnaire • Information from Health Visitors' portfolios 	9:00- 10:15
Break, networking and posting views	10:15 - 10:45
Group Discussions	10:45 -11:45
Plenary session	11:45 - 12:00

9.2 Individual stakeholders' views about the changes

A number of notice boards invited stakeholders to comment on the changes and the approach taken to assessing health impacts. Notice Board headings echoed the titles of the five presentations given that morning. The headings and the views posted under each heading are shown in Box 9.2. The comments have not been edited but the Steering Group has added some additional clarification to some comments in italics.

Box 9.2 Views expressed on Notice Boards during Stakeholder Event

<p>Reasons for the Change</p> <ul style="list-style-type: none"> • Meeting needs of community rather than routine historical practices • Working with voluntary groups and other agencies more • How big is a team? • Teams are very keen to work geographically and in CD way - being supported in resourcing these changes is needed • Team building support would be useful to ease the change • Should geographical teams be together because of vicinity or deprivation/need? • Consider impact on clerical/admin staff • Wide based analysis post change not pre change • Some areas have been geographical for many years so no real change
<p>Epidemiological Analysis</p> <ul style="list-style-type: none"> • Community profiling: more management support for profiling • We need community profiling to look at needs in areas not covered by indices of deprivation • Have more deprived areas got more HVs - how proved! • We need time to profile and skills to do it properly. This will help substantiate investment of resources • No. of 0-4's does not represent extent of HV need therefore does not represent input • Use local action plans for resource Vs needs data

- Whole HV teams need to be examined in data not just HV WTE. This would make more sense
- Does HV resource include vacant caseloads? (*yes - the data presented were of HV establishment*)
- Is patient mobility represented statistically? If not this does represent need i.e. vulnerable families have high mobility rate
- Immunisation rates remain consistent despite geographical working
- Focus on quantitative data at present. Qualitative data would inform our practice
- HVs looking at current epidemiology at present. HVs etc not reducing figures - need to change practice e.g. reduce deprivation cancer etc.
- Statistics out of date. Child health was contacted this week to prove this. (*This comment apparently relates to the presentation of census data and the need to have a mechanism for reviewing teams resources when populations change rapidly for example sudden changes in birth rates or new housing estates*).

Public and Patient Involvement

- Unique and innovative ways of engagement for development of service provisions
- Focus on community's families and young people
- Work more closely with practices. Improve communication not work in isolation.
- Use public forums
- If we truly want to be community led we need to listen to our communities and we in turn need to be listened to
- Communities are diverse. Let's spread service across the board
- A common directory, ring binders for GP's and this backed up with a database
- Organise a working group to explore ways forward to meet needs of BME communities

Practice Manager Questionnaire

- Would it not be better to use face to face qualitative reviews rather than simplified questionnaires
- Some GPs against change. HVs know what works in HV's practice
- Should have been more consultation with GP's right from the beginning
- More details needs to be made available and if possible more involvement from practices locally in the changes
- Link with Improving Working Lives. Translating to practice
- Child not registered and vaccinated is a team responsibility HV, practice nurse, GP
- Why did GP not contact social services or our child protection team for information on children if concerned when they can't get hold of HV?
- GPs need more training and support re child protection regularly
- What was improvement in HV service?

Portfolio Analysis

- Portfolios need to express +ve and -ve issues e.g. poor clerical and admin support to teams and its impact
- What is -ve activity? Didn't know these existed!!
- I think evaluation is crucial, not only self-evaluation but client and team. Team meetings have helped develop our portfolio
- We started ours and it's full. We've included evaluation of the input as well - to make sure the client evaluates us and the resource is invested in the correct place Stainforth.
- Portfolios can be a useful tool to show the good work going on in an area
- Does portfolio analysis really show resources matched to need? Staff morale status. Staff stress status. Increased workload. Increased vulnerable families.

How many needs are not being met? Does portfolio outline difficulties providing same service to clients i.e. support when numbers are increasing, depressed mums, breast feeding

- More group work and more positive feedback from families
- Do portfolios show ethnicity within population served?
- Excellent HV to midwifery communication. Postnatal women complaining on some instances that they have been seen by a HV they do not know or recognise
- How geographical working impacts on team: people thrown together; No team design/fits/support
- What costs will geographical working affect? People leaving, increased workloads increase rates of new births, more child protection work and vulnerable families
- Training came after implementation of geographical zoning. No training re team building
- Could community staff be given incentives to use other forms of transport e.g. bicycle

9.3 Stakeholders experiences and opinions expressed in discussion groups

Facilitators explored individual and group views, for their overall impressions and specifically for experiences on a number of issues:

- Are the changes leading to an increased way of public health working?
- Have the changes increased efficiency?
- Have the changes enabled better use of information?
- Have risks to childhood protection been avoided?
- Have risks to immunisation coverage been avoided?
- Has disruption of links with Primary Care Teams been minimised?
- Any communication points?

Responses to these issues are collated below:

9.3.1 Are the changes leading to an increased way of public health working?

This was explored by seeking views on (a) whether there is increased support for families and (b) whether there are increased skills in community work.

Examples of additional support to families included new provision of community clinics, work with additional client groups (e.g. through working men's club), revitalisation of play groups, and to coming across families in non-work contexts (e.g. at the shops) which offers new contact and support opportunities. Although concern was expressed about not giving enough *individual* support to mums overall stakeholders are of the opinion that the changes are providing increased support for families.

Opinions were less clear about whether community skills had increased - or what these might be. A couple of specific examples of CD work were offered

(Wheatley/Clay Lane team used the local press to publicise that HVs are working across a range of client groups, not only in childcare, and in Sprotbrough, HVs are involved in road safety work). Some HVs thought that increased local contact was developing their knowledge base and they were becoming "more of a presence" in their areas. As a result, families are now approaching some for support.

Overall, views are that geographical working does not automatically result in increased skills but offers opportunities for CD working. CD skill development is still piece meal at the moment, perhaps as might be expected. An issue that was raised was that of linking to other professionals working locally and how boundaries between different areas of practice might be managed.

9.3.2 Have the changes increased efficiency?

There is definitely less time travelling for some – but not all. Some HVs are still travelling to patients to complete a package of care begun before the geographic changes. (There are some queries re mileage allowances). Longer visits are now possible in some areas because of the reduction in travel time.

There was substantial agreement that under-resourcing of the administrative element of the changes has led to problems and led to HVs spending time chasing records/contacts etc. In addition, some staff have experienced confusion over protocols for birth notifications and antenatal care.

Some teams have had to become acquainted with a number of new administrative, management and funding boundaries e.g. Sure Start and New Deal for Communities (NDC). These can influence the types and range of services that can be accessed by patients and may cut across efficiency gains. Community Forum and PCT boundaries are coterminous but not with Health Visitor Zones. Additional time and effort is required constructing working relationships with a number of different teams.

9.3.3 Have the changes enabled better use of information?

Health visitors are beginning to network in the community and to have more knowledge about their areas. However, HVs have not been informed about Community Forums and other mechanisms for community participation in their areas. Some information about their boundaries and roles would be helpful.

The same problems exist as before the changes about who is working in the area and who to contact about what. This is a particular issue for "keeping safe" element of child protection where there seems to be some uncertainty about who is connected to which computer system.

The extent to which HVs can feedback information on their communities to PCTs is of course constrained by what they know. There was very little evidence of HVs being in a position to fulfil this role as yet. However, one

example was given. No bus service meant that orthoptics services provided in Bawtry were not accessible from Auckley. *"As a direct result of HVs bringing this to the attention of the PCT, discussions have begun about providing a service in Auckley."*

Having access to the hard data from the Public Health Intelligence Unit is felt to be very valuable for determining priorities and allocating resources but it is felt to be "too early" to expect any data on the impact of the changes on inequalities. Two specific concerns were expressed; provision for asylum seekers may have deteriorated and on going problems with language barriers may be hindering delivery of services to small ethnic populations.

9.3.4 Have risks to childhood protection been avoided?

Concerns about "who knows what" and the extent to which protocols designed for a different context are appropriate to the new ways of working have already been referred to. Specific experiences seemed to focus on communication problems. Views were split on whether these were new issues or long-standing unresolved matters given another airing. Due to the change to geographic working, some HVs are experiencing an increase in their workload (perceived at up to 75%). This plus an increase in the birth rate in one area makes service delivery difficult with allocated resources and may lead to increased stress levels for staff which might constitute a risk to child protection.

9.3.5 Have risks to immunisation coverage been avoided?

Early statistical evidence indicates that coverage rates are slightly improved and the overall view from the event is that risk to immunisation is not an issue. There were reports of immunisations now being available through new community clinics and that these presented additional opportunities for "a whole range of health promotion activities". There was a request, in regard to health promotion and immunisation, "that we are all singing from the same hymn sheet".

Concerns were expressed at the stakeholder event about:

- Problems for practices identifying which HVs to contact when there is concern about child immunisation.
- How immunisation sessions can be managed most effectively, following the changes to Health Visitor working.

9.3.6 Has disruption of links with Primary Care Teams been minimised?

A number of diverse points were made on this issue:

- This was a lost opportunity to integrate HV and Primary Care Team records.
- HV communication with primary care team is "still good" – but there are now many more HVs to maintain a relationship with (Midwife).

- More parents are reporting no HV contact within 14 days of birth.
- The HV link role between GPs and community may be lost. Implications?
- The link health visitor system seems to be working in some areas, for some practices and not for others. Variations may be the result of how both health visitors and general practices are organised and resourced .

The following comment was also made:

“Our GP's have not found the changes easy. They don't like clients from other practices coming to our building. We feel pushed out of the primary care team. They don't like us using their building. We feel uncomfortable.”

This may suggest that the changes to health visitor working may be perceived by some GPs, HVs and others as threatening to self, group and/or professional identities and practices. It might be anticipated that the "loss" of a valued and trusted resource (staff, buildings, relationships, etc.) should evoke feelings such as bewilderment, anger, resentment, blame, distrust, and betrayal. The task from an HIA perspective is to understand what threats to service delivery arise from these experiences of loss and to assess whether, when and how they will be addressed.

9.3.7 Any communication points?

Communication problems, particularly between HVs and GPs, were referred to by several participants. Problems include:

- Difficult to contact GPs.
- Difficult to contact HVs
- HVs and GPs unlikely to "come across" one another as in the past or be able to have discussions at short notice because no longer in the same building.
- A GP finding it difficult to contact the right HV for each patient because now dealing with eight or so HVs.
- Difficulties where HVs are not at the same base point.
- Some contact problems – mobile phones and/ or known contact times would help for urgent matters.
- Care needed about confidentiality over the phone/faxing information etc at the moment when HV and other (health) professionals may not be known to one another.
- One health visitor team have designed a form to improve communications.
- Some participants were of the view that any problems arose from long standing communication difficulties, not the change to geographic working.

9.4 Overall observations

Overall, stakeholder views as expressed on the 6th November are that:

- Its very early days as yet.
- The implementation has not been problem free. There are some resource difficulties and shortfalls that might be hindering a successful implementation.

- Was the decision to phase-in the changes over time the right one? Would a “big bang” approach have produced less confusion? For example, it was reported during discussions at the stakeholder event *“the impact on admin and clerical staff was not considered. This has put a lot of pressure on them. The staged approach has helped, but the length of time is wearing them out”*.
- There is a need to differentiate the impact of change to geographic working from impact of the way the change was introduced and managed. GP comments tend to focus on how the change to geographic working had been introduced. Would more consultation/information about the changes and the implications for practices have assuaged some of their concerns? For example, it seems that GPs were not given a copy of the Blue Folder “for funding reasons”.
- Some Health Visitor teams and some GP practices seem to have a sense of loss arising from the changes. Many working relationships have changed and perhaps in some cases severed. Access to buildings, information, resources, and clients have changed - in some situations positively but in others they have become less certain and more complex (this has been a particular problem in west PCT). Who fits where and who has what roles and responsibilities in delivering services has become less clear. All staff (clinical, administrative and community) affected by the change are now in a period of adjustment and professional and personal negotiation around tasks, duties and protocols. Clients similarly have limited awareness and understanding of what the change means for them. The question for PCTs is *how can these processes of negotiation and adjustment be best managed?* One suggestion made at the stakeholder event is that Health Visitors attend GP practice meetings.
- Has sufficient attention been paid to building the new area based health visitor teams? A comment was made about teams being “shoved together” - making work co-ordination difficult.
- Are core HV services delivered less well as resources are diverted to meet a broader CD remit? One participant commented that *“I am gaining clients but losing resource. There is only so much I can do”*.
- Is the HV role being diluted? Are health visitors replicating/replacing services provided by other professionals? In making planning and resource decisions it was suggested that all staff and all grades need to be included and that perhaps other professional should be working geographically.

10 Conclusions

This section describes the process used to draw the conclusions of this report. It then presents the overall conclusions for Doncaster PCTs, suggestions of how the conclusions may be of relevance to other health communities and specific recommendations as to how Doncaster may maximise the potential positive health impacts and minimise negative impacts in the future.

10.1 Process of producing conclusions

The HIA Steering Group was used as an expert group to decide on the impacts of the change. The group members gave opinions on the impact of the change based on the evidence collected and their personal opinion. A scoring grid was used to clarify the discussion and identify areas of consensus and disagreement. The grid was developed from the original views of the Steering Group about likely positive and negative impacts (Table 2.2) and modified in the light of comments from the stakeholder event. The grid consisted of 11 statements listed in Section 10.2. The Steering Group was asked to give two scores to each statement: a weighting score reflecting the importance the group placed on the statement if it was true and an impact score representing the group's view of whether there was evidence the statement was true. The scoring was based on evidence available to the group six months after the change. The scoring system is summarised in Table 10.1.

Table 10.1 Scoring used in weighting and rating the different health impacts

	Meaning	Range
Weighting score	Importance the group attaches to the statement if true	+5 High +1 Low
Health impact score	Groups view of whether there was evidence the statement was true 6 months after the change was introduced	+2 Significant positive health impact +1 Some positive health impact 0 Evidence was available and suggested no overall health impact -1 Some negative health impact +2 Significant negative health impact

An earlier version of the scoring grid distinguished between impacts on children, parents and other clients with needs. It was decided not to use this more complex grid because the group did not find it useful to distinguish between impacts on children and parents, and because the group was aware of only very limited evidence of impacts on activities away from health visitors'

core activities with families. Furthermore the group were unsure whether it is reasonable to expect health visitors to address such activities in any substantive way given the current limits on resources and the increasing demands of the family agenda.

10.2 Reasons for the conclusions of the HIA

Scores for the 11 individual statements are given below with a commentary on the reasons for each score. In some areas the text may implicitly suggest recommendations, these are made explicit in Section 10.7

10.2.1 Since the change there is increased support for families in need

Weighting	Evidence of health impact on families	Combined weighting with impact
5	+1	+5

This statement was given maximum weighting because previous local consultations (Section 4) indicated this was a high priority for parents. The statement also reflected the Steering Group's view of the main priority for health visitor services.

The evidence for health impact was felt to be limited but overall in a positive direction. There was a suggestion in the practice managers comments of some negative impacts on some families who had been disrupted by the change process (Section 7). There was evidence of some positive impacts (although still limited) recorded in the portfolios (such as the new clinics, events and services recorded on page 48-50). The conclusion of 'limited but positive impact' was supported by the views of the discussion groups at the stakeholder event.

10.2.2 The change to geographical working has had a positive health impact because health visitors are now using a more community development way of working

Weighting	Evidence of health impact on families	Combined weighting with impact
4	+1	+4

The statement was given a weighting of 4 based on the statement in HFAC4 that there is 'persuasive but indirect evidence that these ways of working are at least as likely to improve health as traditional health care approaches'.

Much of the portfolio evidence relates to teams acquiring community development skills but it also list several examples of specific developments such as community clinics and community events (described on page 49 and 50). Discussions at the stakeholder event showed some difference of opinion about what community development skills are but there were some limited examples of work that could be expected to have positive health impacts such as road safety work (Section 9.3.1).

10.2.3 Health visitors now spend around 20% less time travelling so can give more time to clients

Weighting	Evidence of health impact on families	Combined weighting with impact
2	+2	+4

The weighting of 2 represents the view that although reducing travelling time is welcome, it was not in itself a principal justification for the change.

Although the mileage data give an indirect measure of time spent travelling, the data were supported by comments from some, but not all, health visitors that they had some extra time for clients as a result of the reduced time spent travelling.

10.2.4 Health visitors have more knowledge about neighbourhood this means they can help their clients more effectively

Weighting	Evidence of health impact on families	Combined weighting with impact
4	+2	+8

The weighting reflected the evidence in HFAC4 and the Steering Group's opinion that knowledge of local conditions and services is important for individual, family and community based interventions.

The impact of +2 was given on the basis of evidence from the portfolios that some teams have actively collected information and made links and the fact that the HIA process itself had made data available from the census and strengthening links with community development workers. There was however extremely limited evidence from the practice survey that this information has yet been passed on to other members of primary care teams.

10.2.5 There is evidence that health visitors are now feeding back more information on needs to organisations such as PCTs and DMBC

Weighting	Evidence of health impact on families	Combined weighting with impact
3	No evidence	N/A

The weighting of 3 reflects the group's view that this is highly desirable, but not health visitors' most essential priority.

The group felt there was an absence of evidence that the PCTs and DMBC were using information at a strategic level that had been fed upwards from health visitors. There were isolated examples of specific initiatives at local level such as road safety (Sprotbrough) and advocating for an othoptic clinic (Auckley).

10.2.6 Health visitor resources are now distributed more transparently and equitably. This makes it easier to address inequalities.

Weighting	Evidence of health impact on families	Combined weighting with impact
4	+1	+4

This weighting reflects the group’s view of the importance of responding to local inequalities. The published evidence for the effectiveness of targeting is summarised in Section 3.5.

The fact that it took a lot of effort to establish the distribution of resources prior to the change demonstrated the previous system was not transparent. The group’s opinion is that overall the new system does target resources more equitably but the impact score was not the maximum possible because of the limitations of the analysis described in Section 5.3.2.

10.2.7 There is evidence of a deterioration in the effectiveness of child protection

Weighting	Evidence of health impact on families	Combined weighting with impact
5	0	0

Child protection was given maximum weighting by the group.

There was no evidence of any actual child protection incidents resulting from the changes. Five practice managers stated they were aware of detrimental impacts on child protection. This was balanced by:

- Views expressed by social services to the health visitor communication group that procedures were simpler because teams had responsibility for all the children in an area
- The views of some health visitors expressed at the stakeholder event that child protection is potentially strengthened by health visitors being responsible for all the children in the area
- The views of the child protection liaison health visitor who feels that the emphasis since the Climbié inquiry that all communication has to be formally recorded mitigates to a large extent the risks associated with the potential loss of informal conversations between GPs and health visitors.

10.2.8 There has been a demonstrable deterioration in immunisation rates

Weighting	Evidence of health impact on families	Combined weighting with impact
5	0	0

This was giving the highest weighting because of the strong direct evidence that immunisation is beneficial to health.

Section 6.2 shows that there has been no evidence of any impact on immunisation rates. In fact no positive or negative would be expected this soon after the change but PCTs receive quarterly monitoring on immunisation coverage data so on-going monitoring should be straightforward. Six general practices reported concerns in this area but health visitors at the stakeholder conference did not fully share these concerns because they felt there could also be benefits to immunisation coverage from increased work with hard to reach groups.

10.2.9 There has been a negative impact on health because in general links with primary care teams work less well

Weighting	Evidence of health impact on families	Combined weighting with impact
4	-1	-4

This was given a high weighting by the group because this is a key link for family centred practice but not given maximum weighting because there are other important links for health visitors.

There were no reported significant events leading to a definite negative health impact (the immunisation of the baby not registered with the practice (Section 7.3.3) was an organisational rather than a health risk). However 12 practices reported problems in running baby clinics this will have some negative health impact because of the effects on primary care morale and on clients' perceptions of services.

10.2.10 The changes have had a negative impact on health because communication between HVs and GPs is less effective and takes up more time

Weighting	Evidence of health impact on families	Combined weighting with impact
3	-1	-3

The statement was given a weighting of 3 because the group recognised the importance of efficient and effective communication. It was not given a maximum weighting because its health impact may not be direct and there are other important links for health visitors.

Seven practices in the questionnaire had experienced problems in contacting health visitors. The stakeholder event comments agreed there were problems but also felt that some communication issues between some practices and health visitors pre-dated the change. The view was also expressed that an opportunity had been missed to amalgamate general practice and health visitor records. The stakeholder event also emphasised the demands that had been put on administrative staff in terms of implementing the change.

10.2.11 The change has had a detrimental effect on the attractiveness of Doncaster for health visitor

Weighting	Evidence of health impact on families	Combined weighting with impact
4	+1 -1	0

The statement was given a high weighting particularly because recruitment is an issue in Doncaster and the service depends on it.

There was evidence of both positive and negative impacts. The portfolios and comments at the stakeholder event revealed stress resulting from the change, forming new teams and making new relationships. There was a suggestion that some health visitors may have moved within Doncaster to teams that have experienced less change of cases. The portfolio also revealed evidence of enthusiasm for new ways of working and the Steering Group felt there were advantages in having an approach that is consistent with national policy and current health visitor training. There have been several recent recruits from out of the area and the changes may have been one factor in attracting these recruits. The group therefore felt that the evidence for positive and negative impacts for this statement was balanced.

10.3 General discussion on the conclusions

The overall balance of the combined weighting and impact scores was in favour of a positive health impact (overall score +18). It should be noted however that this score is far less than the maximum possible positive score (hence the importance of the recommendations given in Section 10.7 to minimise negative impacts and to ensure that all potential positive impacts do occur).

There are two general limitations to the evidence:

- This report is only six months after the change and in fact the change itself was phased in over time, so many important impacts (both positive and negative) would not be expected to have materialised yet. This highlights the importance of recommendations for future monitoring of impacts. The groups would also like to emphasise the fact that geographical working is just one potential option in enabling public health ways of working. Whether or not geographical working is essential, it is certainly not sufficient on its own to ensure that public health working develops. This highlights the importance of the recommendations to continue to provide facilitation and support for public health ways of working.
- In some cases it was not possible to be sure whether negative views related mainly to how the change had been implemented or were criticisms of the system of geographical working itself. The next section discusses the fact that there was substantial criticism of some aspects of the way the process of change was managed. The fact that five general practices said

they now had fewer reservations about the change than when it was first introduced suggests some stakeholders may be adapting to the new system. However it is still very important to implement the recommendations to mitigate the negative impacts resulting from how the change was introduced.

10.4 Reflection on the change process in Doncaster.

Some issues were highlighted that have implications for the PCTs that go beyond this specific change.

- The complexities which arise as a consequence of PCTs delivering some services geographically and some services through practices.
- The potential for some general practices to feel threatened if services are switched from being practice based to geographically based.
- The on-going demands being placed on health visitors who, both before and after the change, had to relate to both area and practice geographies and to social and medical models of health.

There were some specific comments from the practice questionnaires and at the stakeholder event about how the change was implemented:

- Some stakeholders commented that the concurrent HIA was eliciting opinions that should have been sought before the decision to change was made. Although in some ways the PCTs could be congratulated on agreeing to what was mainly a 'bottom up' initiative there was a lack of use of change management diagnostics prior to the change being implemented
- The PCTs appear to have underestimated the efforts needed to implement the changes smoothly – particularly the additional burdens placed on administrative staff and the unmet need for facilitating the process of team building
- Although a communication subgroup was established some stakeholders (mainly general practices) were not satisfied with how information about the change was communicated. For some issues this was apparently because of lack of resources such as not providing practices with folders giving details of all teams
- Although there is a tendency to concentrate on the views of those expressing resistance to the change there was also evidence of positive impacts from the change process itself in the portfolio analysis and it is hoped the HIA in itself had some positive impacts (see next section).

10.5 Reflection on the use of HIA methodology

This is the second HIA in Doncaster after the Finningley HIA. It is different to the majority of recently produced HIAs such as those available via the HIA Gateway (www.hiagateway.org.uk) in that this report is a concurrent HIA (the majority are prospective) and it addresses a health service change (most address the health implications of changes outside the health service).

Evaluation of any change is expensive and time consuming, however if this change had not been evaluated the PCTs would have risked substantial opportunity costs in terms of not acting to minimise on-going negative impacts and making changes to maximise potential positive impacts.

Participating in the HIA required a considerable commitment for steering group members on top of their usual tasks. It was only possible to carry out the HIA in this format because Central PCTs Public Health Directorate, the Public Health Intelligence Unit and CRESR provided significant resources. There are questions for the PCTs for future HIAs in terms of how to decide, out of a large number of potential areas for HIA, which should be selected, and how to match HIA design to the resource available?

The Steering Group found the HIA methodology to be a useful way of reaching a judgement on the overall impact of the changes up to now and to explain how the judgement was made. Over the life span of the steering group there was an increase in members concerns about, and use of, evidence. Informal comments have also suggested that the HIA may have some formative effect in terms of helping to explaining the underlying thinking behind the change and the reasons for different stakeholders reactions to it. The HIA has also provided the impetus to produce census data for health visitor teams and initiating some contacts such as those between community development workers and health visitors.

10.6 Relevance of the conclusions for other health communities

The policy agenda and evidence base summarised in Sections 2 and 3 may well lead other PCTs to consider changing to geographical working. Whether or not to make this change would depend on the existing social and health care geography in the area concerned and the strength of existing relationships between health visitors and key services such as primary care teams and other health and local authority services. The emphasis on geographical working in Every Child Matters (DES 2003) with school catchment areas being important for family centres and extended school services is another consideration that has arisen since Doncaster made the decision to go geographical. The final decision for health communities is whether the efforts of re-negotiating one set of relationships and forming a new set is justified by the potential benefits. The Doncaster experience suggests that after six months there is evidence of an overall positive impact however the potential pitfalls in the amount of effort consumed by the change process, the stress on some team members, the administrative implications and the potential to damage relationships with primary care teams should not be underestimated. A similar experience was reported in Derby (PHAAR 2003).

10.7 Recommendations for Doncaster PECs

- I) **On current evidence geographical working should continue**
- II) **The PCTs should clarify the overall objectives and the distribution of resources within the health visiting services**
 - i) *Give guidance on the extent to which resources should be weighted in favour of more deprived areas*
 - ii) *Give guidance on the extent to which it is reasonable to expect health visitors to offer substantial services to needful groups other than families within current resource limits*
 - iii) *When the work of the local HFAC4 review group is completed (by April 2004). The aims and broad objectives of the health visitor service should be communicated to all stakeholders.*
- III) **The PCTs should act to minimise the negative impacts of the changes**
 - i) *Reduce negative impacts on primary care*
 - a) Write to all practices with a brief outline of the PEC's view after six months of geographical working and include practical information such as maps of health visitor team areas and contact lists
 - b) Each health visitor team should make explicit efforts to provide primary care teams with information on local services using mechanisms such as personal contacts by link worker, attendance at team meetings, links with reception staff, leaflets and notice boards etc.
 - c) All health visitors seeing a practice's patients need to be aware of the arrangements in that practice for services such as baby clinics, eight week checks and immunisations
 - d) Practices should develop policies for how they deal with other practices' patients at baby clinics especially with regard to immunisations
 - ii) *Reduce other negative impacts*
 - a) Circulate other stakeholders such as midwives and community development workers with lists of team members and link workers
 - b) Develop a robust system so that health visitor teams are aware of all pregnant mothers and communicate policies for prioritising antenatal visits by health visitor team members to all stakeholders.
 - iii) *Provide resources to facilitate team building for health visiting teams*

Recognise that health visitor teams require time for communication within teams and for learning with other health visitor teams. Health visitors' contribution to primary care teams should be supported by providing protected time for them to attend primary care team meetings such as "*in practice TARGET*" (local practice based education sessions).
- IV) **The PCTs should maximise the potential benefits of geographical working**
 - i) *Ensure health visitor teams continue to receive training in community development and public health ways of working*

- a) Continue to provide protected time for health visitor facilitators to encourage the sharing of good practice between teams
- b) Encourage the further development of team portfolios
- c) Develop closer links with local universities training health visitors
- ii) *Enable and encourage health profiling*
 - a) Hold a meeting between health visitor team representatives and the Health Intelligence Unit to help teams understand the range of quantitative data available to them and how they can enrich this by adding a qualitative perspective
 - b) The Public Health Intelligence Unit should provide information on the Black and Minority Ethnic make up of each neighbourhood
 - c) Health visitor managers and teams should review the resources available in zones where there are possible mismatches between resource and need (as suggested in Section 5).
 - d) Health visitor managers should develop a clear mechanism for adjusting resources when there are large changes in numbers of cases.
- iii) *Develop a mechanism to enable Health Visitors to feed back health needs information to PCTs.*
 In each PCT there should be an annual meeting between the DPH and the health visitor team leaders

V) The PCTs should use routine systems to evaluate the ongoing impacts of the change

- i) *Ongoing analysis of significant events*
- ii) *Monitoring of quarterly immunisation cover statistics with comparison with other districts if rates fall*
- iii) *Ascertain the views of PCT resident panels and of service users as recorded in health visitor team portfolios*
- iv) *Health visitor managers to monitor the recruitment and retention of health visitor staff in collaboration with the human resources department.*

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