



The information and planning needs of health visitors.

HARRISON, Joan P.

Available from the Sheffield Hallam University Research Archive (SHURA) at:

<http://shura.shu.ac.uk/20694/>

A Sheffield Hallam University thesis

This thesis is protected by copyright which belongs to the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

Please visit <http://shura.shu.ac.uk/20694/> and <http://shura.shu.ac.uk/information.html> for further details about copyright and re-use permissions.

100235263 0



TELEFON

ENCLOSE WITH ITEM

If date only given this is BLDSC return date.
Otherwise follow lending library's instructions as given below.

DUE BACK 25/5/1989

I declare that this item is required only for purposes of
private study or research. PLEASE SIGN BELOW

Date

20/3

Signature

H Moore

JF39476

GOOCH

REFERENCE



ProQuest Number: 10702789

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10702789

Published by ProQuest LLC (2017). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code
Microform Edition © ProQuest LLC.

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

**THE INFORMATION AND PLANNING NEEDS OF HEALTH
VISITORS**

by

JOAN P. HARRISON

Being a thesis submitted in partial fulfilment of the requirements for the degree of M.Phil.
(C.N.A.A.)

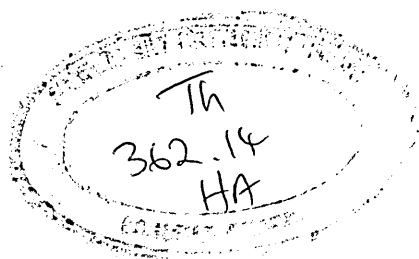
SPONSORING ESTABLISHMENT

Sheffield City Polytechnic

COLLABORATING ESTABLISHMENTS

Department of Health and Social Security,
Sheffield Health Authority

MARCH 1988



CONTENTS

| | Page nos. |
|---|--------------|
| <u>FRONT SHEET</u> | |
| <u>CONTENTS</u> | i |
| <u>APPENDICES</u> | ii |
| <u>FIGURES AND TABLES..</u> | iii |
| <u>ACKNOWLEDGEMENTS</u> | iv |
| <u>ABSTRACT</u> | v |
| <u>CHAPTER 1</u> | 1 |
| Introduction | |
| 1) Health Visiting the community, politics and profiles | |
| 2) Information and the organisation | |
| 3) Information Science literature | |
| 4) Methodological approaches | |
| 5) Method | |
| <u>CHAPTER 2</u> | 46 |
| Results of the Health Visitor Interviews | |
| <u>CHAPTER 3</u> | 80 |
| Results of the Senior Nurse Interviews | |
| <u>CHAPTER 4</u> | 97 |
| Results of the General Manager Interview | |
| <u>CHAPTER 5</u> | 101 |
| Workshop Results | |
| <u>CHAPTER 6</u> | 117 |
| Results of the Evaluation Questionnaire | |
| <u>CHAPTER 7</u> | 125 |
| Discussion | |
| <u>CHAPTER 8</u> | 156 |
| Conclusion and Recommendations | |
| <u>REFERENCES</u> | 161 |
| <u>APPENDICES</u> | A1 |

APPENDICES

| | | | page nos. |
|----------|------|---|--------------|
| Appendix | Ia | Introductory letter to health visitors | A1 |
| | Ib | Second letter to health visitors | A4 |
| | IIa | Introductory letter to managers | A7 |
| | IIb | Letter to Director of Nursing Services and General Manager | A8 |
| | III | Interview schedule for health visitor sample | A9 |
| | IV | Interview schedule for senior nurse sample | A13 |
| | V | Interview schedule for General Manager | A15 |
| | VI | Evaluation questionnaire | A16 |
| | VII | Workshop information provided for health visitor sample | A21 |
| | VIII | Handout: "Looking at the caseload" | A26 |
| | IX | Handout: "Handling enumeration district data" | A29 |
| | X | Letter to "Tuesday group" health visitor sample | A30 |
| | XI | Memo from "Friday group" sample to Management | A38 |
| | XII | Memo from health visitor negotiating work with Management | A40 |
| | XIII | Health plans | A43 |

TABLES, FIGURES AND GRAPHS (in the order they appear in the text)

| | | page nos. |
|-----------|---|--------------|
| FIGURE I | Management structure of health visiting | 38 |
| TABLE I | Attendance and completion rates of sample member | 44 |
| GRAPH I | Years worked as a health visitor by sample members | 46 |
| GRAPH II | Number of caseloads worked on since qualifying | 48 |
| TABLE II | Activities of health visitors described as policy, guideline and expectation | 64 |
| TABLE III | Categories of community information sought by health visitors | 110 |
| FIGURE II | Information sources and subsequent uses of community profiles | 134 |

ACKNOWLEDGEMENTS

I would like to thank the D.H.S.S. for sponsoring this research, particularly Liz Scott for her support. My appreciation and thanks go to Dr. Gerald Larkin, Director of Studies and Head of Department of Health Studies, and especially to Anne Dean and David Ellis who have supervised the research. In the Community Unit of Sheffield Health Authority Mrs. Margaret Butler, Director of Nursing Services, has been especially helpful and my thanks also go to all the managers and health visitors who worked so hard in contributing to this study. Special thanks go to Mavis Gretton who typed the study with professionalism and humour.

ABSTRACT

Title: The Information and Planning needs of Health Visitors

Author: Joan P. Harrison

Rationale

The health visiting service is not planned on the basis of the health needs of the local population. Although relevant information is available it has not been made accessible for use. This study aims to:

1. Obtain baseline data regarding aims, planning methods, health goals and information needs of health visitors in selected practices in Sheffield.
2. Provide information concerning the health visitors' potential caseload and monitor its impact on the production of community profiles and identification of health goals.
3. Evaluate whether health visitors perceive positive change in their planning abilities and whether information provided meets their information needs.
4. Evaluate the social and political effects on the organisation of the health visiting service relating to the information provision.

Nature, Scope and Method

An action research approach is used. The sample included, health visitors (N = 31) and their managers (N = 8), who were interviewed with an audiotaped interview schedule, piloted (N = 11). The health visitor sampled attended information workshops resulting in their building community profiles, negotiating practice with managers and producing an innovative method of planning. Workshop discussions and interview results were relayed back to all participants. The health visitor sample completed an evaluation questionnaire. Organisational changes during the research period were recorded.

Contribution to knowledge

Community profiles can be used to assist community diagnosis relating the planning of the health visiting service to the health needs of the population. Profiles can fill information gaps existing in the service. Organisational changes to aid profile effectiveness include implementing, an information policy and system, appraisals, clear general policy statements, management training, and addressing a series of changes sought by health visitors. Alternative sources of funding for the service are suggested, as is grassroots representation in the planning process. The study provides an insight into the information and planning needs of health visitors in their organisational setting.

CHAPTER 1 : INTRODUCTION

Chapter one is divided into five main sections. These are:

- 1) Health visiting, the community, politics and profiles
- 2) Information and the organisation
- 3) Information science literature
- 4) Methodological approaches
- 5) Method

1) Health visiting, the community, politics and profiles

In this section the researcher discusses the principles of health visiting and their derivation. The difficulties of working with a community are examined and the problems of unmet needs, lack of information and the need for planning are explored. The use of community profiles as an information source is discussed.

2) Information and the organisation

The organisational setting is described and emerging problems, conflicts, and demands on the health visitor are identified. Power sharing and general policy-making are linked. Existing National Health Service policy about information is examined and questioned. Alternative radical ideas about information use, such as community diagnosis are explicated and existing data sources for the research are explained. The resulting aims of the study are stated.

3) Information science literature

The definitions employed in user research are discussed and several studies of relevance to the current research are reviewed. Methods in information science are briefly discussed.

4. Methodological Approaches

Various approaches to the research are discussed identifying the theoretical influences on the researcher in choosing an appropriate method. These include qualitative research, illuminative evaluation, grounded theory and action research. The problems of "insider" research and the position of the researcher in the subject organisation are examined.

5. Method

The chosen method is stated and explained, and the research procedure outlined. Exclusions and withdrawals of sample members are discussed.

HEALTH VISITING. THE COMMUNITY, POLITICS AND PROFILES

In the 1970s health visitor educators held three major conferences at which they debated the underlying principles of health visiting. They agreed that health visiting be defined as follows:

"The professional practice of health visiting consists of planned activities aimed at the promotion of health and prevention of ill health."

Council for the Education and Training of Health Visitors (1977) (30)

Between the 1976 conference at Nottingham University and the 1977 conference at Loughborough University, geographical groups of practitioners, field work teachers, tutors and administrators involved in health visiting met to discuss the functions and principles of health visiting. They identified three unique functions of health visiting.

- 1) Identifying and fulfilling self-declared and recognised as well as unacknowledged and unrecognised health needs of individuals and social groups.
- 2) Providing a generalist health agent service in an area of growing increasing specialisation in the health care available to individuals and communities.
- 3) Simultaneous monitoring of the health needs and demands of individuals and communities; contributing to the fulfillment of these needs; and facilitating appropriate care and service by other professional groups CETHV (1977) (30)

At the Loughborough conference four principles of health visiting, based on a belief in the value of health, were formulated as follows:

- 1) The search for health needs.
- 2) The stimulation of awareness of health needs.
- 3) The influence on policies affecting health.
- 4) The facilitation of health enhancing activities "CETHV (1977) (30)

It is clear that in order to adhere to these principles health visitors require information about individuals and communities so that they can produce planned activities. In 1985 the Health

Visitors Association produced a report (1985) (82) in which they indicated the kinds of information health visitors might require to work with communities. A specific recommendation was;

"Population registers should be established to enable health visitors to identify the number, age and location of persons within each potential client group. This information should be supplemented by further information including; morbidity and mortality figures; census data regarding household structure, housing, social class and ethnicity; surveys of consumer opinion; information about the provision of other services; unemployment rates, etc. The health visitor is then able to produce a more systematic and local health need - led approach to her work."

Health visitors in Sheffield have tended to have a traditional approach to their work focussing on individuals and families rather than the community as a whole (Harrison (1986) (81)) compounded by a lack of access to the kinds of information noted in the HVA document. There are indeed many difficulties in working with a community, not least of which is defining the community itself.

Luker and Orr (1985) (125) discuss at length the different meanings of community as does Scherer (1972) (171) arguing that "community" is not necessarily geographical in nature as it is often assumed to be in health visiting. Sanders (1975) (170) offers a useful model of community, describing four theoretical dimensions. These are a spatial unit, a place to live, a way of life and an arena of social action. A spacial unit might identify maps, census data, morbidity and mortality. A place to live would include cultural dimensions such as civic groups and ethnicity. A way of life covers aspects such as opinion polls, crime rates, employment and housing, and finally an arena of social action includes conflicts and co-operation among groups, city budgeting, voting and newspaper articles.

In the Community Nursing Review (Chairman: Julian Cumberlege) (1986) (86) the term "neighbourhood" was used instead of community and this approach was criticised, for example by Allan and Higgins (1987) (2) for suggesting,

"An image of local integration which many studies have shown to be highly questionable."

They continue,

"It does not follow that those living in the designated areas share a common heritage, a common way of life, common interest or indeed anything else."

This view was predicated by Sherer (1972) (171) and links with a certain sentimentality in the present government about the nature of communities which conveniently fits their policies of making cuts in N.H.S. funding and failing to take political responsibility for the outcomes (Hildrew 1987) (85). This does not however necessarily mean that community nurses are themselves sentimental about communities, they are aware that:

"Communities can be harsh and primitive as well as supportive" Allan and Higgins (1987) (2). In 1987 Cumberlege (43) reviewed the effects of her first report stating,

"The whole point about the community nursing review was that it called on nurses who really know their patch to produce a health service for that neighbourhood."

"Examples such as the Finnish experiment, where heart disease has been cut dramatically show what can be done not by treating patients but by working in neighbourhoods and influencing people's lifestyles. This is something at which nurses excel"

In a period of financial constraints she also makes the point that "Information gives power". (Handy (1985) (79))

"Calling for more resources must be specific, targeted, backed by investigation and come from people who have a good track record of success. No future government, of whatever political hue will plough public money into a service which cannot prove its worth I think there are three aims for the next year, more power to the people, more power to the team and more power to the community nurse." Cumberlege (ibid.)

This government's attitude towards the community has been seriously questioned in the nursing press, for example Gaze (1987) (69) argues that the movement of patients out of hospital into the community has been managed badly, with a lack of N.H.S./Local Authority co-operation causing problems for the mentally ill, mentally handicapped, old and handicapped. Meanwhile a growth in the private sector has shifted the funding burden onto supplementary benefit. Dickson (1987) (51) in a leader entitled "The Conspiracy Theorists may be right - could this report be the

first stage towards dismantling the N.H.S.?" goes further, asserting that the Audit Commission for local Authorities in England and Wales (Chairman Griffiths 1986) substantially undermines accountability of the state for the health of the public.

At the same time as the nature and provision of care is being questioned, numerous studies have consistently reported enormous inequalities in health. The D.H.S.S. 1980 (47) publication normally referred to as the Black Report was most influential in this respect and was followed by local research, for example Thunhurst (1983) (188), Manchester Polytechnic (1984) (8). In "The Health Divide : Inequalities in Health in the 1980's", Whitehead (1987) (202) says:

"In summary recent evidence is showing that poor members of our society are shorter, have poor dental health, are more likely to be overweight, more likely to be ill, tend to have higher blood pressure, and lower survival rates following cancer and coronary heart disease Studies have shown that unemployed people have high mortality rates and are more likely to commit suicide. The General Household survey also showed that they have a higher level of illness The Child Poverty Action group believes that a third of all the children in Britain are living in families who are in or on the margins of poverty".

Alleway (1987) (7) reviews Social Trends 1987, which indicates the health problems found in the community now. There are a large elderly population, projected to have an increasing number of over 85 year olds, homelessness, rising unemployment, drugs, alcohol and smoking related illnesses, hypertension, sexually transmitted diseases and in particular AIDS. Positive signs include rising cervical smear uptake rates linked with lowering death rates from cervical cancer and increasing vaccination rates except for whooping cough.

In the face of such need Tucker (1979) (191) believes,

"The implication for community health workers is inescapable. The most meaningful preventive actions, those most effective in producing a safe and healthy existence for the community are universalist that is, political ... Participating in these activities will involve some risk."

Indeed for health visitors their third principle ".... to influence policies affecting health" actually requires them to be political because it is in the political arena that policies affecting health are made. How is the health visitor to approach her task in this complicated setting? In a previous study in Sheffield the researcher identified a traditional individualistic pattern of health visiting

(Harrison (1986) (81) with a ratio of health visitors to general population of 1:5567. Health visitors were also practising as if they had received a set of guidelines for visiting from management, although no written guidelines were available. There was no apparent health visiting response to the societal changes indicated in the quotations from Alleway and Whitelaw.

The new Sheffield City Polytechnic health visitor syllabus included a caseload profile to supplement studying the neighbourhood and students emerged into the field with concepts of community data which practising health visitors had not yet attained. The researcher suspected that the health visitors' knowledge of the community was slight or intuitive. Hunt (1982) (92) was followed by Wilson (1986) (204) in examining ways in which caseload profiles could be constructed and other workers, for example Jane Dauncey in Oxford developed their ideas. A caseload profile was an analysis of data about the clients health visitors were already seeing. A community profile included clients living in the area, which the health visitor was not necessarily seeing, in addition to broader data as discussed by Sanders (1975) (170). Managers began to see the importance of community data, for example Devlin (1986) (46) interviewed two health visitor managers, Nora Saddington and Molly Kerswill,

"Another Cumberlege recommendation is that Health Authorities should draw up population profiles for neighbourhoods showing demographic trends, morbidity and mortality and social and environmental information. In Dartford and Gravesend that information will come from field workers.

'Health visitors and district nurses are being encouraged to produce caseload profiles. We are getting a lot of local information in this way. Most of the primary health care teams have age sex registers,' said Mrs. Keswill. But she laments the passing of the medical officer of health's annual report

.... She wants detailed profiles of different areas, 'in that way if there was say a high infant mortality rate in one area, I could pin point exactly the block of flats where these children were and take action'"

In the literature on epidemiology, writers have noted that the co-ordinating role of the medical officer of health is greatly missed, for example in Rosen (1986) (163) discussing Swedish community diagnosis, and in Thunhurst (1983) (118).

The interviews by Devlin were also interesting because both the senior managers were having difficulties with the setting in which they required information. Both mentioned lack of resources as a difficulty and one was having problems imposed by her general manager so that she had less freedom to act. (D.H.S.S. (1983) (48) Griffiths Report). Against this adverse background she was trying to improve information use. Devlin continued,

"Mrs. Saddington said South Birmingham had adopted an increasingly pro-active rather than reactive approach to providing community nursing services. A good information system is essential for this, she believes."

It may be argued (Scrivens 1985) (172) that community nursing services would interfere unduly in the lives of the public if they were both pro-active and had good information systems but this is not a new issue in health visiting. Health visitors function in order to promote health and prevent ill health, the activity of searching for health needs is by definition pro-active. They would argue that the way in which this task is achieved, for example with due regard for confidentiality and in consultation with clients in a partnership, is the crucial question. One view expressed by social work senior managers is that it is paternalistic to provide help of any sort to clients unless they have asked for it. This is in direct conflict with health visiting theory which offers all clients help unless they refuse it. Because the working patterns of the health visitors and social workers conflict in this way there are important implications for communication and liaison between them and a need for understanding each others' role.

In this section the researcher has outlined the principles of health visiting, and discussed the difficulties health visitors face in working with a community. These difficulties arise because communities are hard to define, health visitors do not have ready access to information about them and they face increasing unmet health needs. While the theory of health visiting allows many approaches the Sheffield health visitors continue a pattern of traditional health visiting. The use of community profiles has become recognised by managers and students as a method of tackling these difficulties, a method which would allow health visitors to become more pro-active in their approach. It would also combine well with the recommendations of the Community Nursing Review (1986) (86), and potentially ~~empowering~~ empowering styles of management encouraging bottom-up planning and need led health care. Such an approach also has implications for future funding of

the service in that health need will need to be demonstrated at field level to attract resources. In short in order to plan health care health visitors require accurate community information.

INFORMATION AND THE ORGANISATION

"Interests and social structure should be understood in order to examine information environments." Brown (1985) (24)

"Analysis of ... aims and objectives, its structure, both formal and informal ... will have implications for the type of information provided." Dyson (1986) (58)

The subject of this research is health visitors and their information and planning needs but in order to understand their information needs it is important to see them in the context of the organisation in which they work. Scrivens (1985) (172) describes the National Health Service (N.H.S.) as

"... a curious organisation, with a semblance of hierarchical management and a rhetoric of local autonomy...."

West and Savage (1987) (200) have done a study of health visitors in order to examine stress levels in the organisation. Their findings indicated:

1. Poor staffing levels with little or no cover for holidays and sick leave.
2. A dearth of clerical assistance.
3. An ill-defined role for health visitors.
4. Lack of support, supervision and counselling.
5. A lack of adequate post qualification training.
6. Poor management/staff communication and a vastly overburdened management.
7. Pressures on health visitors from the home/work interface.
8. Lack of an appraisal system.

They describe a hierarchical organisational structure based upon directive management and would see a participative administrative style as more appropriate. They remark,

"Throughout the conduct of this study we have been impressed by the care, concern, commitment and genuineness, that management and health visitors bring to their service."

They also consider health visitors to be highly innovative within the boundaries and constraints of their position.

These are the features of an underfunded organisation, as Dobby highlighted when conducting research with health visitors:

"For a significant number of health visitors in the pilot exercises, this small increase in workload was the straw which broke the camel's back and this must be seen as a depressing reflection on the current poorly resourced state of the service." Dobby and Barnes 1987 (55)

If Checkland's (1981) (32) approach of applying a root definition is used then health visiting is situated in a hierarchical organisation provided with limited and controlled resources with the task of providing an ever expanding service to promote health and prevent illness. Without going further it is clear that there are internal conflicts and dysfunctions. From a systems approach the organisation is owned by the state, has broad goals and aims, serving the population of a large northern city, (as has been mentioned the ratio of health visitors to population is 1:5567), in the external environment of clients homes and clinics, with an ethic of care and enabling. It is significant that individual health visitors carry their own caseload which does not overlap clientele with other health visitors. This means the job is essentially isolating. Health visitors may be based in health centres, clinics or G.P. surgeries in groups ranging from one to nine, the majority being based in twos at any given site. West and Savage indicate that 90% of support is given by colleagues to health visitors, husbands and partners provide 57.6% of support, other relatives and friends 38% and senior nurses (immediate managers) come a poor fourth at 30%. These figures were in answer to the question "Who listens to you when you need to talk about problems at work?"

The immediate hierarchy in which health visitors appear to function is as follows:

General Manager community Unit
Director of Nursing Services
Assistant Director of Nursing Services
Senior Nurses
Health Visitors

However, this simple structure does not begin to describe the actual structural network in which the health visitor operates. The health visitor also acts as a member of a primary health care team in which formal relationships are constantly at issue.

"When primary health care teams were first set up nurses were "offered" to GP's or almost any terms in the eagerness to get the teams established. But patterns of work and co-operation were never negotiated". Kratz (1986) (111)

The health visitor has obligations to and relationships with different groups and individuals within the community in which she works. In their role of referring to other agencies Sheffield health visitors contacted 130 different agencies in a period of a month (Harrison 1986) (81) with all of whom *they have* differing roles and relationships. Broadly speaking these included Hospital and Community Health staff, Education, Housing and the Family and Community Services departments of the local council, probation staff, GP employees and a wide range of voluntary agencies. Particularly important contacts would be with midwives, social workers and GPs with whom the health visitors will frequently share clients.

Cumberlege (1986) (86) put the emphasis on the neighbourhood nursing team (N.N.T.) and the primary health care team and indeed recommends, that management should follow the pattern of N.N.T.s rather than having separate hierarchies for different types of community nurse. In 1987 she wrote (1987) (43)

"We felt that change is quicker and more successful when it comes from below."

But the way in which health visitors are employed and controlled by the basic management structure makes change very difficult to achieve from the bottom up. As Katz and Kahn (1966) (102) have argued,

"If people are involved in determining policies and share in the returns from collective effort, they regard the organisation as of their own making. There is little need for convincing them through indoctrination when in fact the organisation is theirs."

"The essential difference between a democratic and an authoritarian system is not whether executive officers order or consult with those below them but whether the power to legislate on policy is vested in the membership or in the top echelons."

White (1987) (201) points a possible way forward for the organisation to begin a semblance of power sharing,

"The Cumberlege Report opens out many new opportunities for health visitors which will only become available if the new style neighbourhood nursing manager gives priority to clinical values, and is a facilitator rather than a controller."

"They (the nurse managers) should seek to gain professional authority through an improved knowledge base. One way of achieving this is by each manager getting together with health visitors to agree a philosophy and a policy for that particular area. Both the philosophy and the policy should be reviewed each year and agreed with the district management as district policy. This would then give a framework within which the health visitors could develop their own work. It would also be a useful professional tool from which standards could be reviewed and budgets and workload monitored and negotiated."

Katz and Kahn (1966) (102) have said

"For almost all social structures the most important maintenance source is human effort and motivation."

Unfortunately health visitors have not been involved in making policies, agreeing philosophies or taken part in motivating activities although, as agreed in discussion with Dr. West the motivation of the health visitors and their commitment to clients are the only reasons the existing system appears to function. The health visitors appear to have gained their motivation from a strong

socialisation process and the rewards they experience from clients, but they have been excluded from power sharing. As Smith (1987) (181) put it:

"Nurses simply do not yet understand the notion of power, although they are slowly waking up to the fact that as a workforce they are the largest constituent of the N.H.S.

It is important to consider the use of information in such a structure in terms of the purpose of the organisation.

"The purpose of health care rests on political and social decisions. The political values are well known, that need should be the sole criterion of the receipt of the service and that the funds should be raised on the ability to contribute." Kennedy (1980) (104)

Kennedy here discusses the standard view of the N.H.S., but Scrivens in her examination of the use of information technology in the N.H.S. asks,

"What actually is the function that the N.H.S. is here to perform - the better care of patients or the good husbanding of national resources?" Scrivens (1985) (172)

She continues,

"In the present information systems developments the trend of work has been to devise systems for management, for costing and resource allocation. But if the system exists solely in order to save money it seems to cut across some of the fundamental logic for the provision of a national health service free at the point of consumption for all those who need health care. If IT exists to enable more patients to be seen more quickly and more easily and more humanely for less cost than the present, information policies have not communicated this objective at all. And indeed if it were an explicit objective, the discussions about information systems would have a very different tone from that which is presently heard."

The greatest recent changes in information within the Health Service have been following the report of the steering group on Health Services Information (1982) (183) (Chairman Korner). In which it is stated that information should be gathered about the types and number of client contacts field level staff make, for the specific purpose of providing management information to aid costing and resource allocation. It is not surprising that the Korner recommendations followed the implementation of the Griffiths recommendations (D.H.S.S. (1983) (48)) that general

managers should manage the Health Service in the style of a business. It cannot be denied that managers would have the greatest difficulty in organising the service without some form of measurement of outputs of the system. As in South Birmingham, (Saddington (1984) (168)) the systems set up to provide Korner-type information have sometimes had added to them the collection of data which can usefully be fed back to fieldworkers to aid them in planning their work. This feedback however was not the main purpose of Korner.

If the purpose of the organisation were indeed to provide need-led health care then the data gathering system would have been constructed in a very different way. The emphasis would instead have been the information needs of field level staff at the point of care delivery. It might alternatively have been about the kind of information a community needs in order to participate in deciding what health care it needs.

Croft and Beresford (1986) (42) comment,

"If the government is serious about community care and really wants to make the best use of public money, then it must first listen to what the community has to say and let it in on decisions about the services it needs."

Korner has approached neither of these questions adequately. In Sweden these questions have been addressed and are described by Rosen (1986) (163). The process of information gathering is known as community diagnosis.

"Community diagnosis is a process of collecting, describing, analysing and disseminating information about health status and its determinants in the community. Its ultimate goal is to improve the health status of the population in that particular area by way of improving the basis for decision-making and by creating a positive environment for community involvement". Rosen (1986) (163)

He makes the points that

"According to experiences in Sweden and the United States of America local differences are not intuitively known by local health personnel",

and

"Local data create more concern and commitment among politicians, health personnel and the general public than national data."

Finally he linked community diagnosis with the planning process as follows:

"If community diagnosis is not to be merely a mayfly, it must be integrated in the regular planning process. Health planning on the other hand, must also change its aim and direction. A more decentralised planning with a higher degree of local involvement are some prerequisites to enable planning to break through in practical health work. This means that the decision-makers ought to concentrate more on management by objectives than on the control of data. Let the basic units (clinics, primary health care centres, etc.) be given more influence over how their work should be carried out within the framework of the existing budget. A decentralised planning provides greater scope for local institutions as well as greater involvement in planning issues."

There have been several initiatives in Britain along similar lines. For example community workers linked with health associations have produced local surveys of health in small projects (Ginnety (1985) (72), Betts (1985) (18), Wells Park Health Project (1984) (198), Catford Community health project (1984) (29)). Sheffield Health Authority in 1986 produced "Health Care and Disease, a profile of Sheffield" (175) amalgamating health and disease data based on electoral wards. This made such data more locally based than it had previously been, providing morbidity and mortality data and a category particularly interesting to health visitors "diseases with a preventable component". This study had followed the Sheffield City Council study "Areas of poverty in Sheffield" (1983) (173) which essentially related census data to electoral wards, becoming even more detailed concerning pockets of poverty in the city. Work by Thunhurst (1983) (188) and Jarman (1983) (98) had laid the basis for statistical comparisons of health data. Interest within four important bodies in Sheffield, the City Council, the Family Practitioner Committee, the Health Authority and the Council for Voluntary Services resulted in the formation of the "Sheffield 2000 Health Planning Team" on which members from each organisation were represented. Their task was to translate health and disease data into health promotion activities. Their most recent publication has been "Healthy Cities 2000" (1987) (174) which provides a set of targets for health in Sheffield by the year 2000 based on World Health Organisation targets and translated for local relevance. Two other sources of health concepts ran concurrently with these initiatives. Firstly the Health Care Strategy Group organised by Sheffield City Council with councillors, health service trade union representatives and other interested bodies, e.g. Council for

Racial Equality, Radical Midwives, Radical Health Visitors, met monthly to criticise and contribute to debates at Health Authority Meetings. Secondly a locally based health project based in a community centre, the South Sheffield Project, began to examine ways of improving the health of residents in a particularly deprived area of the city. The researcher became involved in both of these groups.

It became obvious that a great deal of community data relevant to the practice of health visiting was available within the city although health visitors did not yet have access to it. Because this data was available the questions of whether health visitors wanted it, how it might be used, in what form it needed to be presented and whether it could be used for planning health care could be addressed. Before such data could be presented it was important to ascertain health visitors and managers views about their information needs in the context of their aims, health goals and planning methods. If such information was indeed required by health visitors it could be provided, and the effects of the provision evaluated. This thinking led to the aims of the study which were as follows.

1. To obtain baseline data regarding aims, planning methods, health goals and information needs of health visitors in selected practices in Sheffield.
2. To provide information concerning the health visitors potential caseload and monitor its impact on the production of community profiles, and identification of health goals.
3. To evaluate whether health visitors perceive positive change in their planning abilities and whether information provided meets their information needs.
4. To evaluate the social and political effects on the organisation of the health visiting service relating to the information provision.

INFORMATION SCIENCE LITERATURE

INTRODUCTION

An examination of the information science literature reveals two major areas of study. Firstly storage and retrieval and secondly user studies. This discussion will focus on user studies which are more pertinent to the present research field. Many of the early user studies concentrated on the information needs of scientists and technologists, often in academic life, and in the hard sciences. For example Price (1970) (156) looked at how the use of information related to the number of papers scientists published or cited, Myers and Marquis (1969) (137) examined how information inputs linked with progress in technological innovators, and Garvey and Griffiths (1968) (68) identified that younger members of the scientific and technical communities have poor access to informal communication networks.

During the early development of information science, studies of the needs of practitioners were notable by their absence as discussed by Roberts (1976) (159).

"An information science which cannot in its theory and practice take account of the information problems of local government social welfare agencies, commerce and industry, to name only a few examples seems not only a contradiction in terms but well on its way to making itself redundant Many of the "theories" or generalisations have been derived from investigations of information-privileged user groups scientists and academics in particular. Far less effort has been expended on the study of information phenomena relating to worker groups such as industrial engineers, government bureaucrats, local authority departments etc. or the general citizen."

He goes on

"The social implications of communication and information are such that only the widest social base is acceptable as an area of study for information science."

The comparatively low profile given to practitioner research began to change in the 1970s and broad based studies of the general public began to emerge indicating a new openness in information science.

An early example is Warner, Murray and Palmour (1973) (197) who examined the information needs of the urban public in Baltimore exploring the social and demographic features of information problem presenters.

Crawford comments in 1978 (41)

".... the scope of user studies has been extended to include users in a wide variety of disciplines among them psychology, education, policy making and law. It appears that almost everyone's needs are now being surveyed - senior citizens, urban populations, minority groups as well as scientists and technicians."

Before discussing the practitioner research relevant to the current study it is helpful to explore the definitions used in information science and to consider some of the methods employed. Because it is a young science there is considerable controversy about defining basic terms such as "information", "need", "want", "demand", "use", "requirement" and "user". Dervin (1986) (45) comments,

".... information need has been defined as a state of needing anything the researcher called information".

She makes the point that user research has not been done from the point of view of the user.

Crawford (1978) (41) contributes to the debate as follows,

"There appears to be a consensus that "information need" is a difficult concept to define, to isolate and especially to measure. It involves a cognitive process which may operate on different levels of consciousness and hence may not be clear even to the inquirer himself. If a user could specify what is needed under defined conditions, his problem might well be on its way toward solution."

Line (1974) (120) makes the following distinctions. A need is what an individual ought to have for his work, his research, his edification, his recreation, etc. A want is what an individual would like to have, a demand is what an individual asks for and a requirement is a bridging term meaning what is needed, wanted or demand. He also looks at "use". He says it is what an individual actually uses, and this may be dependent on the availability of material to use. It may be the result of browsing or accident, it may be a satisfied demand or it may be recognised as a want or need when received, although not previously articulated into a demand.

These definitions are important in this piece of research since the health visitor users are provided with information they have asked for in addition to information the researcher suspects would be of use to them. Ford's (1977) (62) definition of user:

"A recipient who has perceived an anomaly in his knowledge of the world and is trying to find messages which are aimed at connecting that anomaly. By implication he not only recognises that anomaly but is trying to correct it",

goes only half way to recognising that users may have unexpressed needs.

Dervin (1986) (45) expresses this more succinctly:

"The evidence shows, for example, that users frequently have trouble stating these needs, particularly when pressed to specify what resources will fill them. Further, the way needs are expressed changes over time, even during a brief interview."

Cater (1982) (28) comments that "information" and "communication" are often used interchangeably but that they signify different things.

"Information is giving out; communication is getting through".

One of the aims of the current study is both to inform and communicate.

Paisley (1968) (148) reflects on factors affecting information needs which research should take into account as follows;

1. The full array of information sources available.
2. The uses to which information will be put.
3. The background, motivation, professional orientation and other individual characteristics of the user.
4. The social, political, economic and other systems that powerfully affect the user and his work.
5. The consequences of information use, e.g. productivity.

He continues

"As a result in many studies it is hard to glimpse a real scientist or technologist at work, under constraints and pressures, creating products, drawing upon the elaborate communication network that connects him with sources of necessary knowledge."

Paisley's point here is that information use should be seen in the context of the user's world view and that many studies have suffered from poor conceptualisation in this respect. This study aims to place the information use of health visitors within their working context.

The reviews of user studies in the Annual Review of Information Science and Technology repeatedly bemoan the poverty of methods employed in Information Science and the failure of researchers to learn from previous studies. Particularly vitriolic in this respect is Allen (1969) (3). He makes two comments useful to the current researcher, firstly

"Few studies have attempted to pursue information beyond its consumption by a user"

and secondly,

"There is a fair amount of truth in the adage that familiarity and some objective understanding of an activity are a prerequisite for interpreting research results."

The present study attempts to pursue information beyond consumption by the health visitor to productivity, and secondly the researcher, as discussed in Chapter 1 has a familiarity and subjective understanding of the health visiting organisation.

Wood reviewed and classified methods employed in studies of information users and their needs as follows;

- "1) questionnaires
- 2) interviews
- 3) diary methods (systematic self observation by the user)
- 4) observation (by the person studying the user)
- 5) analysis of existing data" (1969) (208)

It is surprising to the reader that although there are evaluation studies in the literature (Slater and Keenan (1967) (177), Line (1964) (118)) that an action research approach is very rare. Harris (1981) (80) approached his research with an illuminative evaluation strategy but such a use

of workshops for evaluating and using information is unusual, even though Paisley's (1968) (148) ten point scale opened the door for this sort of research. Paisley identified the individual as part of many systems, as follows:

1. The cultural system
2. The political system
3. The membership group
4. The reference group
5. The invisible college
6. The formal organisation
7. The project team
8. The individual
9. The legal/economic system
10. The information market place

It seems logical that the recognition of groups would merit investigation of how those groups, as groups, use information whereas many studies continue to study users as individual members of groups. Nursing research appears to have used this method more readily, for example Hunt (1987) (94), Orton (1986) (147). There is a difference here between studies of people in, for example, the work team, Allen (1969) (4), Pelz and Andrews (1966) (154) and the way they communicate with each other (sociometric studies) and the way they would comment back to a researcher as a group about an information source. One could, for example, track the way in which a group of workers perceives and discusses a piece of information, as part of this research attempts to do.

Ford (1977) (62) comments,

"A programme of research might begin with identifying a sub-group of users, the next step would be to establish the tasks for which information is required and the amounts, urgency and preferred packaging of such information".

He sees the aim of much research as being the production of adequate information systems and lists the requirements of such systems;

- "1. Information must be accessible.
2. Information must be timely.
3. Information must be task specific.
4. Information must be in the form suited to its use.
5. Users belong to identifiable group with needs in common.
6. Information provided must interact with the users.
7. Systems must allow the user to browse.
8. Systems must adapt to users behaviour patterns.
9. Informal communication is important."

These requirements will need to be borne in mind in the recommendations of the this study.

PRACTITIONER BASED RESEARCH

Practitioner based research relevant to the current study includes research by Streatfield (1982) (185) concerning community workers, Wilson (1985) (206) concerning the probation service and Wilson, Streatfield and Mullings (1979) (207) concerning a social services department. Recent masters studies at Sheffield University have looked at the information needs of community health senior staff (Bransom (1973) (19)), nursing staff (Gilbert (1976) (71)), local authority planners (Conroy (1975) (38)), legislators (Patrick (1977) (152)), local communities (Ledsham (1978) (114)), social services departments (Barnes (1975) (13)), physiotherapists (Smith (1978) (180)), and primary schools (O'Brolchain (1973) (142)).

Streatfield's study (1982) (185) of community workers demonstrated much that could also be said of health visitors for example:

"The array of knowledge which may be considered to be of potential value to community workers is very broad If they are based "in the field" away from the organisational headquarters they may prove relatively unsusceptible to the norms of the organisation Like other people working on the boundaries of their organisations, community workers may be 'subverted' to the interests of their clients rather than the bureaucratic values of the employing body".

And finally he comments on information systems useful to community workers,

"Community workers need continuous information about their employing organisation, its policies and activities and about "their" neighbourhood and what is happening in it and to it; regular news of developments in community work practice; and other types of information at various times in the development of a project or involvement with particular groups. The minimum information service requirement for effective performance of community work includes adequate organisational information services, a well developed "grapevine" linking the community worker and his community, and access to a library covering community work and social policy literature."

From Wilson (1985) (206) the central issues in information systems are identified as follows;

- a) who are the information users and what are their needs for information?
- b) what information resources exist and how can one get access to those resources?
- c) what 'technology' (manual or machine) is needed to satisfy users' needs from the resources available or capable of development?

Again, he describes features of a social service department transferable to the community health service;

"Work in social services departments can be characterised as;

- a) governed by statute and associated procedure
- b) fragmented by character
- c) involving (for some grades of staff) a major part of their working week in being spent in meetings
- d) involving oral communication for a larger part of information transfer."

He makes two recommendations at the end of his report that there should be

- 1) A policy statement which embodies clear objectives for the communication of information,
- 2) The decision to employ professionally qualified information staff to help implement the policy and develop the system.

The study by Wilson Streatfield and Mullings (1979) (207) otherwise known as Project INISS was notable for the painstaking thoroughness of the participant observation method. Many of their comments and findings are pertinent to the current study. For example;

"It has been suggested by other studies that there is a significant relationship between organisational climate and information flow The only significant relationship revealed by analysis was that attitudes towards management were least favourable at the bottom of the organisational hierarchy."

They comment on the difficulties experienced by staff concerning information flowing along organisational channels;

" - limitations in the communication channels e.g. delays in internal post

- procedural delays e.g. "The time consuming necessity to confirm in writing decisions which have already been taken over the telephone before anything will happen."

- difficulties in managing or reacting to the information flow e.g. identifying priorities

- differing perceptions"

Wilson raises four final issues present in the community health field,

- 1) Information officers who are not given specific guidelines appear to gravitate naturally towards providing services to readily accessible middle management staff.
- 2) New staff take time to find out who does what and to make efficient use of the internal network of contacts
- 3) Adequate procedure manuals and local directories are not available
- 4) It is simplistic to claim that staff will not read relevant literature, a factor which may influence this is inaccessibility.

HEALTH RELATED PRACTITIONER RESEARCH

Wood and Thomas (1985) (209) report on how occupational health nurses gather information. They based their study on interviewing a sample of twenty-nine occupational health nurses and explored their qualifications and experience, society membership, library use and focussed on reading, and audiovisual materials and finding specific information. Like Wilson they

found informal, particularly oral communication to be very important. The nurses did not read much and used few other information sources and felt isolated in their workplace. Wood and Thomas regarded them as "typical practitioners in their information seeking behaviour". O' Brolchain's (1973) (142) study was interesting because of a discussion about planning and the decision making process. Ledsham's study (1978) (114) had used a community profile approach to understanding the information needs of local people. He used the method of interviewing "key figures" in the community as spokesmen. This was helpful in contrasting with the community profile approach using statistical evidence in this study.

The information needs of hospital workers were explored by Alan Beevers (1979) (15) from a "workers rights" approach. Here he based his study on unstructured interviews with seventeen hospital workers and conducts a useful discussion particularly on the barriers to information flow. He considers psychological, physical, hierarchical and accessibility problems of information provision.

Fitter (1986) (61) has studied the use of micro computers in general practice. The main uses appeared to be to produce repeat prescriptions, recall patients for screening and to register patients. However he perceived that improved computer use for management and analysis could alter the role of the general practitioner. The input of information produced from the computer could enhance the G.P.s role as a manager, a businessman or woman or alternatively reinforce their position as practitioners and carers. Its relevance to the current study is much like the contrast between community diagnosis and the implementation of Korner as discussed in the section about the Health Service organisation, each of which would be likely to have a different effect on the health visitor's role. It reminds us that the effect of information inputs can be political.

Smith (1978) (180) looked at a sample of two-hundred-and-fifty physiotherapists using a postal questionnaire, receiving a response of 156 replies. This study was also perhaps typical of practitioner activities and was interesting because of the features of those practitioners. The physiotherapists acquired their information through journals 81.4%, work colleagues 55.8%, meetings 51.3% and books 46.8%. Colleagues outside work were a source for 38.2% of the

respondents. The purchase rate of books and journals was low, libraries were used by less than half of the respondents, and respondents wanted more study leave. Part timers used information sources less than full timers, and physiotherapists with a teaching qualification made the greater use of sources. In general the searches for information related either to a need to keep up to date or in connection with a particular patient.

In a study of the information needs of nurses Gilbert (1976) (71) included community nurses in a sample of seventy-eight. Using a guided interview she examined the main obstacles to information use which were lack of time, lack of readily available sources and lack of knowledge about how to use literature effectively. She commented,

"Hardly any of the needs of the community staff are being catered for."

She identified two sorts of information required by health visitors,

"For much of their work they are on their own, thus they have a greater need for literature. The health visitors need a great deal of local community information which they have to build up themselves, but they also need information on psychology, sociology, government information. Health visitors need information on the latest policies for preventive medicine and health education (and) also need information about the social services".
Gilbert (1976) (71)

She feels that apart from courses very little help is offered to the community staff and that library services need to be taken out to the nurses. Among her recommendations are that a librarian should be visible to staff and that collections of books should be available at work sites because,

"Nurses use sources close at hand rather than better less accessible sources."

Bransom (1973) (19) studied the information needs of community health senior staff and comments;

".... there should be some innovative regrouping of all types and sources of information since the current national network is research/education orientated at the expense of the "implementers" of health care who need the most information".

He continues,

"The community factor introduces the need for a more integrated approach to health, which will relate environmental demographic, socio-economic and epidemiological characteristics to the community health profile."

Among his findings he recommends a study of different grades of staff in the community to find out whether they have significantly different information needs. He also recommends a wider library stock which is better exploited, a circulation system for relevant journals, a scanning service, a rapid service for providing specific facts, bulletins, display of material from national conferences and a selective dissemination of information service.

METHODOLOGICAL APPROACHES

QUALITATIVE RESEARCH

Qualitative research is now well established as a legitimate approach in the social sciences (Rowan and Reason (1981) (157). The subject of study in this research demands a qualitative approach for various reasons. Firstly because the area, like much nursing activity, is not well researched and a descriptive, grounded theory approach is therefore more appropriate (Field and Morse (1985) (60). Secondly the researcher is examining a process of assessment intervention and then evaluating it. Quantitative methods are not easily used to explore complex processes, restrict the scope of the study, are insensitive to anomalies, and do not necessarily respond to the varied concerns of all interested parties (Gale (1983) (66)). Jolly and Gale (1976) (99) also argue that quantification does not guarantee objectivity.

Interviews, discussion groups, written reports and questionnaires were the methods chosen for the current study to allow scope for richness of data, flexibility and ongoing learning from the data. Gale describes a series of procedures qualitative researchers can use to ensure the validity of their findings:

- i) Circulation of draft reports for comment.
- ii) Reference back to sources of comment
- iii) Submission of researchers arguments to discussion
- iv) Cross checking researchers note taking
- v) Clear differentiation between fact and speculation or interpretation
- vi) Indicating personal and other interpretations
- vii) Description of data collecting methods
- viii) Indication of personal views of the researcher

- ix) Check that participants recognise their situations and opinions reported. Gale (1983) (66)

Qualitative research has a long history in educational research which faces the same difficulties of examining complex processes. Kilty (1976) (106) argues that nursing research has much to learn from educational research while newer publications such as Munhall and Oiler (1986) (136a) place nursing research in a qualitative perspective.

Parlett (1981) (151) and Hamilton et al (1977) (77) discuss the illuminative evaluation paradigm as an approach to assessing educational processes. Their essential argument is that studies should not be divorced from the real world, that account should be taken of change during the research period and that "impressionistic" "anecdotal" and "subjective" accounts may be very important to the understanding of innovatory programmes. Again they emphasize the reporting of atypical results and the variety of questions posed by different interest groups. Stufflebeam et al (1971) (186) demonstrates a similar method defining educational evaluation as

"The process of delineating, obtaining and providing useful information for judging decision alternatives."

He tackles the question of whether educational evaluation may be seen as research as follows,

"Insofar as the decision making context is highly generalisable and the intent is to provide new information without precedent, the purposes and methodologies of research and evaluation may be equated.

Stufflebeam et al (1971) (186)

This is not to say that the researcher in the case will wholeheartedly adopt an illuminative evaluation approach, but that these ideas have influenced her approach.

An important issue in any qualitative research is how categories or concepts arise from the data and how these should be ordered and given weight. This has been tackled by many writers but in particular Glaser and Strauss in the "Discovery of Grounded Theory" (1967) (73). They argue that theory can be generated from the substantive field of study by an immersion of the researcher in the data and a constant reassessment of the data in relation to the theoretical

categories, what Spencer and Dale (1979) (25) describe as a "flipflop" between their ideas and the research data (Bulmer 1976) (25)). Turner in two papers (1981) (192), (1983) (193) describes the practical aspects of how this is achieved and how grounded theory may be used to analyse organisational behaviour. He says

"Qualitative social research generates large amounts of non-standard data which makes analysis problematic." Turner 1983 (193)

He considers the approach of grounded theory to be well suited,

".... to the analysis of data collected within organisations by means of participant observation, direct observation, semi-structured or unstructured interviews and case studies."

As in illuminative evaluation grounded theory requires that the course of the study cannot be charted in advance, that modification and changes occur as the research process goes forward (Hamilton et al. (1977) (77)). The researchers position as a health visitor made considerations of "insider" research important. As an "insider" the researcher did not have difficulties of being accepted, or in understanding the institution and environment of research. On the other hand an insider is likely to approach the study with preconceptions and biases. Burgess (1980) (26) writes at some length of the difficulties of insider research and of how to build independence and distance into the project.

Three circumstances eased these difficulties. Firstly the researcher was already established as such, having completed a previous project, secondly she had undergone training in qualitative and quantitative methodologies and thirdly for the workshop phase of the project she worked with an "outsider" since this was thought to be the aspect of the project most open to biased interpretation. Indeed Lund and Christensen (1986) (126) who had themselves run workshops in the field of health care strongly advised the researcher not to run workshops alone for this reason and because of the excessive demands they imposed on a researcher. A further influence was that of action researcher.

The concept of action research was first credited to Lewin (1947) (116). He argued that complex real social events should be studied in an integrated system, not divided off for study in a

laboratory. He took into account the needs of an organisation and its power structures and indicated the relevance of the researchers own motives and values.

"He identified several roles for research staff, for example as consultants on methods of action, as evaluation experts, as experimentalists pretesting a proposed administrative policy, and as autonomous researchers who had earned the sanction to carry out pure research and contribute to long term policy." Foster (1976) (63)

In action research the collaborative nature of the relationship between change agent and client is emphasised so that the researcher shares information about objectives, research and means of change within the "client".

"Rapoport (1970) defines action research as "a type of applied social research differing from other varieties in the immediacy of the researcher involvement in the action process (It) aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework." Foster (1976) (63)

Diesing (1972) (53) emphasises the holistic quality of descriptive research.

"As many of the concepts as possible should be derived from the subject matter itself, from the thinking of the people being studied; and the other concepts should at least not be foreign to their way of thinking."

Various approaches are open to the action researcher, Foster quotes Bennis (1963-64) as follows,

"He can expound behavioural theory, provide a critique of client problem solving attempts, draw attention to contradictions, comment on interpersonal relations, provide experimental evidence, outline dilemmas or summarize the present situation so as to help with the prediction of trends for the future."

The role of the researcher is not to manage change (Kirkpatrick (1985) (108), Hunt (1979) (90)) but to study it. But the collaborative relationship is in itself difficult arranging the research so as to avoid manipulation and the contamination of results by the researcher. In this aspect action research is not so different from other kinds of qualitative research and requires the same checks for reliability and validity discussed above.

Lippit (1959) (123) describes a list of questions the action researcher must pose himself, using the term "consultant" to refer to the researcher. These questions are as follows;

managers and health visitors and the discipline of an academic piece of work. The researcher was employed by the Health Authority whose staff she was studying. This led to a delicate balance of power between her immediate senior, the Director of Nursing Services, and obligations to independent research. The researcher would from time to time be required to be seen to be "doing something useful for the organisation" and would for example be asked to advise about issues unrelated to the research, teach on various courses or perform public relations functions on behalf of the community nursing service. The researcher used the criteria that other activities were either indirectly useful for the research, or helped to maintain relationships. If neither of these criteria were fulfilled these activities were refused. Although the current study is on too small a scale to be called action research proper the features of collaboration and involvement by the researcher in the research process were used in this study. The flexibility of changing the design as the work progressed and the difficulties of analysing complex real life situations as they occurred were also aspects addressed by action research methods.

Having discussed qualitative research, educational evaluation, action research, grounded theory and the researcher's position in the organisation it is now appropriate to outline the method used.

METHOD

After a preliminary literature search the research was undertaken in five phases as follows:

PHASE I

Permission seeking and introduction of the study to health visitors and their managers.

Selection of health visitor sample (N = 31) with access to age-sex registers.

Selection of managers (N = 8) in direct management of health visitors.

PHASE II

Devise and pilot baseline guided interview schedule.

Analysis of audiotaped pilot responses and revision of guided interview schedule.

PHASE III

Carry out and analyse baseline interviews (N = 39).

Assemble information for provision in workshops.

PHASE IV

Arrange information provision workshops for health visitor sample.

A) Meeting of whole sample (N = 31)

B) Each sample member attends three workshops (9 in all).

C) Meeting of whole sample.

All workshops to be audiotaped and feedback to take place at subsequent workshops.

Workshops A) B) carried out at fortnightly intervals, workshop C) six months later to assess developments. Discussion content to cover formation of community profiles and possible utilisation of information.

Feedback interim report on baseline interviews to all those interviewed.

PHASE V

Devise and carry out evaluation questionnaire for health visitor sample. Analyse data from discussions from Phase IV and evaluation questionnaire. Assess changes in planning on the basis of information provided. Evaluate the potential utility of the strategy to facilitate more general change in health visitor theory and practice in Sheffield. Prepared final report.

RATIONALE

In Phase I permission was sought to ensure access to personnel and facilities for the research. The project was introduced to all health visitors and their managers to gain the interest of the whole unit and to encourage co-operation with the project. Health visitors building community profiles would later need their colleagues to understand what they were doing. The sample of health visitors needed to be large enough to conduct a valid study and small enough to allow analysis of the results. All health visitors with access to age-sex registers were considered as they would have had more opportunities to handle epidemiological data and have more facilities available to them for building community profiles. All managers in direct management of health visitors were invited to take part to gain an overview of the organisation and to help the final implementation of results.

The baseline interviews were carried out to examine the thinking of the participants and the setting in which they worked and to produce data about the kinds of information they wanted. The interviews were piloted to reduce errors and refine the instrument (Phases II and III).

Phase IV formed a pattern of workshops. All the sample members needed to be introduced to each other so that they could communicate about the project and details of smaller workshops could be introduced in the first meeting of the whole sample. Most of the work was done in small workshops to enable communication and feedback. Workshops were planned at two week intervals to allow sample members time to complete work between workshops and to enable the researcher to analyse previous workshops for feedback. Comment and feedback within the groups and between the researcher and group members enhanced the richness of the data and allowed problems to be addressed as they arose.

The final workshop would ideally have been held two months after the last small workshop which would have given time for the implications of the project to arise. It was held six months later because the researcher was ill for a period. This had the benefit of allowing a longer period for the profiles to be used. The research interview results were fed back to all health visitor

and manager participants so that there was a maximum sharing of ideas in the organisation and all benefited from everyone's ideas.

In Phase V an evaluation questionnaire was implemented to assess the overall outcomes of the project particularly in relation to planning effects. These were then analysed with the discussions from Phase IV in a more formal format ready for inclusion in the final report.

INTRODUCING THE STUDY

The management of health visitors in Sheffield is organised in three sectors within which health visitors communicate. Each sector has a monthly meeting attended by senior nurses and health visitors. The researcher attended each sector meeting and explained the outline of the study, answering any forthcoming questions. The General Manager of the unit, Area Nurse and Director of Nursing Services gave permission for the research to proceed. The Director of Nursing Services maintained contact with the researcher in monthly meetings throughout the study period.

IDENTIFICATION OF THE HEALTH VISITOR SAMPLE

Since the study was to include the use of epidemiological and other health data it was considered appropriate to draw a sample who might be more likely to have experience of this sort of data. Health visitors with access to age-sex registers held by general practitioners were such a group.

The researcher contacted by letter all the health visitors (N = 102) employed in Sheffield Health Authority, fifty-four of whom appeared to have access to age-sex registers. Not all GPs have age-sex registers yet which is why not all health visitors had access to them occasionally a GP also refuses access to registers by health visitors. The researcher wrote a second more detailed letter (Appendix I (a) & (b)) to check that more than 50% of the caseload was derived from a practice with an age-sex register, and to enquire whether the health visitor was willing to take part in the research. Eight decided not to take part for different reasons, for

example, they already felt overworked, or they were interested in another research project. Fifteen health visitors wanted to take part but on closer examination they were not suitable for a selection of reasons for example, their caseload was not 50% on an age-sex register, they were intending to take imminent maternity leave, or they were expected to leave the Authority or move caseloads. The remaining group of thirty-one health visitors became the research sample. A new health visitor joined the Authority and wished to take part, a member of the sample unexpectedly changed caseloads and left the sample, so the final sample was thirty-one.

The researcher contacted those who had offered to take part but were not suitable because they were leaving or on maternity leave, and had the experience in the past of age-sex registers although not currently. They were asked to form a group for piloting purposes which they agreed to do. They would be appropriate because they had the same knowledge as the main sample but would not be included in it. The main sample were located in twenty different health visiting bases.

A card index of participants was made with name, base, telephone number, interview dates, and letters sent and received, so that the researcher could easily identify that all the sample had received all the necessary information.

The researcher sent letters again to the sample group requesting that they list and postcode all the streets on which they visited clients and to identify which times during the week were most convenient for them to attend meetings. This information was for use during the workshop period of the study.

INVOLVING THE MANAGERS

In order to engage three hierarchical levels of managers in the study nine relevant managers were identified. Figure I shows their relationship with the health visitors.

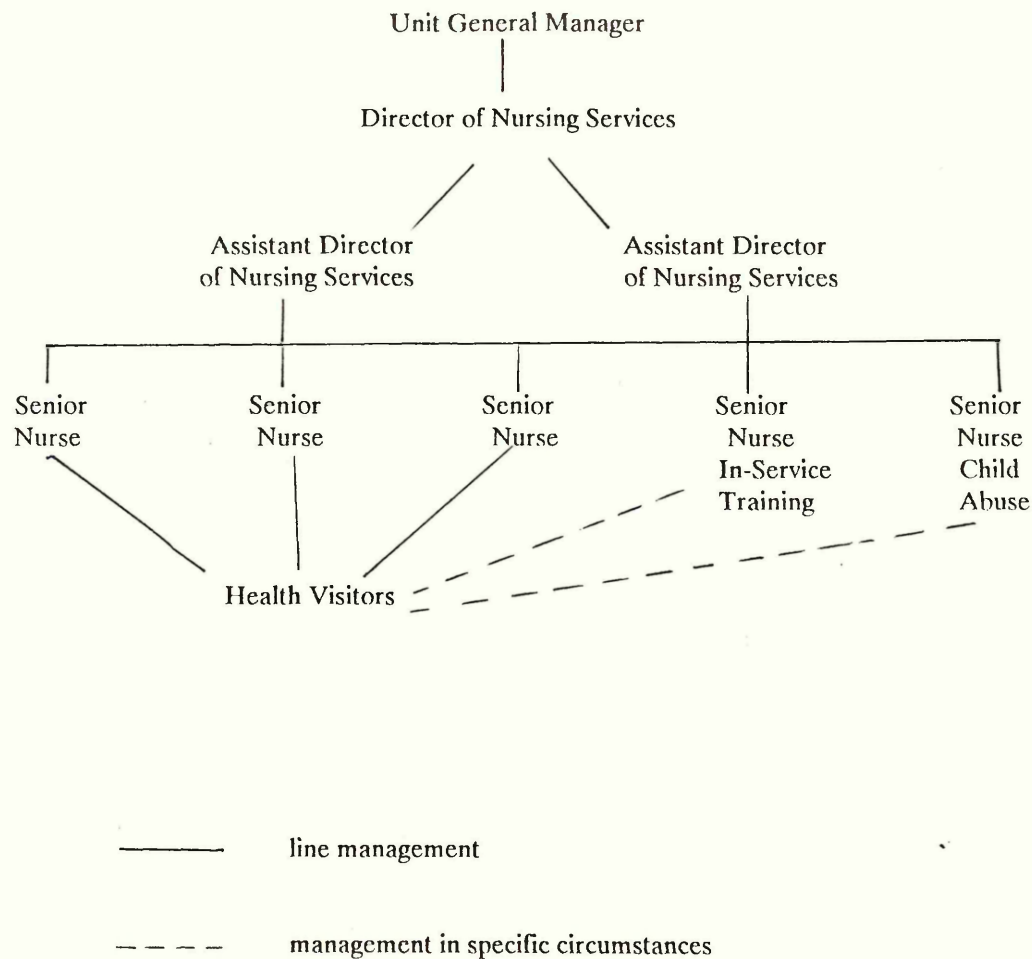


FIGURE I

Management Structure of Health Visiting

The researcher wrote to the nine managers requesting their co-operation in the research and their consent to being interviewed (Appendix IIa). All but one manager agreed to take part. The position of the Director of Nursing Services and the General Manager posed particular difficulties of confidentiality for local purposes. If their views were to be represented, since there was only one person in each of those roles, they could be personally identified. The researcher wrote to them explaining these difficulties (Appendix IIb) and they both agreed to take part with certain provisions.

The General Manager wished to see a copy of the interview schedule prior to interview but without the right to change the questions and the Director of Nursing Services wished to hear the interview tape after interview to point out any 'cultural misunderstanding'. This was because

she came from a different region of the United Kingdom from the researcher and wanted to ensure there were no language difficulties.

The researcher agreed to these provisions.

DEVISING THE INTERVIEW SCHEDULE

In order to fulfill the first aim of the study, that is;

"To obtain baseline data regarding aims, planning methods, health goals and information needs of health visitors in selected practices in Sheffield";

the concepts inherent in that aim needed to be translated into understandable, crucial and theoretically relevant questions. (Turner (1981) (192)).

The interview schedule is included in Appendix III. In drafting it the researcher considered the following areas. Firstly it was necessary to examine the health visitor's work experience to gain basic data about the interviewee and to understand her point of view in handling data. Her perception of the theoretical purpose of health visiting was sought, and her theoretical, actual and desired contact with different groups of clients. The interviewee described the health needs she identified within her caseload, and in her potential caseload, and on what information she based these views. The expression 'patch' and the statistical ratio of health visitors to clients were used to avoid the semantic difficulties of 'community' (Orr (1985) (125)).

In the work setting the health visitor was likely to be constrained or directed by policies or guidelines received from management. This issue was explored. The interviewer examined how the health visitor planned her work, and on the basis of what information. The health visitor was then asked to imagine information she would like to have, an issue which would be taken further in the workshop stage of the project. (Lund & Christensen (1986) (126)). An important influence on the health visitor's way of organizing her work was suspected to be education or incidents which had happened to her in the field, so a question was included on this issue. In the latter part of the schedule the interviewer examined enjoyment, feedback and effectiveness and indicated ways in which these could be enhanced. Finally the schedule allowed time for additional comments.

The structure of the schedule led the interviewee into the study with easily answerable questions, and concluded with a positive approach to health visiting. In piloting the questions about which clients the health visitors were contacting, were anxiety-producing, so they were spaced out in the schedule. The health visitors in piloting often used the final part of the interview to explain the stresses they felt in their work or explore issues of professional interest further.

PILOTS AND IMPLEMENTATION METHOD

The interview schedule went through a process of four drafts, and was piloted on nine occasions. Ambiguities and omissions were corrected, some questions removed, others divided into separate questions. During piloting issues of presentation and practical application were examined. For example a health visitor who had a hearing difficulty suggested that interviewees should be supplied with their own copy of the schedule to follow during the interview, which was subsequently implemented.

The interview took between fifty and ninety minutes to complete, usually extended over sixty minutes only if the interviewee wished to discuss other relevant issues. A statement explaining the content of the interview was typed on a card which each interviewee read before the interview commenced. The two copies of the schedule were typed and encased in polythene covers. The researcher had available to her a small quiet tape recorder specifically designed for picking up the sound of the human voice. The place and time of interview was experimented with in the piloting stage and the result was that interviews were carried out by appointment with the interviewees in working time at the health visitors base, in a quiet room without a telephone, with an electricity point for the tape recorder, and with the interviewees' colleagues alerted to the knowledge that the interview could not be interrupted except in exceptional circumstances. The researcher chose audio tapes with sixty minutes time on each side to reduce the distraction of turning the tape over. Tapes were identified by the initials of the interviewee on the tape and stored in a locked drawer of the researchers office.

ANALYSIS OF PILOTS

The pilot tapes were analysed.

First a summary of each interview was made to include name of interviewee, date, time of day, length of interview, interruptions or distractions if any, emotional tone, and notable answers or ideas occurring to the researcher as a result of the interview. A partial transcription of each interview was prepared and the researcher checked back with interviewees that the transcription represented what they were trying to say and a second check was made asking the supervisor with health visiting experience to listen to the two of the pilot tapes and produce her own transcription. This was extremely reassuring as the wording of the two transcriptions was almost identical (Gale (1983) (66)).

In each transcription each answer was allocated a question number, labelled with the interviewees initials and the serial number on the tape recorder so that the actual taped answer could be easily reviewed if required. Content analysis as outlined in Glaser & Strauss (1967) (73) and Turner (1983) (193) was applied to the transcriptions, and sentences and paragraphs were reviewed for forthcoming categories to identify how particular 'topics' were introduced and handled by the interviewees. The researcher explored the possibility of using different category codings. Relationships between the answers of different interviewees and between the answers of the interviewees to different questions began to emerge.

INTERVIEW SCHEDULE TO MANAGERS

On the basis of the experience of the health visitor schedule the researcher drew up a second schedule to use with the managers. Covering the same topics, it was necessary to adapt the questions to the viewpoint of the interviewees. During this procedure it became clear that managers up to the level of Director of Nursing Services shared a health visiting culture from which the General Unit Manager was excluded. A further separate schedule was devised for the General Manager. The researcher had had personal contact with all the personnel for a period of longer than a year in most cases, six months in one, and was therefore in a more advantageous

position to create relevant questions. The schedule for nurse managers was piloted twice outside the city with nurse managers from another authority. The researcher repeated the procedure outlined in the previous section.

PROCEDURE

The researcher contacted each member of the health visitor sample by telephone, making an appointment for interview. All thirty-one members were then interviewed under the conditions explained in the piloting section. The interviews were conducted over a period of five weeks, usually two a day, sometimes one, sometimes a maximum of three, and the resulting tapes stored for analysis. Health visitor managers and the General Manager were also interviewed under the same conditions.

All the interview tapes were transcribed and prepared for analysis so that tape serial numbers were recorded with question numbers, and answers could be checked back to the original tape recording if necessary. Categories arose out of the data and analysis of all transcribed material proceeded. These results were then written in report form ready to be fed back to all participants.

INFORMATION WORKSHOPS

A set of eleven information workshops were arranged. All the health visitor sample were to attend meetings at the beginning and end of the series. In between, each sample member attended the workshops spaced at fortnightly intervals in groups of ten or eleven. A detailed description of the content of the workshops is provided in Chapter 5. Each of the workshops was audiotaped and points arising from previous workshops were fed back in subsequent ones. Workshops lasted from two to three hours in each case, except for the final workshop which was a full day and health visitors were encouraged to build community profiles from the vast amount of data presented.

Finally the results of the analysed interviews were fed back to all participants including the managers.

EVALUATION QUESTIONNAIRE

In the final phase of the study an evaluation questionnaire was constructed (Appendix VI). This covered whether anything new had been learnt by the sample members, whether any new health needs or groups had been identified, whether the right information in the right form had been provided or acquired, whether there could be improvements in information provision and any benefits or problems the study had created. It also included a sample plan, the structure of which had been created in the workshop phase with the intention of demonstrating planning on the basis of information.

The health visitor sample were sent the evaluation questionnaire and completed it, to provide feedback about the aims of the study. The questionnaire was analyzed applying content analysis, as indicated in the analysis of the interview schedules, and prepared for reporting in the research document.

EXCLUSIONS AND WITHDRAWALS

This table shows attendance rates for workshops and completion rates for interviews and questionnaires.

| | | |
|--|-----------------|-----------------------|
| Baseline Interviews | Health Visitors | 31 out of possible 31 |
| | Managers | 8 out of possible 8 |
| 1st meeting of whole health visitor sample | | 27 out of possible 31 |
| Tuesday workshop | | 7 out of possible 11 |
| Wednesday workshop | | 8 out of possible 10 |
| Friday workshop | | 8 out of possible 10 |
| Tuesday workshop | | 11 out of possible 11 |
| Wednesday workshop | | 9 out of possible 10 |
| Friday workshop | | 7 out of possible 10 |
| Tuesday workshop | | 10 out of possible 11 |
| Wednesday workshop | | 8 out of possible 10 |
| Friday workshop | | 5 out of possible 10 |
| Final meeting of whole sample | | 13 out of possible 26 |
| Completion of evaluation questionnaire | | 22 out of possible 24 |

TABLE I
ATTENDANCE AND COMPLETION RATE

During the workshop phase individuals found that they had unexpected work commitments or were on sick leave. Over the whole period five health visitor sample members left the organisation altogether, one became pregnant and left to have her baby, and two were promoted to senior nurse posts. By the time the evaluation questionnaire was implemented two further sample members were on long term sick leave. When sample members missed workshops they were followed up by the researcher and information given so that they could continue to take part. The final meeting of the whole sample was poorly attended because health visitors found it difficult to take a whole day away from the field and because some were on sick leave or holiday, study leave or had students allocated to them. The researcher knows this because they telephoned to apologise for non-attendance.

This really demonstrates the problems of studying a sample over a long period of time, a year from commencement of interviewing to completion of the evaluation questionnaire, and was not because they lacked enthusiasm for the project as indicated in the evaluation questionnaire (Chapter 6). The second issue is that the project was seen as in addition to the health visitors field work commitments rather than part of them so where a health visitor was for example called to a case conference about an abused child that would rightly take priority over the research. It also demonstrates the pressure of work found by health visitors and the turnover rate of staff.

CHAPTER 2

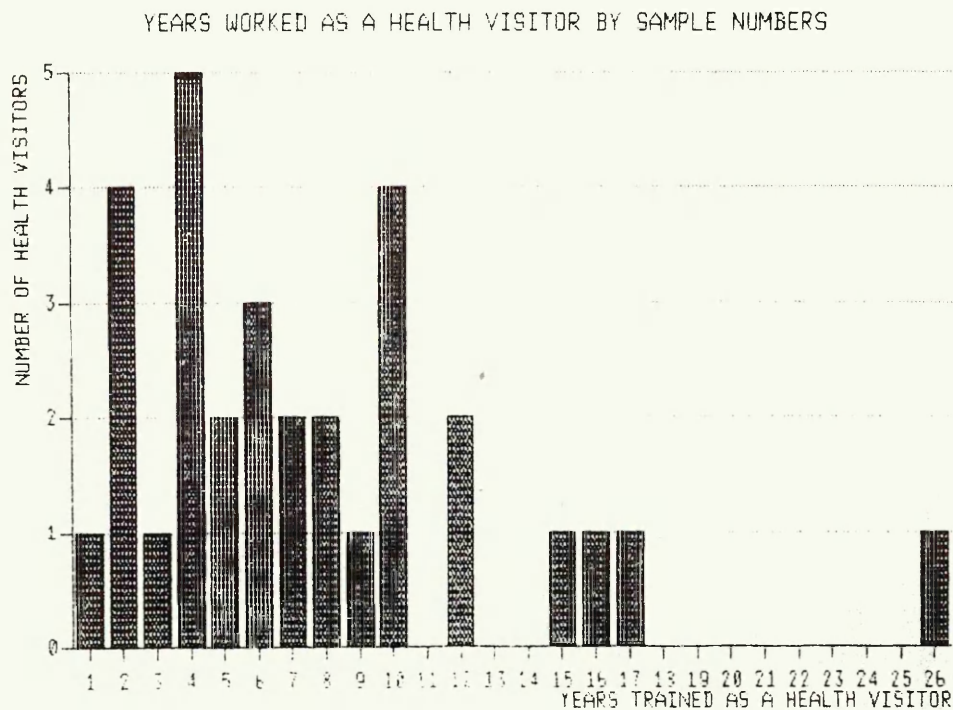
RESULTS OF HEALTH VISITOR INTERVIEWS

Chapters two, three and four comprise the result of baseline interviews with Health Visitors, Managers and General Manager respectively. Chapter two forms the results of interviews conducted with the sample of health visitors (N = 31). Where health visitors are directly quoted the source is identified with initials, but these initials have been coded to maintain confidentiality. The answers to each question are summarised under the question heading.

These results are discussed in Chapter 7.

1. HOW LONG HAVE YOU WORKED AS A HEALTH VISITOR

The shortest time worked was one year, the longest time was twenty-six years and the mean was seven years, seven months.



YEARS WORKED AS A HEALTH VISITOR BY SAMPLE MEMBERS

2. WHICH COLLEGE DID YOU TRAIN IN AS A HEALTH VISITOR?

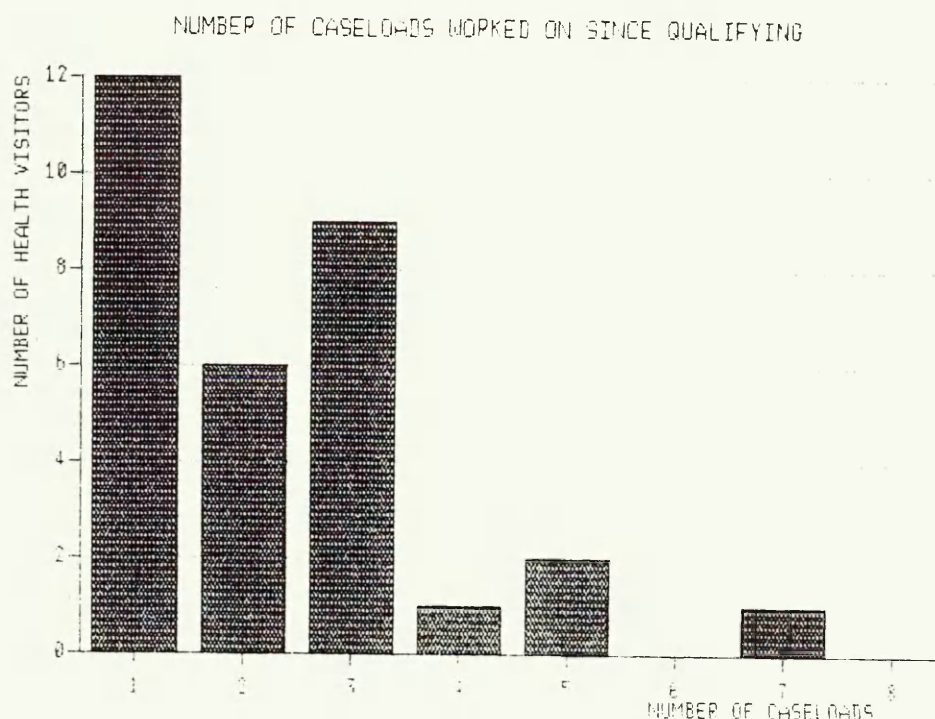
Twenty-five of the thirty-one respondents (80.65%) had training at Sheffield Polytechnic, and a further one had training at Sheffield University. Two had trained in Huddersfield and Leeds, with only three coming from far afield, Hamilton in Scotland, Bristol Polytechnic and the University of Wales.

3. HAVE YOU DONE ANY WORK OTHER THAN NURSING, MIDWIFERY AND HEALTH VISITING? WHAT OTHER WORK HAVE YOU DONE?

To the researcher's surprise only four respondents had done no other work. The variety of occupations and activities was very wide, including a supplementary benefits visiting officer, a window dresser, library assistant, waitress, a Butlins redcoat, lecturer, civil servant, usherette, working on a chicken farm, researcher, community worker, machining underwear, city councillor, and parent lifeline, calculator operator, shop assistant, barmaid, filing clerk and dental nurse. Most occupations fell into the category of "caring professions" or ill paid "women's work" though some defied categorisation, such as "athletics".

4. HOW MANY DIFFERENT CASELOADS HAVE YOU WORKED ON SINCE QUALIFYING AS A HEALTH VISITOR?

The largest number of caseloads worked, excluding "bank" health visiting was seven, the smallest number one and the mean 3.77 caseloads. Six respondents had done bank health visiting in which they worked from three to six caseloads over a short period of time.



GRAPH II

NUMBER OF CASELOADS WORKED ON SINCE QUALIFYING

5. DO YOU WORK FULL TIME OR PART TIME?

Twenty-four of the sample worked full time (77.42%) compared with 69.52% of health visitors in post at the time of writing. Six of the sample were part timers (28.68%) compared with 30.48% of health visitors in post.

6. QUITE OFTEN PEOPLE WHO DO NOT KNOW MUCH ABOUT HEALTH VISITORS SAY THEY DO NOT KNOW WHAT THEY DO. COULD YOU EXPLAIN TO ME WHAT YOU THINK THE PURPOSE OF HEALTH VISITING IS?

The answers to this question fall into two clear groups. Firstly respondents defined the appropriate recipients of health visiting, and secondly described the functions of health visiting. It was suggested that the main recipients should be the whole population with the specific group of 0-5 year olds being the second major group. Some health visitors felt that visiting should be limited to work with 0-5 and their families, others contesting this point.

"I don't see myself as confined to the under 5s. I don't want to be confined to the under 5s." KG.

The elderly, handicapped, mothers, especially new mothers, ante-natal clients and school children were all mentioned as appropriate clients. One comment indicated that the most vulnerable sections of society should form the health visitor's clientele, several thought the community as a whole of "well people" should be the focus of care. The principle of equal partnership between health visitor and client was mentioned. School children, "grannies" and the middle aged were given individual comment. The health visitor was expected by respondents to fulfil fifty different functions. It became clear why health visiting could be such a difficult job to do.

"I find its a very challenging job, but I think its unique. No-one else does quite the same thing. N.G.

The most highlighted functions were the promotion of good health and the prevention of ill health. "Support" was mentioned nearly as often with health education, screening, advice and surveillance coming close behind.

The maintenance of health and the enabling of clients to enhance their own health received attention as did developmental assessments, searching for health needs and the provision of information. Several respondents mentioned monitoring, referral and assessing as health visitor functions and wished to encourage clients to reach their full health potential.

Of the remaining functions the most interesting were that the health visitor should be a political health worker, they should be involved in welfare rights and housing issues and that they should promote happiness.

Some respondents emphasized what health visiting should not be, including "not inspections" and "not emphasizing child abuse". Indeed one respondent felt that health visitors should not teach prevention because it could not be taught.

Typical responses included:

"Looking at communities needs. Supportive role, helping people to look at themselves, looking at their own health needs and their own expectations. Everything that really involves." S.T.

"To try to promote health, improve peoples health situation through education, surveillance, observation with the knowledge and skills you've gained." N.N.

One respondent hoped to improve her clients health to the point where she made herself redundant, another said her function was often to categorize the knowledge a client already had.

7. WHAT GROUP OF CLIENTS SHOULD BE CONTACTED BY HEALTH VISITORS?

The overwhelming majority of respondents felt that health visitors should be contacting all groups in society. For example,

"Anybody who has a need. Any group not just mothers and children." K.C.

"All clients where there are health needs. Everybody's got health needs. Ideally all groups. Obviously each health visitor can't work with all groups - should be service available to everyone." N.N.

"Should see all age groups. Generic visiting." K.N.

"All groups. Family visitor in a small geographical area ideally." K.H.

"Idealistically all groups. From the womb to the tomb. Ante-natal through the pre-school years, school years and pre-conceptual, preretirement, retirement to old age." S.T.

Some particular client groups were felt to have the greatest needs especially the elderly and the 0-5 age group.

"Priorities have got to be the 0-5s because that where desperate situations do arise and where mums feel particularly vulnerable." N.G.

Other groups mentioned several times included 16-65 year olds, ante-natals, and pre-retirement groups. A few respondents highlighted school children, families with a handicapped member or families needing support, vulnerable groups new mothers, menopausal women and those suffering from cancer and their families. Individual comments suggested men, pre-conceptual work and carers as contacts.

As in the previous question some respondents felt there was too much emphasis on mothers and children. One respondent identified the middle aged and school children as not being relevant clients for health visitors.

There was some frustration expressed at the contrast between what the health visitors are trained to do and are able to do in the face of overwhelming client needs. These quotations illustrate this, the second showing a coping mechanism often mentioned by health visitors.

"You can see anybody, it depends where your interests lie, well men, well women, groups with asthma, diabetic problems. It depends, medical, social, emotional problems. I mean, God, to think we're supposed to cover all that lot, we skim the surface and I don't know how much good we do." L.Y.

"Health visitors could visit all those people but perhaps because they physically can't they ought to look at the things they are interested in." E.Q.

8. **WHEN YOU START WORKING IN A HEALTH VISITING JOB WHAT DO YOU NEED TO KNOW ABOUT THE COMMUNITY BEFORE YOU START?**

Most of the respondents felt it was important to know about local facilities, amenities and services many of which they went on to define, for example, libraries, shops, playgroups and nurseries, bus services, clubs for the elderly.

"Initially when you are very green and new you need to know all the amenities available for that area, playgroups, mother and toddler groups, toy libraries, transport and how easily they can get to places. You need to know what kind of area you've got (some have) more special needs than others. H.L.

Many felt it was a help to know the types of housing in the area and the state of employment and unemployment. The age sex structure of the population and the class structure were often mentioned as were information about local G.P.s and social workers. Certain features about the population such as the proportion and type of ethnic minorities resident, the incidence of single parent families and whether families tended to have relatives nearby were seen as significant.

The responses to this question could be divided into four main groups.

- (a) Other agencies, workers and local facilities
- (b) Information about working the patch from the previous health visitor.
- (c) Statistics about the social make-up of the area.
- (d) Geographical and environmental considerations.

These quotations illustrate these groupings:

"Size of the community, location, types of jobs in the area, unemployment rate, health centres, doctors, shops, schools, bus times, everything that relates to that community, crime rate, police involvement. What its like to live there." T.G.

"Who are you going to be working with, who your other colleagues are in terms of G.P.s, other professionals, e.g. midwives, all professionals." K.N.

"Sort of people, students older generations, single parents, unemployed people, intellectual, housing good or bad, whether over crowded. How mobile a population it is, hazards, roads, pollution, groups available in the area toddler groups, self help groups, doctors." K.C.

"Ideally you should live in the community and work in it for ten years before you do health visiting there, thats idealistic so.... basic stuff. Whats the population, age sex, a proper population pyramid that what I need morbidity and mortality statistics Also from people working in the area, schools, libraries, shops, clients all that sort of stuff. As much as possible from the person who's been there working on that patch before." K.G.

9. WHAT INFORMATION WERE YOU GIVEN WHEN YOU TOOK OVER THIS CASELOAD BY THE PREVIOUS HEALTH VISITOR. SENIOR NURSE OF COLLEAGUES? DID YOU OVERLAP WITH THE PREVIOUS HEALTH VISITOR?

Several respondents reported that they had been given information at caseload "handover" by colleagues, some saying they had lived or worked in the area previously and that was their main source. Some had taken on that caseload at supervised practice with the support of other health visitors in the centre, but one unfortunate health visitor had taken on a whole caseload practically from the beginning of supervised practice.

"I was given 100 families but the rest was just sitting there so I took the lot on from the end of the first week really." M.I.

Individual respondents were given very different sorts of information;

"None." K.C.

"The names of streets, lists of current organisations, people needing support visits." K.O.

"A lot of subjective information." M.I.

"Good liaison between doctors and nurses, working class and middle class housing." K.N.

"Driven round the area and told about the housing." K.N.

"Families with special needs." K. H., K.N.

"Taken round boundaries and clinics where G/P. practice was." M.I.

"Resume of problem families." D.C.

"Very little." D.D.

"At risk children." Q.Y.

"Told about health centre politics." K.N.

"Read about the area in local papers." I.T.

"Very little, where it was, nothing else. The silence was ominous, lots of rumours." I.T.

"Comprehensive folder from previous health visitor but one." K.C.

Five of the twenty-one respondents went straight from being a student into their current caseload and a smaller group worked on caseloads that had been split so that they continued to work alongside the previous health visitor. A few respondents had an afternoon of handover with the Senior Nurse but the managers broadly figured very little in respondents answers to this question.

Concerning overlap, half of the respondents had no overlap at all with the previous health visitor indeed the majority had gaps of between one and eighteen months, averaging 5 months gap since the health visitor left. In two cases the previous health visitor had died. Where overlaps did occur, this might be anything from half a day to a few weeks, one respondent

mentioning that a month had been too long. This seemed to be more to do with a clash of personalities rather than a criticism of the time period.

"I was really worried. Frightening outgoing health visitor added to confusion, adding gossip to innuendo. Nobody told you anything." C.C.

Further problems arose in handover were;

"My predecessor actively withheld information and retained all the family cards." C.Q.

Sometimes in the absence of a well organized handover individuals took action themselves;

"I gave up 2 days holiday to spend with the previous health visitor." B.T.

Only one respondent mentioned reading any useful statistics about the area, that was "Areas of Poverty in Sheffield". City of Sheffield (1983) (173). From the answers to this question it is clear that there are considerable problems concerning information provision when caseloads are handed over to a new health visitor.

10. THERE ARE MANY POSSIBLE SOURCES OF A REFERRAL OF CLIENTS. WOULD YOU TELL ME HOW AND FROM WHOM YOU GET THE NAMES AND ADDRESSES OF CLIENTS THAT YOU THEN VISIT?

All of the respondents mentioned referrals from G.P.s and all but one mentioned newborn notifications as sources of client referral. Other health visitors sending "transfers in", social services and clients referring themselves were the other three main groups. For instance,

"Newbirth card. Transfers in from other health visitors G.P. receptionist tells me when a new family register Word of mouth I go into schools quite a lot. Eric the social worker (re-refers) people I already know." M.I.

"From other health visitors. Local people come and seek you out. All sorts of other professionals notifications of birth, children registering with G.P.s. 0-5 year cards." K.N.

The ante-natal list produced from hospitals, other hospital referrals, liaison health visitors and midwives formed an important group. Various different professional groups were

mentioned including school nurses,nursery teachers, practice nurses, district nurses, teachers, G.P. receptionist, home helps, community psychiatric nurses,chiropodists, speech therapists, family planning staff, the N.S.P.C.C., and Adult Education workers.

Health visitors sometimes received referrals from particular clinics or groups they might be involved in such as well women clinics, elderly clinics or psychoprophylaxis classes. Immigrant forms and T.B. clinic referrals for follow up were included. Three respondents mentioned referrals generated from the age-sex register. Neighbours, families, the local community health council, the police or vicar might all refer to the health visitor. Finally the existing records of children on their caseload were used as an information source. These quotations indicate the variety of sources respondents mentioned.

"Newbirths, G.P., Social Worker, School, Nursery, Neighbours, other health visitors, clients themselves." S.F.

"Child health records, Referrals from practice are very good, not 100% but very good. Get on well with receptionists expectation of self referrals. Close link with Adult Education and schools - have a different sort of rapport with clerks and will pass health needs on. G.P.s in the other practice are a dead loss. Here we have a weekly clinical meeting to share concerns. Occasional referral from day hospital, not very good referrals. It would be really good to have lists of the elderly coming out of casualty or hospital wards. Be good to have more liaison with home helps. Good links with practice social worker and field work social workers. Nurses in health centre very good. Play and learn excellent agency for referral of health needs with the Asians. - Social Services day nursery liaise very well. After - years you see the odd ones in supermarket and the street who say do you know about Mrs. so and so, and its that that actually stops me moving." C.Q.

"I work with three G.P.s one G.P. I rarely see, the other two I see once a fortnight and once a week. Both of them refer quite freely and one refers the elderly that have got up his nose, the other is more receptive, younger, refers a real mix. Other than that one of the G.P. receptionists is really excellent, been there a long time, I've got a lot of referrals through her which have been very useful contacts." E.Q.

11. WHAT GROUPS OF CLIENTS DO YOU CONTACT ON YOUR PATCH AT THE MOMENT?

The largest groups of clients mentioned were 0-5 year olds and ante-natal clients. A small number of respondents felt that they contacted all age groups. Many respondents said they contacted a "small number of elderly", perhaps those referred to them only. Handicapped children

formed the next group, followed by a "small number of school children". Mothers, parents with problems, depressed mothers, single parents and families were mentioned with cancer victims or terminal care visits as an unexpected group for the researcher. These groups are very much the traditional model for health visitors clients.

Individuals highlighted particular groups they focussed on because of their particular caseload, pregnant school girls, fathers, homeless families, 0-18 months, mothers of under ones, mentally handicapped clients, "a small number of teenagers", young adults and mental health problems. Several respondents mentioned client groups they would like to but were definitely not reaching including ante-natals, the middle aged, schools and the elderly.

Typical extracts are as follows:

"The 0-5 year olds. A few elderly. One or two handicapped in 0-5 years. Ante-natals we don't see that often. There is a psychoprophylaxis class here each week. Also a lot of marital and social problems among parents of 0-5s. I don't go into schools." U.N.

"Limited to mums who are pregnant, under 5s and one or two elderly. See ante-natals if I get the information soon enough - try to get one visit in." C.E.

"Under 5s elderly, the whole spectrum. Ante-natals, under 5s. I'm lucky because we have an ante-natal and baby clinic combined so I can pick them up. Based at the G.P.s. G.P.s phone a lot - I have to make sure they are not duplicating they spread it all over everywhere if they want to get shot of a problem. Also do some terminal care support. K.N.

"Five to ten year olds, giving parents support, young teenage mentally handicapped people, young stroke victims try to amalgamate with other services. The odd crisis visiting to the elderly. I can't do routine visiting unless its a long term problem. Kids under school age with depressed mothers, often telephone support." H.I.

"Predominantly children, ante-natals from bookings, occasional old person." I.F.

"Mainly mothers and young children. Very little else." D.D.

12. WHAT GROUPS OF CLIENTS WOULD YOU LIKE TO CONTACT?

In contrast to the answers to question 11 respondents isolate four main groups of clients they would like to contact. These were the elderly, the middle aged, ante-natals and women in a

well woman context. It is important to appreciate that the respondents would see this as in addition to work with the under 5s and their parents.

"It's glib to say the whole range. I don't know whether I would personally like to contact them because I feel I've got enough to do, but I'd like them all to be contacted which is different isn't it? Taking on extra middle aged group work or pre-retirement work would be very satisfying but I wouldn't want to do it at the expense of what I'm doing now. I think we do that well in Sheffield. There is still more to do in that area, we do the young babies well to be perfectly honest. We don't do anything else well." N.N.

"I'm fairly happy with the job as it is at the moment. I'm sure there are others that you could do a lot of work with, but my time is taken up with the 0-5s and I feel that is pretty important." D.T.

Other groups of clients respondents would like to contact included those needing pre-conceptual work, pre-retirement groups, the bereaved, parents of handicapped children and the handicapped generally, menopausal women and teenagers. Several respondents indicated they would like to contact a whole range of groups and several others said they would like to put some more work into the under 5s group. A few respondents said they would like to contact post-natal women, first time parents, schools, young mothers, clients with hypertension, or depression, and men, particularly unemployed men for example.

"Everybody, far more with young mums on things like nutrition, general childcare Self assertiveness, self awareness Fathers from a comprehensive education - used to mixing with girls. They are very aware of lack of skills - Childcare. I feel I ought to say elderly but I don't, gear it to the forty to fifty year olds, can do better preventive work with those, nutrition, weight, smoking etc." T.G.

"All of them. I think we are underutilized." Q.F.

"I want to see the people who want to see me." K.G.

The final groups mentioned by individual respondents were diabetics, carers, the socially isolated, overweight women, school leavers newly "on the dole", grandmother classes, Asian families, heart problems, chronic illness, asthma and exzema sufferers, well person clinics, mother and toddler groups, single parents, 65 year olds, hospital discharges and hysterectomy counselling.

One respondent shed light on the possible reason for focussing on a particular group.

"Its important to do something of your own design that you see the need for. Otherwise you become bored and task orientated I try to do at least two elderly a month - takes an afternoon per visit. Its a break from the others like a holiday to change direction." K.C.

While the elderly in this area undoubtedly had health needs the reason the health visitor is giving for visiting is her own job satisfaction. Another respondent clarifies the lack of information on which decisions about how to focus work are made;

"Like Cumberlege says we are in a rut. Record keeping, we do too much. We don't need to write down "walks well", "eyes tested", we could just put a tick. Cut down on paperwork and do more health education. Get more involved in the community and be a person recognisable in the community so that people know what you do and where to find you, be accessible. We are cut off up here We don't get ideas about why people die, what people are suffering from, why people go into hospital, ill-health wise. I don't really know what the health needs are and the G.P.s don't seem particularly helpful I need to know where to get information from." C.E.

And finally one of the continuing themes;

"I feel I should be contacting the elderly. I get rather disheartened. Unless we are provided with a lot of resources and facilities all we are doing is just visiting." D.C.

13. **WHAT ARE THE PREVENTABLE CAUSES OF ILL HEALTH ON YOUR PATCH?**
CAN YOU IDENTIFY ANY OTHER HEALTH NEEDS?

Although respondents identified fifty-three preventable causes of ill health, seven of these were mentioned particular frequently. These were depression, poor nutrition, unemployment, smoking, housing, stress and poverty. Following these came the needs of the elderly especially poor nutrition and tension. Isolation and marriage breakup were noted; accidents and environmental hazards, e.g. fumes from the corporation tip, were also included. Several answers had a similar theme of poor education, lack of motivation, unrealistic expectations of children, odd health priorities, people expecting to be unhealthy, not recognising early signs of illness in children and living at times of day not compatible with child rearing, in the respondents view. For instance.

"Poverty, unemployment, low expectations of health. Its part of the culture. Children poorly nourished. Expect children to be under the weather most of the time. There are very few children here that I could say were, well, bursting with health Children constantly attending the doctors." M.I.

"For the elderly loneliness, a lot of people living close who really, there are facilities available for them to mix but I think when you've lost your spouse you lose motivation." E.Q.

"I don't know if its any higher in this area but just stress and unemployment. The stress of coping and being isolated." N.G.

"Unemployment. Round this half of the city it is the exception rather than the rule when people are working. I think stress, unhappiness, marriage breakup is a definite cause of ill health. Causes lack of motivation to take your kids anywhere, their priorities are often very strange and they don't use the health service properly. Don't contact the doctor as early as they should do. Either that or they pester the doctor for nothing or call the night service because they haven't got the bus fare down to the doctors or they find it easier than to drag the children there. Even when the kids have seen the doctor they don't get the prescription for several days. No idea that its free They get in this terrible cycle of depression and its very hard to get out of it. With the young mums depression is almost endemic round here We have a certain section of the population who are virtually unemployable now, if they do have a job the stress on the family is almost too much and they give it up almost immediately." K.I.

"A lot of problems related to bad housing. Diet is a problem. Very difficult to get through to some families that you want the children to put on weight but you don't want them to put too much weight on Problems in the winter with coughs and colds, lots of chest problems linked with children being overweight or combined with bad damp housing. Also lots of parents smoking, drink problems." I.T.

Another series of responses described particular illnesses and conditions, for example, asthma, pre-menstrual tension, hypertension, ulcers, gastric and duodenal, squints, breast disease, dental decay, cervical cancer, anaemia, carcinoma of the lung and sexually transmitted diseases. One respondent wondered whether the pattern of congenital heart defects she was seeing locally had an environmental cause. Immunization was considered very important for the prevention of illness. Among ethnic minority groups failures in communication were seen as a cause of ill health. Other causes were unemployment itself, non-accidental injury, alienation from the National Health Service appointments system, the effects of preservatives in food, behavioural problems, lead in petrol, and an over-zealous commitment to a poor vegetarian diet. Examples include;

"Better cervical cytology screening particularly for younger women. Politically its not always easy for them to have routine smears. I don't think every five years is frequent enough anyway. The fibre thing has got through to everybody but we've been talking to mums for years about not having extra sugar and I think thats having some influence I seem to spend a lot of time helping people find their way through the system. We have a good uptake of immunisation in our practice. I've asked for the figures but not got them One (surgery) takes in from most deprived areas and the (G.P.s) are not always sensitive to how difficult those people find using services." S.T.

"Mainly the children, measles, chickenpox - difficult to contain once it starts. If measles (vaccine) uptake was better it would prevent a few measles, and whooping cough - the uptake is not bad but it could be better." M.P.

"Diet specially the 60 plus group. We do a ten week relaxation course, change in their way of living, change in diet - you see the person change over the year, social conditions, e.g. homeless families rehoused but in a depressed area. Shows in psychological problems in children. Change, for example employment to unemployment you see a fall in their health." N.Y.

14. HOW DO YOU KNOW THESE ARE THE HEALTH NEEDS ON YOUR PATCH?

The majority of respondents reported that they know because of what they found and saw, because of what people told them and because they were experienced health visitors and therefore used to recognising health needs.

"I can't tell you the number of cases with asthma etc but you can see the poverty highlighted in the children's failure to thrive, in parents overweight, the way they use the surgery inappropriately with health related stuff that really all social. Very nebulous stuff to prove. They walk in and tell you." C.Q.

"I've met them so frequently in houses without tabulating them - you just do meet them on every visit that you do." N.N.

"From visiting families - they normally present these problems to you. It's not an area where people try and hide the problems they are experiencing things like that you notice generally or by talking to people." K.N.

"Through the experience of visiting them - quickly evident." K.N.

"Just listening. I haven't been in touch to find out statistics. Observing." M.P.

Several respondents felt that they got information from other workers in community forums and professional group meetings, from G.P.s, practice nurses, district nurses, midwives, chiropodists, schools, police, librarians and listening to other health visitors talk about the area. A

small group of respondents felt they didn't know the local health needs replying "I don't know", "guessing", and "intuition and value judgements".

"I don't know specifically. I suppose its experience and intuition and value judgements which may not be valid. Its a possibility if you are not careful you may be totally wrong. I'm very aware of that but I don't have any figures to back them up. Its the judgements you make from what you see. There may be a whole other life going on that you never come into contact with, if you knew about it it would totally change your perception of the area you work on." E.Q.

Statistics from the Health Authority and other written material such as Poverty and Health in the City of Sheffield (1983) (188), The Profile of Health and Disease (1986) (175) and circulars were mentioned by a small group of respondents. Several respondents said they expected to see modern diseases, such as heart disease, one remarking "you know the causes and you see the effects". Only one respondent said they acquired information from the G.P.s age-sex register.

On a more personal note, one respondent mentioned her own feelings as she went round the high rise flats gave her an insight into what it must be like to live there, and another said she knew the health needs because the relaxation classes she and her colleagues provided caused positive change in the attitude and happiness of her clients, she could see their progress.

15. THE PREVIOUS STUDY I DID SHOWED THAT THERE IS ONE HEALTH VISITOR TO ABOUT 5.1/2 THOUSAND PEOPLE IN SHEFFIELD. WITH AN AVERAGE CASELOAD YOU MIGHT CONTACT UP TO 1000 INDIVIDUALS INCLUDING THE IMMEDIATE RELATIONS OF YOUR CLIENTS. HOW DO YOU KNOW THE HEALTH NEEDS OF THE OTHER 4.1/2 THOUSAND PEOPLE IN YOUR PATCH?

Of the thirty-one respondents, twenty-three said they didn't know. A few suggested that liaison with the G.P. and other professionals gave some insight. Several said they used the local and national press, media generally, statistics and the inequalities in health document. Some said they just guessed, or extrapolated from general information or reading literature such as the Health Visitor Association magazine. Others said they heard from the extended family,

neighbours or used the families they did see as a yardstick of local trends. There really did seem to be a lack of adequate information.

"No-one has ever given us a break down of how things are in this part of Sheffield, what you are interested in, what you could do about it. That would be exciting but also frustrating." S.T.

"We could use the computer, I don't know if we could cope with what came up." N.G.

"We just guess. We don't know how many handicapped adults there are or elderly people with needs not being met." N.N.

"You haven't got time to look at the needs of the population you are visiting." K.B.

"I must admit I don't feel confident about dealing with other age groups, but until we do I never will." I.T.

"Depression, bereavement, dietary problems and battering we are not picking up." N.Y.

The respondents seemed to be saying that they almost did not want to know the health needs of the remainder of their patch because they could not deal with them in addition to their existing work.

16. ARE THERE ANY POLICIES OR GUIDELINES LAID DOWN BY MANAGEMENT ABOUT WHICH CLIENTS YOU SHOULD SEE? IF YES WHAT ARE THESE POLICIES OR GUIDELINES. IF NO RESEARCHER DESCRIBES VISITING PATTERN ASKS IF IT IS FAMILIAR.

The answers to this question indicate there is considerable confusion about policies and guidelines. The majority of respondents said they had never seen anything in writing although many thought visiting the under 5s was a requirement, priority or expectation. Six respondents thought assessment visits were guidelines, nine thought they were policy, two thought they were neither guidelines or policies, two thought screening was a policy by custom and practice. Different respondents would support their view saying the visits to the under 5s were written in the health visiting records, had been given out at unit meetings or were required on the monthly returns of activities. Several remarked they had been trained to do these assessments. Of those who

mentioned it non-accidental injury related activities were thought to be policy. Two respondents felt that newborn visits were policy because they were statutory. In fact newborn visits are not a statutory requirement, there are no specific statutory requirements of a Health Visitor, only that a service be provided. Ingenious circumlocutions were used by respondents, two of which were "implied policy" and "flexible guidelines".

The status of the sudden infant death survey visits is a good example of the confusion expressed. This study organised by Professor Emery takes place at four weeks post-natally.

"The four week survey has become almost a policy." S.T.

"If the child is a 'Professor Emery high risk' there's guidelines." E.Q.

Professor Emery is based at a building called Thornbury.

"Visiting the high risk babies, ultra high risk. I don't know if this is management or just what Thornbury ask us to do. Its policy and therefore its up to you to tell management if you can't fulfil those policies." N.N.

"Others are ultra high risk visit and weigh weekly. Not guidelines from Sheffield Health Authority (but) from the sudden infant death (study)." I.T.

The following table indicates which activities were thought to be policies or guidelines, neither, or either by those respondents mentioning them. Some respondents had noted a change in attitude by management for example

"I've never read any policies or statements. You pick things up that they expect you to visit children on the special register, handicapped, children with special needs. But as for putting down in writing - I've never had any specific information. When I first came out of college, I saw it as a skeleton, but the attitude from management seems to be more pressurized that we do these visits, they must be done partly because child abuse is highlighted in the press and health visitors are hauled up in court. The pressure has changed." C.E.

"Yes you've got to visit the under 5s or so it comes over. I get a rocket if I have a build up of assessments that haven't been done in our unit meeting no-one says anything. Management says does everyone agree and everyone says nowt. It gets passed. Its (visiting pattern) ingrained since its in the clients heads, it needs revising." T.C.

"I think there is some sort of policy about the 0-5 regime, but we probably do more than that anyway. N.N.

"Yes. Policies for visiting the 0-5 year olds. Guidelines about trying to see the ante-natals. V.G.

"Guidelines about doing more work with the elderly." K.C.

Twenty-three respondents specifically mentioned whether they considered certain activities to be policy, guidelines, either or merely an expectation of them. The results were as follows:

| ACTIVITY | POLICY | GUIDELINE | EXPECTATION | POLICY OR GUIDELINE |
|-----------------------|--------|-----------|-------------|------------------------|
| Antenatal visit | 1 | 4 | 1 | 1 |
| Newbirth visit | 15 | 3 | 8 | 1 |
| Survey visit | 12 | 1 | 5 | 1 |
| 3 month assessment | 13 | 3 | 9 | 1 |
| Hearing test | 10 | 2 | 7 | 1 |
| 9 months assessment | 13 | 3 | 9 | 1 |
| 18 month assessment | 13 | 3 | 9 | 1 |
| 3 year assessment | 9 | 6 | 8 | 1 |
| 4 year assessment | 9 | 6 | 8 | 1 |
| High risk visit | 4 | 2 | 1 | 1 |
| Non accidental injury | 2 | - | - | - |
| Elderly | - | 1 | - | 1 |

TABLE II
ACTIVITIES OF HEALTH VISITORS DESCRIBED AS POLICY, GUIDELINE,
EXPECTATION

17. IS THE VISITING PATTERN I HAVE DESCRIBED RELEVANT TO THE NEEDS OF THE PEOPLE WHO LIVE ON YOUR HEALTH VISITING PATCH? COULD YOU TELL ME A BIT MORE ABOUT THAT?

Almost a third of the sample felt the visiting pattern used as a base pattern by most Sheffield health visitors was not relevant to the health needs of people on their patch. Slightly fewer felt it was relevant. Many of the sample felt that the pattern was all right but not enough in itself. Some said it needed rethinking. Several felt the gap between the 18 months assessment and

the 3 year assessment was too large, and another noted the same problem between nine months and 18 months. One respondent felt it was relevant to her needs, not those of the clients, another felt her work organised her rather than the reverse. Comments included:

"Its only relevant for managers to check on health visitors." N.G.

"It should be less rigid." N.Y.

"Its a useful structure." I.T.

Several felt that the pattern was relevant only to development and not to health needs, an interesting point.

"I feel its relevant because most families that I visit need at least that amount of input." K.N.

"If we are only working with under 5s its quite a good plan but I am working with 350 families - I have no time for anything else." C.E.

A few respondents had developed their own pattern of visiting, here is an example,

"Its not relevant. I visit more often in the first year. At the months visit I discuss with the mother how often she will need support over the next three months - at home or in clinic. I see every child every three months until they are two at the very least. If you don't see them at least three monthly they are not going to use you as a source of information because they've forgotten who you are - then every six months until they are four. I'm sure it would be felt to be too frequent but in this area they get used to you coming and they are waiting with their questions, you don't have such a long visit because you are up to date with whats happening and you've never lost anybody for very long." C.Q.

18. **DO YOU KEEP TO THIS PATTERN OR DO YOU HAVE A PERSONAL SET OF GUIDELINES WHICH YOU USE?**

Many of the respondents said they used both the set pattern and additional visits. A slightly smaller group said that they kept to the pattern. A smaller group still used their own guidelines.

"I keep to the guidelines and supplement it. Basic pattern plus judgement." K.C.

"I keep to the pattern to 18 months, after that its more selective." C.E.

"I try to keep to the pattern as much as I can." L.Y.

Several respondents said they saw the younger babies more often, responded to problems or crises, or visited at particular times, for example, at a year or two years. One health visitor placed the emphasis on home visiting, where another said she did a lot of work in the clinic.

"I use the ages, picked out from the birth book. Sometimes I visit weekly or two weekly. If you leave them 19 months to 3 years you are visiting a lot. If you put in a 2-2.1/2 year visit you are over loaded. I don't quite know how to cope. The feeling you are held responsible when you don't find something. In the States it is different based on when the client wants to see you. Responsibility is with the mother. There is a lot more responsibility given to parents.!" N.Y.

Some respondents mentioned they specifically responded to individual needs,

"I don't do a rigid pattern of my own, I tend to assess each one as it comes along." K.N.

"Its awfully difficult it depends on the individual. Depends how the mother's coping, whether she's basically well herself, whether she's living on her own, if she's got mum next door giving support, or a multip, having kids every year for the last 4 years then obviously you know if the previous child rearing pattern has been O.K., you know she's going to be all right with this one generally speaking, providing no obviously signs of post natal depression. If its a young isolated mother thats had a difficult delivery you might go every day, or if its a lass that struggling to breast feed - again you'd go in fairly frequently, or a family where there are other kids where you are concerned about the care of those kids, I'd be knocking on the door every time I passed until I was sure they'd got over the crucial stage of having the new baby around." B.D.

It was in answer to this question that one respondent suddenly said she had never worked on one caseload, but had always worked in a situation where she had also been covering for someone else.

19. **DO YOU PLAN YOUR WORK? TELL ME HOW YOU DO THAT. WHAT DO YOU BEAR IN MIND?**

The majority of respondents used a worksheet of assessments taken from their birthbook and updated each month. More than half mentioned their diary as a planning tool,

some used the telephone to contact clients, which of course is only possible in areas where clients have telephones. Several mentioned writing notes, cards and letters to clients and a third of the respondents had tried index cards sometimes with an unsatisfactory outcome.

Respondents described planning round "fixed points" or commitments, these being activities such as newborn visits, hearing tests, baby clinics, visits to children at high risk of sudden infant death, case conferences and study days or urgent calls from clients. For example,

"I tend to work from a birthbook to pull out assessments, make a separate list of whats due. Diary - use it to follow up or put in for a given week. I book visits, surveys. Don't necessarily book newborns. If people are on the phone I tend to ring them. No other indexes. I remember people by names rather than addresses I probably could plan quite a long way ahead, but I don't. In previous areas I didn't have a chance to plan. I'm still not a very good planner." K.N.

"Yeah. I plan using my diary. Each time I visit I write my visit up in the car as soon as I've done it and decide when I'm going back and write that in my diary. That creates drastic pressures, but I can't think of a better system. I'm booking my diary up well in advance." S.T.

"Yes as far as I'm able. They have to be very variable because situations are unpredictable." K.C.

"I make a list each month and each week. Work entirely in my diary plus a big list for the month. My diary looks very jumbled. Other peoples diaries look so tidy its a source of wonderment to me I write in the weeks visits on Monday, newborns surveys and clinics are written in on the right day." K.H.

Respondents mentioned many considerations they would take into account for example: students, the geography of the area, working from the youngest children up to the older ones, referrals from other agencies, especially G.P.s, and looking at an ante-natal book. Three respondents were blessed with very good memories and could remember all their families, some planned in their heads, not on paper.

The researcher was surprised to note that only three respondents articulated that they started with a set of priorities from which they planned, and none justified their planning by saying they were addressing the most important health needs in the area. Maybe the answer lies in already being overloaded with "what is expected" by management.

"I tend to know what I've got due, what I've got overdue, and what I've got really overdue (laughter), who I've got to go and see each week otherwise I have a terrible fear in the night - God what's happened to that child, we've all got some of those haven't we." H.I.

20. **IS THERE ANY INFORMATION YOU WOULD LIKE THAT WOULD IMPROVE THE WAY YOU PLAN YOUR WORK? WHAT SORT OF INFORMATION IS THAT?**

The respondents produced seventy-one different fields of information they would like to help with their planning. These can be broadly divided into four main areas.

Firstly concerning screening and lifestyle issues, secondly conditions and illnesses, thirdly features of the existing communication structure, and fourthly a miscellaneous group.

SCREENING AND LIFESTYLE

Above all respondents wanted accurate information about immunisation, both those due and uptake figures

"If immunisation could be up to date. Somewhere where I could always know the immunisation state." N.N.

Admissions of elderly to hospital and notification of their deaths as well as actual data about where to find them were seen as important. Smoking and alcohol consumption rates locally as well as solvent abuse, experimental cigarettes and numbers of children alone after coming home from school particularly among adolescents, were sought.

"How many people actually smoke? I don't know if it's available but it would be nice to know Also alcohol on the increase, I'd like to know more about that, more background on drug addiction." Q.Y.

Levels of obesity, number of drug addicts, cancers, one parent families, unemployed, menopausal women and parents under 22 years would be found helpful for planning.

CONDITIONS AND ILLNESSES

Principally respondents sought morbidity and mortality figures generally but especially concerning positive smears, coronary heart disease, depression, chronic illness, and accidents in the home. Bronchitis, ear infection, epilepsy and breast cancers were mentioned.

"Incidence of death from coronary heart disease, the morbidity rate, positive smears, the rate of cervical cancer, breast cancer." S.T.

"Repeated ear infections to pick up hearing losses, mums who've been in for depression, particularly post natal depression, ones who've defaulted ante-natal appointments." K.B.

"I worry about where the handicapped people are." K.H.

Respondents asked for notification from G.P.'s when parents in a family were ill, rapid feedback from hospitals when children were ill and notification when a member of a family they were already visiting was taking medication. Several respondents wanted notification of handicaps, mental and physical in their visiting patch.

STRUCTURE AND COMMUNICATION

Respondents wanted accurate ante-natal lists with defaulters indicated, early knowledge of hospital admissions, especially from casualty, transfers in and out constantly updated, and accurate relevant information from G.P.'s. Concerning nurseries, respondents wanted to know when children were attending nursery and when they had been seen by the school nurse, feedback, from the primary health care team, particularly when other members were seeing the same family as the health visitor, a message leaving service, and feedback from post-natal and family planning clinics was felt would be helpful. Respondents wanted to know when children were attending the G.P. frequently, especially when nothing much was wrong, children attending day care and childminders and children being fostered. Good liaison with the Hallamshire Hospital and feedback from the eye surgeons was requested. Some respondents sought earlier feedback, for example:

"Sometimes information is late coming through, it comes through so many hands." T.C.

"We get very little feedback from the Educational nurseries. I suppose looking at mums it would be nice to have information about what happens at family planning at the G.P.s, post-natals, etc. if we got information about transfers in, or maybe all people coming into the area, a register at the G.P.s would be good." B.D.

"You get to know information, e.g. hospital admissions, too late." I.T.

MISCELLANEOUS

Respondents asked for an array of other information for example an update of local amenities you could give out to families, what was happening in the area, more statistics, leaflets when you need them, not a two week wait, a profile of the area.

"I'd like a much better in depth profile of whats in the area so that the work would be a bit more meaningful." Q. Y.

One respondent asked for "what management expect of us", and then asked "how effective is visiting by appointment in a deprived area?". One felt a necessary tool was a list from the previous health visitor of all the families needing support. Respondents wanted access to welfare rights information, to know when mothers would be out, to know what can be prevented, the "health needs of the people I don't see", what people would like, any major family shake up and finally what goes on behind the doors.

"Health needs of the people I don't see. What would people actually like - the ones you recognise health needs in." K.N.

21. DO YOU USE YOUR G.P.s AGE SEX REGISTER? WHAT DO YOU USE IT FOR?

All of the respondents had access to an age sex register but half of them replied that they never used it. Of the remainder it was used for elderly screening, tracing people, checking immunisations and estimating population. One respondent mentioned that work was planned, another had traced back the family of a deaf child to see if any genetic component could be found.

Others had used it to print out ante-natal patients, give a breakdown of ages in the 0-5 range, for transfers in and for a disease and conditions register, which sounded the most promising use.

The variety of responses is illustrated by the following quotations,

"I haven't no, there is one." B.T.

"No. Its not geared to prevention." S.T.

"No." M.M.

"Use it for elderly screening clinic. Screen all over 65. Apart from that I don't use it." K.N.

"I do. For checking, to check if registered here. For tracing kids. Here they have a disease register e.g. diabetics, blood pressure screening, smears. They stick a dot on. We have a computer here. You can pick out all the children who have not been immunised. They are very good at sending out letters. The G.P.s have a baby clinic. I like to think that I run it. I used the age-sex register when I very first came and started to count through how many people there were. I gave up at about 6000 and something. To see what sort of people and age groups. Can't pull of age bands yet but that what he's working on now. Can pull out cervical smears, blood pressures, repeat prescriptions, things like that." M.I.

22. **IF YOU VIEWED YOUR CASELOAD AS THE WHOLE POPULATION ON YOUR G.P.s AGE-SEX REGISTER WHAT INFORMATION WOULD YOU WANT FROM IT?**

The answers to this question bore a great resemblance to the answers to question 20. In a similar way the responses can be divided into screening and lifestyle, conditions and illnesses and miscellaneous.

SCREENING AND LIFESTYLE

Respondents particularly wanted information about age ranges and groups in the practice, numbers of unemployed, elderly, and immunisation feedback. Particular sections of the population included the pre-retirement group, men aged between 35 and 60 years, people living

alone, menopausal women and one parent families. Again incidence of smoking, drinking alcohol, obesity and drug addiction were requested. In addition marital and educational status, diet, use of the contraceptive pill and literacy levels were sought as well as ability to communicate in English. Individual respondents mentioned numbers of widows and widowers suffering bereavement, people needing chiropody, people taking early retirement, those with anxiety and personal problems, the mental health of young men and those taking tranquilizers. Couples thinking of starting families were identified for pre-conceptual work, breast feeding rates, hearing test and assessments due were all considered useful. Others mentioned identifying positive health, kinds of employment and linking motorbike accidents with age groups.

Examples in this section include,

"I'd like to see smoking or not then we'd know where we were targetting. Whether they are unemployed or not - that has a lot of bearing on what people eat. Whether a women has been sterilized, had a hysterectomy things like that." W.Y.

"How many single parents mental health of young men, depression, use of tranquillizers, psychiatric admissions." T.G.

CONDITIONS AND ILLNESS

This group includes all those mentioned in question 20, particularly morbidity and mortality rates, coronary heart disease and positive smears. In addition diabetes was mentioned by several respondents as were hypertension, hysterectomy counselling and the handicapped. The mentally handicapped, handicapped 18-60 years old, blind and deaf were all highlighted. There was also an awareness of bowel problems with the risk of bowel cancer, female sterilization rates and the history of cot death. Cancer of the lung was felt to be important in Sheffield.

The following quotations illustrate the types of conditions highlighted.

"Obviously information should be at your fingertips of all the handicapped, the young handicapped, especially mental handicap, all those chronically ill diabetes, hypertension." H.I.

"Hypertension, diabetes, alcoholics, that sort of thing. Handicaps." N.D.

"Incidence of suffering or dying from carcinoma breast, carcinoma cervix, those statistics."

MISCELLANEOUS

This section included other members of the primary health care team seeing the same client, transfers in and out, accurate ante-natal lists and children being fostered. The size of the G.P.'s practice, defaulters from medical assessments and teenagers attending special schools were required. One respondent asked "can you predict emotional health?" and identify people who need counselling. Another suggested finding clients who had never seen any health care worker. An interesting idea was to use the computer to identify aspects of clients that were the opposite of what was required, for example all those who smoked, were overweight and took the contraceptive pill, or all of those who had missed a screening process. One enthusiastic respondent said,

"Everything, I'd like to know everything". L.Y.

23. IF YOU HAD TWICE AS MUCH TIME WHAT WOULD BE THE BEST HEALTH VISITING USE OF IT YOU CAN THINK OF?

Many of the respondents felt they would like to have more input into their existing caseload for example,

"With the 0-5s I'd like to do some family work, with the whole family, a lot more intensively than I do now." N.N.

"Providing more input to a lot of the families I'm already visiting." K.N.

Other groups of respondents felt they would like to update themselves, take part in Health Education or Liaise more with other workers. Several felt they would like more time to plan their work.

"To be able to plan properly, instead of doing it in a rush, doing the basics, it would be nice to have a broader outlook and really plan and really think how you could do it if you get the chance." B.T.

"To read more, to look into research, and more time to plan and prepare for a student." D.T.

"I'd like to be able to think more, plan more, read more; health education - group settings." C.E.

"I'd like the opportunity to research what else there was to do. To take time out and have a look at what people wanted you to do. Take two or three days just to plan." N.N.

Several respondents mentioned that they would like to attend a counselling course, visit the elderly, ante-natals and work in a "well woman" setting. Many other groups and activities were identified for example work with the unemployed, the bereaved, post-natal support groups, working with an interpreter, single parents, preconceptual groups, handicapped adults and pre-retirement groups. Some of the more interesting activities included teaching self awareness and assertiveness, linking with occupational health and teaching play. Two respondents felt they would like to identify client need more successfully, for instance,

"Try and find out different needs and groups and try to do something about them. Try to catch up with existing work Be good to find out whats needed before we started anything new. A bad year really its been difficult. A nice holiday would help." I.F.

"Talk to clients about the things they want to talk about." N.Y.

24. SINCE YOU TRAINED HAVE YOU DONE ANY READING, TRAINING, RECEIVED TEACHING OR HAD ANY INCIDENT HAPPEN TO YOU THAT HAS MADE YOU ALTER THE WAY TO ORGANISE YOUR WORK? TELL ME ABOUT IT.

There was a feeling from many respondents that their practice had gradually changed as they became more experienced. Several respondents mentioned in-service training, giving it a mixed reaction.

"In-service training in general is disgusting, disgraceful, totally ineffectual. I haven't been to anything in-service training that has helped a scrap." C.Q.

"In-service training I go to as many as I can, because they're useful." B.T.

"Some very useful in-service training, and some absolutely useless in-service training." N.G.

Respondents had attended different courses they felt had altered the way they organized their work particularly the field work teachers course, management courses, teacher training, assertiveness training, co-counselling, relaxation courses, the SAFTA home tutors course, Marie Curie course, occupational health course and a particular refresher course. The influence of personal experience was mentioned several times, for example,

"But since having my own children every child is different its altered my views Personal experiences have made me alter just personal experience and growing old!" U.N.

"The big things are the things that have changed how I felt about myself and my perception of women's role in society, have changed how I've gone about my job. And getting more information about alternative practice, meeting practitioners. All external to the job." K.G.

"Being a mother has helped me personally. I had had a rip roaring post natal depression. Its a valuable but painful experience to have." K.D.

Reading had contributed to the respondents activities, the Health Visitors Association Journal was cited, Project 2000 (1986) (194a), the Cumberland Report (1986) (86), the Child Development Programme (1984) (32a), and reading books and articles generally. Other influences included "working on the bank", or the non accidental injury register, being a member of Radical Health Visitors, the Health Care Strategy Group, attending conferences, sharing an office with a social worker and a reprimand from management. The incident of cot death had influenced two respondents to be more vigilant, and to worry more about infants. One respondent said,

"I tend to go from trauma to trauma, crisis to crisis. Cot death (has given me) a respect for centile charts." K.H.

Others mentioned specific training about record keeping and litigation as altering their pattern of working.

25. DO YOU ENJOY BEING A HEALTH VISITOR?

Over half of the respondents replied "yes". Only four felt they did not enjoy it. There were various qualifying comments;

"Once you are out with the clients its all right." S.T.

"I hate the paperwork." T. G.

"Some days yes, some days no." M.P.

"Its frustrating." K.C.

"Its tiring." N.N.

"Sometimes I feel grossly undervalued." Q.Y.

26. **DO YOU ENJOY WORKING ON THIS CASELOAD?**

Of the thirty-one respondents, twenty-six said they enjoyed working on their current caseload, far more than said they enjoyed health visiting. Qualifying comments included,

"Its all right." D.D.

"Most of the time." K.C.

"I don't enjoy the strain sometimes." D.C.

"I did enjoy it but now its too stressful" T.G.

27. **HOW DO YOU KNOW WHEN YOU ARE DOING THE JOB WELL?**

More than half of the respondents replied "I don't think you do know" emphasizing how difficult it is for a health visitor to evaluate her own work. A large number felt that they knew because of the "response you get from clients". Feedback from clients included letters from clients, when a client gets over a problem and when a client's health improved.

Several respondents commented how unusual it was to get thanks and that they never get feedback from their senior nurse. Positive feedback from G.P.'s and colleagues were however included.

Other forms of feedback were based on the work itself, so when there is no epidemic of enteritis, a drop in the accident rate, a good immunisation uptake rate and a reduction in the number of crises, because they had been prevented, respondents felt they were doing well. One commented that it was not when your assessments were completed. Several respondents said that

it was how comfortable you felt in yourself and that you "just judge for yourself". Only one respondent said she was constantly evaluating to her own standards.

The difficulty of assessing how well you are achieving as a health visitor is emphasized in the following quotations.

"God only knows. I don't know. Nobody gives you any feedback really. You may get something from families, no one else tells you." K.Y.

"I think that's very difficult. I think you rarely do. I don't think it's a job where you by and large get feedback To have appraisals would be more beneficial. All you rely on is your own analysis of the situation really." B.T.

"You just get to know within yourself. When you are feeling O.K. you are all right, when you are not feeling O.K. you wonder." K.H.

28. **WHAT WOULD HELP YOU TO BE MORE ENTHUSIASTIC AND EFFECTIVE IN THE JOB?**

Above everything else respondents felt they wanted a supportive management, for example.

"Management that would support but wouldn't interfere and impose what they see as being best for everybody when they don't know a damn thing about it." T.C.

"More recognition from senior nurses." D.T.

"I think recognition from management that you really are doing your best." E.Q.

A firm second was clerical help or a reduction in clerical work.

"We are clogged up by this stupid avalanche of paper flooding down on us." H.I.

"Clerical help." S.T.

"Clerical help." K.C.

Thirdly came the need for more time.

"Time, the biggest thing to be more effective." D.T.

"More time and less caseload." L.Y.

"I really feel that if I had a lot more time I could put a lot more energy into actually educating people in terms of their health." K.N.

There were various other pleas for more in service-training, to have an atmosphere of innovation, being able to plan aims and fulfil them, and requests for more information.

Respondents wanted more money, less stress and more support, and a counsellor for health visitors themselves. Two respondents wanted a better physical working environment and another wanted someone else to work with.

There were requests to improve the transfer of records and to have a lunchbreak every day. A couple of respondents mentioned how tired they were, one saying being younger would help! The primary health care team functioning well and the development of a computer for the G.P. practice were looked forward to by two respondents. Finally a radical change in everything was all one respondent required,

"Effective? - A radical change in nurse training, a radical change in doctor training, a radical change in the government in this country, a radical change in the way the work ethic is stuck upon us. More freedom to respond to consumer need rather than what has been done in the past. Freedom and respect from the hierarchy that we do know what we are doing if we are given the chance." K.G.

29. IS THERE ANYTHING ELSE YOU'D LIKE TO TELL ME?

Only five of the respondents felt there was nothing more they wanted to say. The remaining twenty-six respondents used the time to develop ideas, explain difficulties and anxieties and make suggestions. Four were worried that they were only providing a skeleton service in their area, they were all from different health centres. Many comments related to the same theme.

"I think we are in a rut and a lot of health visitors at this time seem to feel demoralised in a way." C.E.

"If we knew the managers better it would help." U.N.

"Managers need to listen to staff." K.B.

"There needs to be better communication in the service." K.N

"Basically there is no orientation for people coming back in." K.B.

"The isolation is pretty terrible in this job." M.I.

"We need formal support systems for health visitors." M.I.

"You feel covered with guilt at the end of the month." B.T.

A discussion about stress was followed by another about counselling. Practical improvements in the way the job could be done included having hand held tape recorders for record keeping, hours should be geared to accommodate health visitors who were themselves working mothers, that the records needed altering, that the advantages of G.P. attachment should not be lost in the rush to become "geographical" and that health visiting needed to become a research based profession. The elderly persons support unit was discussed and concerns that health visitors would only visit clients up to 2 years of age. There was a call that health visitors should listen to clients more and respect the integration of alternative ways of looking at health care. Finally there was a request for more information,

"If we had more information we'd be able to target our work to more important things." K.N.

CHAPTER 3

RESULTS OF SENIOR NURSE INTERVIEWS

Chapter three consists of the results of baseline interviews with health visitor managers. In this section the number of people is so small (N = 7) that initials have not been used on quotations, instead position in the hierarchy has been indicated, Director of Nursing Services (D.N.S.), Assistant Director of Nursing Services (A.D.N.S.), Senior Nurse (S.N.) and occasionally General Manager (G.M.) and Health Visitor (H.V.)

Structure of Health Visitor Management

Unit General Manager (1)

Director of Nursing Services (1)

Assistant Director of Nursing Services (2)

Senior Nurses (4 in these interviews)

Health Visitor (31 in these interviews)

These results are discussed in chapter 7. Prior to submission the Director of Nursing Services read, and gave her permission to print, both the partial transcription of these interviews and the subsequent discussion of them.

1. WHAT IS THE PURPOSE OF THE HEALTH VISITING SERVICE?

Respondents felt the main purposes were prevention of illness and promoting health. Other ideas included inducing attitude change towards health, providing advice, support and health education. One respondent felt it was to check normal development and normal family health, another said it was to encourage people to take responsibility for their own health and covered all age groups. Identifying health needs, referring to other agencies and identifying social needs were felt to be important.

2. WHAT GROUPS OF CLIENTS SHOULD BE CONTACTED BY HEALTH VISITORS?

The overwhelming majority felt that all age groups should be contacted by health Visitors, particular groups being the middle-aged, elderly, pre-retirement age groups and well women. Two respondents mention that profiles were needed, for example,

"I think what I am saying really is that the Health Visitors have got to know their own patches, and organisationally we have to go have some feedback on that." DNS

It was felt that services needed to be designed to meet gaps in needs and that priorities needed to be revised. Other sections of the population being specifically mentioned included men, adolescents, ante-natals, pre-conceptual care, young mothers, women in social classes four and five with families, single parents, babies and the 0-5s. Another respondent made the point that who should be contacted varied with the health visitor's area.

3. WHAT INFORMATION SHOULD HEALTH VISITORS HAVE BEFORE THEY COMMENCE WORK ON A PATCH?

The majority of respondents felt the health visitors should have a profile, job holders file and group profile of each visiting area.

"Well as much as is practically possible. Certainly a caseload profile and an idea of the neighbourhood and the services available." SN

"They need to have, really a profile of their area." SN

"A job holders file that will contain relevant environmental, demographic information, procedures, policies, everything relating to the job, resources." DNS

"Health profile as well as services and networks. Ideally it should all be ready and handed to them." SN

Several thought they should have demographic information, know about local resources and significant people in the area, know about policies and General Practitioners.

Respondents felt knowledge of shops, schools, playgroups, old peoples homes, home helps, adult education, vaccine and immunisation figures, social workers, community workers, ethnic minorities, families causing concern, number of elderly, housing, employment and unemployment, luncheon clubs, agencies in the area and the transport were all relevant. One respondent mentioned in-service training so that the managers knew the health visitor could do the job, two mentioned that information about health trends was important.

Other relevant information included an in depth induction course with the senior nurse making herself available for one or two weeks to new staff, and an introduction to colleagues, and the records held on clients. Two respondents felt it was important for newcomers to judge the mood of the organisation. Another mentioned that often an overlap of staff was not possible because resource constraints meant jobs could not be advertised until they were vacated.

4. **WHAT DO YOU CONSIDER TO BE THE MAIN CAUSES OF PREVENTABLE ILLNESS IN THE AREA OF SHEFFIELD YOU COVER?**

Many conditions were highlighted, especially poor nutrition, smoking, heart disease, depression and unhappy relationships, poverty and unemployment, and home accidents. AIDS was now seen as posing an important problem as were, rubella, cervical cancer, gastroenteritis, cerebrovascular accidents, alcoholism, drug dependency and misuse of services. Lifestyle problems included going to bed early and getting up late, little exercise and not enough fresh air in the view of one respondent, lack of motivation, non uptake of immunisation by social classes four and five, lack of knowledge, poor hygiene, lung disease and lead in the air were all mentioned. One respondent who had been health visiting in Sheffield for a long time described how after a day's visiting it used to be that her underskirt was black from the waist down because of dirt in the

atmosphere. She vividly described not being able to see across the city except on Sundays and Bank Holidays when the steel firms were not working. She was linking the change after the Clean Air Act with what one hoped would be an improvement in lung disease figures for the city.

"Its wonderful to what it was. I never realised 'till I saw the carvings on the Town Hall, they shot blasted all the soot off it. You suddenly realised you'd got this rather nice building and black city centres became this very pleasant sandstone, We know the soot was there because we could see it. I won't pick blackberries any more because I feel they are probably soaked up in lead." SN

Another respondent felt that two of the main causes of preventable illness were architectural planners and the present political system. The researcher feels that many would want to agreed with her.

5. HOW DO YOU KNOW?

Five of the seven respondents mentioned reading reports, particularly Poverty and Health in the City of Sheffield (1983) (188), and Health Care and Disease a Profile of Sheffield (1986) (175).

"Colin Thunhurst's book made it possible to see Sheffield geographically, I did appreciate reading that report." SN

Other than that responses included statistics, experience of working, information from the health visitors, observations, general knowledge, local press and local radio.

6/7 ARE THERE ANY POLICIES OR GUIDELINES LAID DOWN BY MANAGEMENT ABOUT WHICH CLIENTS HEALTH VISITORS SHOULD SEE? WHAT ARE THESE POLICIES AND GUIDELINES?

The confusion as to what were policies and what were guidelines that the research had found among health visitors was also reflected among their managers. Even where an individual manager felt clear about the distinction, of which there was only one, she did not of course then agree with her colleagues. Examples of confusion are:

"Right. The only policy I really know of, or guideline is the one for high risk children. O.K. I have an understanding, as a health visitor, that in Sheffield we visit children under the age of five and we have a planned visiting programme. I can't honestly say I've ever seen written down officially what that planned programme is. There are guidelines for visiting high risk children whether that is a policy or a guideline or whether the two are inseparable in that situation, also obviously for children who are at high risk of non-accidental injury." SN

This same respondent in answer to question 15 said that the assessments of children under 5 were policy and should be used for "checking" health visitors. One respondent remarked that there were "policy guidelines" for the under fives and that there were guidelines related to immunisation. One remarked there was nothing applicable to health visiting in the policy book. Two respondents felt clear that there were guidelines for ante-natal visits, new births, surveys, assessments, within the child surveillance programme, but one added that people refusing access to health visitors also had a guideline. Another respondent felt that there were guidelines for medical, hearing and vision tests, child abuse and the survey visit. One senior nurse remarked "surveillance and assessments have become policy by use" SN. An ADNS said that there were policies for TB visiting and infectious diseases.

The DNS said that policies were "ready to be revised" and that there would be "broad principle policies in future".

8. CAN YOU DISTINGUISH BETWEEN POLICY AND GUIDELINE?

Of the seven respondents six felt that policies were "non-negotiable, something you have to do." One felt,

"Policy, something definitely written down that you can refer to and it should be in a policy manual." SN

Some respondents felt a good example of policy was the procedure for child abuse, another felt that vaccination and immunisation procedure was a policy. The point was made that they were made for the protection of client and health visitor. One of the ADNS's thought the child abuse procedure was a policy, another thought it was a guideline. Drawing a distinction between the two one respondent said:

"Policy is something that's in the health authority policy manual - in that red file, a guideline is just something that suggested, recommended by management or peers." SN

9. **ARE THEY WRITTEN DOWN IN A PLACE ACCESSIBLE TO HEALTH VISITORS?**

Three respondents said that policies were accessible to health visitors "because the senior nurse keeps them", two said they "took it for granted that everyone had been circulated". However one of the senior nurses said the policies were not accessible to health visitors because she kept them at her worksite. Another senior nurse said policies were accessible to three of her staff out of 28. One of the ADNS's said "I understand that in fact every health visitor has the guidelines to hand" and both ADNS's said the guidelines were supposed to be in a plastic folder in each health centre.

One of the senior nurses identified the same problem as the health visitors.

"The 0-5 ages have almost become a stick to beat us with instead of a guideline to visiting." SN

A senior nurse said that all new health visitors had guidelines on high risk children and TB procedure.

10. **ARE THESE RELEVANT TO THE MOST IMPORTANT HEALTH NEEDS IN SHEFFIELD IN YOUR VIEW?**

Broadly speaking while valuing current health visiting practice respondents felt that resources constrained the service to the point where the most important health needs could not be met, for example:

"It has a relevance but it certainly had little impact on the main causes of death as defined in the health profile." DNS

"No." SN

"I just don't think the health visiting resources are there to cope as we should do." SN

"We are preventing things in little children and we shouldn't lose sight of that." SN

"Not entirely relevant because it concentrates on 0-5's." SN

Another point of view was that the existing service should adapt more,

"I don't think we look enough at what your area's needs are I don't think we are flexible enough to adapt to what those needs are." SN

11. HOW DO YOU THINK HEALTH VISITORS PLAN THEIR WORK?

Respondents tended to think health visitors planned around their 0-5 year assessments using a birthbook, visiting within prepared objectives, using newborns, babies at risk and surveys as their priorities. Ante-natals were thought to be an important group to visit, also child abuse was mentioned. One respondent felt the major input should be to the under 2's. Mechanisms for planning included, diary, book, sheet and index cards. One respondent thought that health visitors filed in months, that they tended to duplicate their planning system and that they should visit by appointment.

It was felt that health visitors would "look at problems first" and also "look at the routine work" first. Health visitors would respond to direct calls from clients, do the visits that "must be done" and be flexible with time and "avoid ongoing commitments". The difficulties of flexibility and visiting by appointment were shown in this question.

"Fieldworkers - they've got to be flexible. They've got to be very quick thinking and decide what is their priority that day." ADNS

Finally respondents thought health visitors would have "geographical considerations" and plan so as not to waste travelling time and petrol.

12. IS THERE ANY INFORMATION WHICH IF IT WERE READILY AVAILABLE TO FIELD WORKERS WOULD IMPROVE THEIR ABILITY TO PLAN THEIR WORK?

The answers to this question were firstly about information and its use and secondly types of information that could be provided. It was felt that any information about a caseload would be useful but that staff needed to be trained to use it.

One respondent remarked.

"If we didn't have the 0-5 programme there are vast amounts of information we could use." SN

It was suggested that routine planning could be done on a child health system and take up of service and trends could be fed back. Another respondent felt it would be easier for health visitors to plan if they worked more geographically. It was felt important to plan on the basis of facts,

"Sometimes they haven't got the hard facts, it's a lot of intuition, the facts may be there but they may not have the time to see those thoughts and ideas are correct." ADNS

A further aspect of information would be in order to improve communication within and also between services.

Types of information that could be provided included home accident and vaccination and immunisation print outs for each locality, surveys of age distribution, numbers of single parents, elderly, young mothers, unemployment incidence, number of women, breast feeding rates, smoking and alcohol drinking, social stress and an age-sex register with health indices. Diabetes, hypertension and financial conditions were also highlighted. Other information included faster liaison with hospitals, whether a child was attending nursery, up to date social work involvement and where the support services could be contacted.

13. IF YOU HAD TWICE AS MUCH TIME AVAILABLE, WHAT WOULD BE THE BEST USE OF IT FOR THE HEALTH VISITING SERVICE?

During these interviews it became clear that the ADNS's felt they were overburdened with paperwork, for example;

"So much information comes through I need another nine hours to get through it." ADNS

"More time at my desk." ADNS

"Time to absorb the meaning of statistics." ADNS

"More time to plan." ADNS

The senior nurses on the other hand tended to be seeking more involvement with the health visitors,

"Provide longer training sessions on one topic." SN

"More time discussing cases with health visitors." SN

"More time with fieldwork students." SN

"More clinical work." SN

One respondent felt she would like more time with her manager.

The DNS answered this question as if it was time for the service as a whole and included the following:

"Look at caseloads in more depth have a realistic bank service some relief health visitors on proper contracts input into the middle aged, conceptual counselling, well women groups, second level of risk group babies extend the back up services and out of hours service and have a second in-service training tutor."

Despite the pressures on themselves it was clear that these managers were aware of the stress for health visitors and cared about it:

"In this organisation we are about people caring and equally it is very important that we are seen to be caring." ADNS

"They (HV's) have a tremendous need to talk about their work the health visitors caseloads are too big as well. They need more time because they are always feeling just like I do, that they've never done the work that they wanted to get done in the day. I should see each health visitor give her actual individual attention." SN

14. WHAT INFORMATION WOULD YOU LIKE IN YOUR OWN JOB WHICH YOU LACK AT THE MOMENT?

The ADNS's and DNS wanted existing information summarised either in a precis or in graphic form and that that information should be better organised. Several respondents wanted more clerical staff to process information. Generally respondents wanted information specific to their own post, for example:

"What's going on at the moment in respect of child abuse, what's their (HV's) biggest concern about child abuse." SN

"To know what in-service training people have had and bring in staff appraisals so I can work from the results." SN

"When every person starts and leaves employment." SN

Other issues included disease rates, accidents rates, information on schools, getting to know G.P.s, know more about the health visitors areas, employment and unemployment rates, services in the local communities and vaccination and immunisation up take rates. Senior managers wanted to know "what we actually do" DNS and the "quality and quantity of work achieved." ADNS

One senior nurse made the point that she could get information but the problem was how to circulate it to her staff, another felt she needed more staff and more pay.

Finally accessible information about all contact points was sought so that all the updated phone numbers of all local agencies were on computer and accessible immediately.

15. HOW DO YOU THINK THIS COULD BE PROVIDED?

The DNS felt her information could be provided via the information officer

She commented that information collection involved health visitors having time to do training and that in turn caused financial considerations. Other comments included:

"I've got to go out and get it." SN

"I want a personal secretary." ADNS

"Computerisation." SN

"Joint reports with council departments could be established." SN

"Information from the health visitors." SN

"Via the senior nurses." SN

16. HOW DO YOU KNOW WHEN YOU ARE DOING YOUR JOB WELL?

The majority of respondents said it was because of positive feedback from other people, several went on to detail examples:

"Positive letters from clients to health visitors." DNS

"Happy letters from those resigning." ADNS

"If you can communicate with your senior." DNS

"When my boss said well done." ADNS

"Colleagues in other disciplines say well done." ADNS

"I feel I have the trust of my boss." SN

Some respondents felt unsure or unhappy, for instance:

"I don't know." SN

"There aren't many rewards." SN

"I am a bit depressed sometimes." SN

"I don't see enough of my seniors." SN

"If there are any complaints." ADNS

Job performance review was mentioned by two respondents which was expected to be operating through the service in the near future.

Although as one ADNS remarked the attempt to introduce performance measures had failed the previous year, she added,

"It's not always easy to tell everybody that they are achieving a lot because there is always something that wants doing that hasn't been done very well anyway." ADNS

Two senior nurses felt positive when health visitors changed the way they worked on the advice of the senior nurse

Other measures of achievement were:

"Being satisfied with the actual standard of work." ADNS

"Positive change in the use of resources." DNS

"Structural evidence of equity in caseloads." DNS

"That you can produce a five year plan." DNS

"That you produce a three year in-service training plan." DNS

"Getting good attendance at training sessions." SN

"Being asked to repeat training sessions." SN

"When information and report writing is not waiting to be done." ADNS

"When staff find me available." SN

"You need to know what's expected of you." ADNS

"When you reach the aims you set yourself." ADNS

17. **HOW DO THE HEALTH VISITORS KNOW WHEN THEY ARE DOING THEIR JOBS WELL?**

Most of the respondents felt that when the clients seemed satisfied and the health visitor had completed her assessments these were the most significant measures. The second group were feedback from colleagues and occasionally from senior nurses. Two respondents felt the health visitors didn't know and one remarked it was a "thankless job", with very little feedback from clients. Raised immunisation uptake and lowered local morbidity and admissions to hospital were suggested as measures. One senior nurse remarked "They know in themselves", another felt they compared themselves with other health visitors and judged against their standards. How other members of the primary health care team responded to them was suggested as well as there being no complaints. Finally the satisfaction of seeing children go to school well and happy was included.

In answer to this question a discussion ensued in which an ADNS said,

"There are some measures, how you do your programme how you plan your work because if you don't plan you don't work to best effect." ADNS

18. **WHAT WOULD HELP YOU TO BE MORE ENTHUSIASTIC AND EFFECTIVE IN THE JOB?**

In answer to this question respondents wanted more clerical help and more time to do their work. Two remarked that they already felt enthusiastic, one giving the reason as:

"The calibre of entrants into health visiting gives me enthusiasm." ADNS

A senior nurse said she would like staffing to remain at the right level and an ADNS said "more staff at my level."

Job performance reviews were again mentioned as were more commitment from staff, positive feedback, "change", improved staff morale and improved recruitment and training. One ADNS looked forward to a well

functioning child health system. A senior nurse felt she would like to be based in a health centre and to feel that she was fairer to students, another said she would like to be better organised.

19. WHAT WOULD HELP THE HEALTH VISITORS TO BE MORE ENTHUSIASTIC AND EFFECTIVE IN THEIR JOBS?

Respondents felt the health visitors would like to be given support, to be aware of what happening on their area and to be taken out of the service, given a change, for example to go on some training courses. Staff appraisals were again mentioned as was a manageable caseload. It was felt health visitors wanted a lower volume and greater variety of work. The DNS said health visitors would benefit from clerical support and a better communications system. A senior nurse felt the health visitors would like more independence and flexibility and less supervision of numbers, less counting."

It was thought that health visitors would be more enthusiastic if the establishment was kept up to the norm, they had information and equipment to hand and they knew they were achieving their aims. They would benefit from identifying needs to argue for resources and from using the health visiting process, the ADNS's felt. The point was made that the social atmosphere in the health visitors office was very important.

20. WHEN A HEALTH VISITOR BRINGS YOU A PLAN OF A NEW WAY OF WORKING THEY WOULD LIKE TO TRY HOW DO YOU REACT?

The responses to this question were particularly interesting.

Some respondents said it depended how much research the health visitor had done and how the plan was presented, several said:

"I hope positively." SN, ADNS

"I'd receive it with great enthusiasm." SN

"I'd be thrilled." ADNS

However two senior nurses said:

"I'd always throw it back to them." SN

"I probably don't like it at first." SN

In the category of "depends" came the following:

I'd take it to my superior." ADNS

"I'd give it due consideration." ADNS

"Depends whether it is a new way of doing routine work or a development."
ADNS

21. **IS THERE ANY WAY IN WHICH WE COULD USE PLANNING OR INFORMATION
TO IMPROVE THE SERVICE THAT YOU CAN THINK OF?**

It was felt that patch priorities would highlight areas of need and various sorts of specific information were mentioned for example, picking up children who have been missed by the service, percentage of older children attending hospital, percentage of elderly receiving the service, child clinic attendances and local use of immunisation data. This information needed to be local,

"You need to get figures specific for an area." SN

The use of existing information arose in two further quotations:

"If the information is there we've got to respond to it as protectors of the national health." SN

An additional point was that the service should be using the health visiting process.

22. WHAT POWER AND RESPONSIBILITIES DO YOU HAVE IN THE PLANNING
PROCESS OF THE HEALTH VISITING SERVICE?

Two senior nurses felt they had a lot of autonomy in their own "patch". Another said,

"I could be directing staff to do all sorts of things and no one would know about it." SN

Power was linked with responsibility, for example,

"We have a great deal of responsibility." ADNS

"Someone has to decide and take responsibility." ADNS

"Responsibility for a safe service." DNS

Opinions about the kind of power respondents had were as follows:

"The power you've got is vested in you by the people that are around you."
DNS

"The power is tightly controlled within the parameters already laid down."
DNS

"I have the power to say yes or no at the top." ADNS

"Power by persuasion and argument." ADNS

"In a way I think I've got lots of power. In another I think I'm really powerless." SN

The connections with other parts of the service were explained for example:

"The Unit Executive Team has the ultimate decision." ADNS

"We make decisions in conjunction with, for example, the General Manager and medical colleagues." ADNS

"My voice is listened to." SN

"I make a contribution." SN

"I'm one voice out of seventeen senior nurses." SN

"I always inform my senior nurse." SN

23. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

Respondents took the opportunity to expand on themes they had mentioned in the interviews. One respondent felt that health visitors were rather narrow minded and traditional in their approach she felt,

"We don't really look at what the needs of the community are, and then identify what we should be doing, we tend to do it the other way, we go to the guidelines and see what's left, or what we'd like to do." SN

She went on to outline the importance of the health visiting service,

"Numbers of health visitors - they are going to get more and more important, as more and more patients are being kept in the community and discharged into the community, even well people in general, more and more emphasis has got to be put on the community as a whole and so we are going to have to think about training more and more staff to work in this role we need to plan properly where these health visitors are. They are not all in the right place." SN

Different points were made for instance, the idea that health visitors should occasionally swap patches with each other to gain experience of different caseloads. Other comments in this section were:

"What I would like staff to realise is that there is a decision-making mechanism that won't make decisions in isolation." DNS

"You've got to have commitment to change." DNS

"If we are going to do something let's do it soon." SN

"Handover at school age causes concern." SN

"This country can't go on dealing with the preventable illness its treating at the moment." ADNS

"Senior nurses are in need of as much support as the health visitors themselves." ADNS

"I think there's a great future for health visiting." ADNS

"I think I've worn you out." SN

CHAPTER 4

RESULTS OF GENERAL MANAGER INTERVIEW

In Chapter 4 the results of the baseline interview with the General Manager are summarised under question headings. These results are discussed in Chapter 7. Prior to submission the General Manager read, and gave permission to print, both the partial transcription of this interview and the subsequent discussion of it.

1. HOW DO YOU SEE YOUR ROLE IN RELATION TO THE HEALTH VISITING SERVICE?

The General Manager felt he was there to maintain and develop the primary care service in Sheffield, to foster projects, co-ordinate with other professionals and develop and improve the preventative services in Sheffield. Although he could see a significant role emerging in the care of the elderly he felt,

"Traditionally health visitors in Sheffield have not ventured far beyond the field of child health."

He felt it was his job to ensure

"The aspirations and professional needs of health visitors are embraced in overall plans."

2. WHAT DO YOU THINK THE HEALTH VISITING SERVICE IS THERE TO DO?

It was felt the service was there to prevent ill health, ensure children are healthy and properly looked after and that the needs of the handicapped were addressed so that they received the earliest possible treatment. The General Manager saw the community as opposed to hospital and saw the health visitors' role as keeping patients in the community.

3. HOW DO YOU THINK HEALTH VISITORS FIND OUT WHERE THEIR CLIENTS ARE?

The answers covered birth notification, formal and informal contacts, with an expectation of using the age-sex register in the future. It was thought that the elderly over a certain age were visited by health visitors.

4. HOW DO THEY DECIDE WHICH CLIENTS THEY WILL VISIT?

The General Manager replied that health visitors did a first visit on a routine basis then using their own judgement they screened out those not needing them and concentrated on those needing them most.

5. IF HEALTH VISITORS CAN DEMONSTRATE THAT THEY ARE UNDERSTAFFED IN RELATION TO CLIENT NEED, AND THE JOB THEY ARE TRAINED TO DO, WHAT DO YOU THINK THEY SHOULD DO ABOUT IT?

In response it was felt "health visitors should use every source they can to lobby for additional staff". The General Manager pointed out that the child services in Sheffield came very well up the National league in terms of resources and the "guys who operate the service - the accountants" would need to be convinced that further resources were needed. He said,

"In general terms the health visitors are very well resourced every part of the service is claiming underfunding and understaffing."

6. IS THERE ANY WAY YOU FEEL YOU COULD CONTRIBUTE TO AN IMPROVED HEALTH VISITING SERVICE?

If proper strategic plans, encouraging teamwork and the provision of clear structures for dealing with patients were produced it was felt this would contribute to an improved service.

7. HOW DO YOU THINK THE REGIONAL RECOMMENDATIONS ABOUT APPLYING MORBIDITY FIGURES AND HEALTH INDICATORS TO THE IMPROVED PREVENTION OF ILLNESS IN SHEFFIELD COULD BE ACHIEVED?

The General Manager responded that services could be planned on a ward by ward basis, that resources could be allocated in accordance with needs, and that there should be a joint plan between Family & Community services, the Family Practitioner Committee (FPC) and the Community Unit, based on a health profile.

8. DO YOU SEE ANY ALTERNATIVE FORMS OF FUNDING FOR HEALTH VISITING?

It was felt that joint financing was a possibility.

9. DO YOU THINK THE SETTING UP OF A JOINTLY HELD FPC/HEALTH AUTHORITY-CLIENT INFORMATION SYSTEM FOR THE HEALTH VISITING SERVICE IS A FEASIBLE PROPOSITION?

The joint system was seen as essential, with common records and common systems of data provision and collection, so that each authority had access to data on health screening. Existing barriers were because the FPC and local medical Committee were concerned about data protection.

10. IT HAS RECENTLY BEEN SUGGESTED THAT ALL IMMUNISATIONS SHOULD BE DONE BY G.P.s. WHAT DO YOU SEE AS THE FUTURE ROLE OF THE CHILD HEALTH CLINIC?

The child health clinic was seen as an alternative service to those not wanting to see their G.P. The General Manager felt that health visitors had an essential role in screening and surveillance and that health visitors could take over simple tests traditionally done by doctors, for example hearing tests. He went on to say:

"If G.P.s take over vaccine and immunisation we've got to ensure as far as possible that they take over part of the child screening and surveillance role health visitors act in a supportive role to doctors I see the health visitors as insurance that the doctors are doing the job."

The researcher feels this will come as a surprise to most health visitors.

11. **DO YOU FEEL YOU CAN ADEQUATELY REPRESENT THE HEALTH VISITING SERVICE WITH THE INFORMATION YOU HAVE NOW OR WOULD YOU LIKE MORE INFORMATION?**

The General Manager said,

"Yes I think I can adequately represent the health visiting service."

12. **HOW DO THE MANAGERS OF THE HEALTH VISITING SERVICE KNOW WHEN THEY ARE DOING THEIR JOBS WELL?**

"I don't know", the General Manager replied. "I know as little or as much about the health visiting service as the Director tells me."

He felt that in the Community Unit there were no clear objectives for any of the professions and he could not know what an adequate level of service was because the data had not been collected for that purpose. He hoped that the implementation of Korner would present clear objectives.

"At the moment its inspirational by guess and by God!"

13. **IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?**

It was felt there was nothing further to add,

"No, I don't think so, if we can turn that thing off we can have a chat now."

CHAPTER 5

WORKSHOP RESULTS

The sample of thirty-one health visitors took part in a series of workshops in which they were presented with information on various relevant subjects, a list of which is included in Appendix VII. They engaged in wide ranging discussions about the way the information would be used and the implications of its use for understanding the community in which they worked, building community and caseload profiles and whether the information could be used to inform planning. The findings presented here are discussed in Chapter 7.

The workshops were organised on the following timescale:

| | |
|-----------------------------|----------------|
| Meeting of whole sample | |
| | 2 weeks break |
| 1st session TUESDAY group | |
| 1st session WEDNESDAY group | |
| 1st session FRIDAY group | |
| | 2 weeks break |
| 2nd session TUESDAY group | |
| 2nd session WEDNESDAY group | |
| 2nd session FRIDAY group | |
| | 2 weeks break |
| 3rd session TUESDAY group | |
| 3rd session WEDNESDAY group | |
| 3rd session FRIDAY group | |
| | 6 months break |
| Meeting of whole sample | |

The sessions each lasted about three hours except for the final meeting which was held over a whole working day. The Tuesday and Wednesday sessions were held in the morning and the Friday sessions were held in the afternoon. The potential size of the group at sessions was ten or eleven. All the sessions and meetings were tape recorded with the agreement of all sample members to enable the researcher to review the discussions on each occasion. Co-operation was

good and occasional non-attenders, due to work commitments, or sick leave, were followed up after each session by the researcher and any relevant information forwarded through the post.

The first meeting of the whole sample was held in a large in-service training room, at the top of an old hospital block, familiar to the health visitors. All the group sessions were held in a nearby conference room with large tables, comfortable chairs, a white board and a notice board available. A photocopier was available outside the room.

The final meeting of the whole sample was held in the lower room of the post graduate medical centre, a large room with armchairs, and flip charts were available. Tea and coffee were available at all meetings and sessions and sample members could make a drink at any time. The atmosphere was intended to be informal so that sample members could contribute easily to discussion.

The researcher invited a colleague, Anne Marie Coyne, who was a health economist and researcher to join her in holding the workshops. Ms. Coyne had been involved in writing the Sheffield Profile of Health and Disease (1986) (175) and was familiar with the statistical methods that had been used in this study. Ms. Coyne's role was to support the researcher, answer queries about the profile and to contribute suggestions where she felt they were appropriate.

Meeting of the whole sample

Although the researcher knew all the health visitors taking part they did not necessarily know each other, so they were each given a name badge with a coloured star on it to indicate to which group they would belong. Health visitors in Sheffield are managed in three separate units so the groups were arranged so that members of each unit were in each group to increase cross-fertilization of ideas. They were also introduced themselves by name and said where they worked. Each health visitor was given a list of all the sample so they could contact each other if they wished. The groups were also arranged so that they were held at a time convenient to each sample member. This had been achieved by asking all members of the sample to indicate prior to attendance what times were not convenient to them. Permission was sought and given for taping

the workshop. This was not aided in this first meeting by an electricity power cut so it was necessary for the researcher to take notes of the proceedings. The idea of using information to make profiles of caseload and community was introduced and in order to demonstrate the kinds of data the sample would be dealing with, each health visitor was given a copy of the Profile of Health and Disease, and other readily available data, e.g. dental decay in under 5s by post code, low birth weight, gastroenteritis admissions, and social classes 4 and 5 by electoral ward. To encourage the sample to keep their information together each member was given a red ring-backed folder and maps of the city were provided so that they could draw round the geographical area in which they visited. Although vast amounts of information were available, an individual health visitor would only require that which was relevant to their own visiting area so it was arranged that health visitors would identify what they needed and write it on a communication sheet which they gave to the researcher. Any item they asked for was then photocopied and either given to them or sent to them through the post. On the communication sheet they recorded their names, base, and the electoral ward, polling district and eventually the enumeration districts in which they visited. Most health visitors do not know this information so a large map of electoral wards and polling districts was provided and sample members identified their areas. This would be important for the provision of epidemiological information later, and it was also important so that they could read the Profile of Health and Disease and know which electoral wards to examine. Each health visitor retained a copy of their communication sheet and handed one back to the researcher with any requests on it. As information was provided the researcher handed the communication sheet back. That is the health visitors retained one copy and the other copy was used to shuttle back and forth to the researcher.

Ms. Coyne was introduced to the health visitors and she explained her role. The sample members were asked if they had any questions or comments. There were two. The first was "If we make community profiles will the managers let us use them?" The researcher explained that the Director of Nursing Services was convinced that community profiles were a good idea but that the eventual use of the profiles was really up to the health visitors. She also said that the management had given permission for the research to proceed. The second comment was, "When a health visitor transfers her caseload to a new health visitor they will be interested in different things and

the data one collects will not be relevant for the other". The researcher responded that while different health visitors have different interests the health and illness data arising out of community and caseload profiles would probably be of interest to anyone taking over that caseload. The group proceeded to discuss both of these issues.

The data listed in Appendix VII, was contained in several cardboard boxes and the sample members had a look through these and were told they would have access to all of it at every session they attended.

At the end of the session sample members made various comments as follows:

"You've made me feel enthusiastic again - I feel like I'm raring to go as I always do after your talks."

"Its really good. Really exciting."

"I am so knackered. Just tired, too much to do."

"Goodbye, you are doing a really good job."

The following day the researcher received a letter in the post as follows from a sample member,

"Just a note to say thanks for this morning. I wasn't going to come 'cos I thought it would be the last straw and all that - but as usual - you've made me feel that "Hope springs eternal" and I've now got hopes of making some sort of sense out of this caseload with your help."

The Sheffield Profile of Health and Disease had a supplement in which health in each electoral ward was outlined. Using the communication sheets the researcher photocopied those section of interest to each sample member ready to be distributed in the small group sessions.

1st Group Sessions

This section covers the Tuesday, Wednesday and Friday series of 1st group sessions. Certain material and a set of aims were presented to each group although the subsequent discussions varied. The researcher introduced the session with the quotation from the HVA

document (1985) (82) cited in Chapter One concerning building community profiles. The aims of the workshops were presented as each sample member should,

- 1) Analyse the deficits and resources contributing to health in the community in which they worked.
- 2) Identify preventable conditions and issues relating to them.
- 3) Identify which of these could be affected by a health visiting input.
- 4) Identify priorities for action,.
- 5) Identify a timescale over which action could take place.
- 6) Identify a method of evaluating any action.

One way of approaching the questions was to build a caseload and community profile. The examples of profiles already being used were shown to sample members, one from Jane Dauncey's work in Oxford, and one a caseload profile conducted by a student on the fieldwork teachers course. Each sample member was provided with three articles about how to write a caseload profile (91, 92, 93) and a summary of the answers to questions 8, 13, 20 and 22 from the baseline interview were also fed back to sample members. These broadly covered the information health visitors would like to have about their area (see Chapter 2).

A large map of Sheffield with an overlay indicating enumeration districts was provided together with a computer printout from Sheffield City Council covering all the 1981 census data. Sample members recorded the enumeration districts they covered and the researcher photocopied all the census data relating to their area and provided it for each sample member. Ms. Coyne and the researcher explained carefully the nature and use of census data which was in a raw form. Two handouts were sent to each sample member. One concerning "Looking at the caseload", (Appendix VIII), and the other covering "Handling enumeration district data" (Appendix IX), after these workshop sessions. The ensuing discussion covered problems such as health visitors not having co-terminous area with social workers, assessing ones own skills versus consumer need, the

use of interdisciplinary fora as information sources about an area. Issues arose out of the reading of the Profile of Health and Disease concerning levels of breast cancer incidence in the city and whether a health visitor had the right to try to stop people smoking. Record keeping and in particular patient held records were discussed. It was pointed out that any information provided was static while the community continued to change daily. Sample members asked how effective health education really was, one member opining that the mass media are good at simple health education messages but not at complicated ones. Whether one should use statistics as teaching material with clients was suggested. The sudden infant death survey was discussed at length some members considering it unethical or ineffective.

How health visitors could be involved at the planning stages of new health care initiatives was explored and whether concentrating on children was the most appropriate use of resources was examined. Sample members discussed the style of their managers and assessed the impact of the (then) new Director of Nursing Services. Sample members asked why immunisation rates were not automatically fed to them, and discussed whether all children's assessments should be performed by health visitors alone, not in conjunction with doctors. The use of comparing local figures with national figures on certain issues was discussed. One member considered whether post-natal depression had increased after the Chernobyl disaster. The issue of individual care versus community care was discussed. The use of caseload data (an annual review of certain aspects of a caseload) was questioned. The use of articles in the local press about health issues was suggested for inclusion in profiles. The sample members in one session began to examine how they could make arguments and state the need for different types of health visiting on the basis of the statistics they were uncovering. Sample members worried that their community profile "wouldn't be good" and said the information was "too much to absorb". A further worry was that making profiles would be very time consuming.

Ms. Coyne and the researcher discussed the first sessions and both had formed the opinion that the sample members were *surprisingly* unconfident and unassertive, and efforts were made to try to empower the sample members in subsequent workshops by the style of the

researcher and her colleague. Any information sample members had asked for was photocopied and sent to them.

Second group sessions

This section covers all three second group sessions. This series of sessions mainly covered feedback from the sample members about what they had discovered about their caseload and the community in which they worked. Each sample member had identified differing categories of information they wanted about their visiting patch. Three examples follow which give the flavour of their individual contributions.

1) Categories identified included:

Number of children aged 0-5 years

Total number of families

Ante-natal patients notified

Elderly patients visited

Families giving cause for concern

Children on the non-accidental injury register

Children at high risk of sudden infant death

Children at ultra-high risk of sudden infant death

Immunisation uptake

Breast feeding mothers at 10 days post-natally

Breast feeding mothers at 12 weeks post-natally

Families in which breadwinner was unemployed

Unsupported single parents

Depressed mothers of under 5s

Chronic defaulters of clinic attendance

Children with severe handicaps

Children with severe developmental delay

Families in council accommodation

Families in private accommodation

2) Categories identified included:

Unemployment

Age of mother

Housing

Children on the non-accidental injury register

Children at high and ultra high risk of sudden infant death

Early weaning - solids given to babies at 1 week, 4 weeks, 12 weeks.

Dental health

Immunisation uptake rates

Stillbirth rates

Pre-natal mortality rates

Children born before 38 week gestation

Children with congenital abnormalities

Hospital admission rates for upper respiratory tract and gastro-intestinal infection

Casualty attendances by children

Referrals to audiology, ophthalmology, speech therapy and for general development delay

Problems arising from screening the elderly, e.g. obesity, smoking, medical problems, depression and loneliness, deafness, poor vision, ill fitting dentures, undiagnosed hypertension, backache.

3) Categories identified included:

Area defined by types of house

Number of individuals by age group in caseload including adults

Ante-natal mothers

Working mothers full time and part time

Mothers age at first pregnancy

Children completing routine medical programme

Review of 4 year olds re:

Immunisations missed

Breast feeding when in first year

Speech therapy referrals

Orthoptic referrals

Hearing defects

Other carers, e.g. child minders, nursery attendance, disabilities

The whole group of health visitors together produced sixty-nine categories of information which they were collecting. The following table itemizes these categories.

| <u>CATEGORY OF INFORMATION</u> | <u>FREQUENCY OF MENTIONS</u> |
|---|------------------------------|
| Immunisation uptake rate | 10 |
| Breast feeding incidence at 10 days, 4 weeks and 3 months | 8 |
| Unemployed with children | 6 |
| Social Class | 6 |
| Number of children | 5 |
| Depressed women/post-natal depression | 5 |
| Housing | 5 |
| Isolation, distance from relatives | 4 |
| Children at high risk of sudden infant death | 3 |
| Early weaning at 10 days, 4 weeks and 3 months | 3 |
| Asthma incidence | 3 |
| Chest and lung disease mortality | 2 |
| Children in council accommodation | 2 |
| Chronic clinic defaulters | 2 |
| Hearing defects | 2 |
| Orthoptic referrals | 2 |
| Pre-natal deaths | 2 |
| Speech therapy referrals | 2 |
| Still births | 2 |
| Abuse hard and soft of women | 1 |
| Ages of population | 1 |
| Anxious mothers | 1 |
| Appointment: whether visited by appointment | 1 |
| Attached to G.P. practice of geographical | 1 |
| Casualty attendance | 1 |
| Cervical smear rate | 1 |
| Child minders | 1 |
| Concern file | 1 |
| Congenital abnormalities | 1 |
| Crying babies | 1 |
| Day nurseries | 1 |
| Dental health | 1 |
| Depoprovera: how many women being offered depoprovera | 1 |
| Depression amongst West Indian mothers | 1 |
| Developmental delay : severe | 1 |

| | |
|--|---|
| Developmental delay : referrals for | 1 |
| Disabilities | 1 |
| Divorce rate | 1 |
| Eczema incidence | 1 |
| Elderly | 1 |
| Elderly: screening | 1 |
| Elderly: problems | 1 |
| Eyes: sticky | 1 |
| Families: total number | 1 |
| G.P. presentation: preservation of self and baby at G.P.s | 1 |
| Handicaps: severe | 1 |
| Hospital admission rates for Upper Respiratory tract infection and diarrhoea and vomiting in children over and under 1 year of age | 1 |
| Hypertension | 1 |
| Infectious diseases | 1 |
| Medicals: children completing routine medicals | 1 |
| Menopausal women | 1 |
| Mental illness | 1 |
| Mortality: infant | 1 |
| Number of people | 1 |
| Occupational hazards | 1 |
| Private accommodation occupied by children | 1 |
| Physical illness | 1 |
| Pregnancy: how many are wanted | 1 |
| Pregnancy: mothers age at first pregnancy | 1 |
| Shops: distance from | 1 |
| Single parents: age | 1 |
| Single parents: unsupported | 1 |
| Smoking rates | 1 |
| Teenage mothers | 1 |
| Tranquillisers: use of | 1 |
| Well women | 1 |
| Working mothers: full time and part time | 1 |
| Young parents (Under 22 years) | 1 |

TABLE III

CATEGORIES OF COMMUNITY INFORMATION SOUGHT BY HEALTH VISITORS

Sample members had gone through their caseloads counting individuals falling into the different categories and used broader statistics, e.g. re stillbirths, to identify number or percentages in their area. Issues about the importance of having tight definitions for categories were examined and also how the data informed the sample members was explored. The groups also discussed how far health needs could be derived from the data. Discussions ensued, topics covered whether health visitors who had trained and worked only in Sheffield were institutionalised by this activity. The need for flexibility in visiting clients was contrasted with the need for consistency and two issues, one concerning communicating patterns of health visitor work to clients, and the second as to why developmental checks are held at different intervals in different parts of the country were discussed. A problem to sample members was that G.P.s doing their own baby clinics did not necessarily give vaccines in line with the nationally recommended programme. There was also a conflict in providing an overall service versus gearing work to the individual and a need was identified to provide an intelligent and responsive service for a local area. One sample member indicated that the number of times health visitors respond to individual families' need for support does not show up in caseload figures which only show static data. These do not indicate networks, feelings and changes over time. Sample members began to ask whether each member should do a profile or whether teams of nurses at a given work base should do one together. Various sources of information were re-identified, caseload data, statistics about the area, local professional contacts and what local people think and want. Sample members were asked to write a summary of their findings in their profile and file it with the data they had collected.

The concept of community was again discussed and the idea of identifying one institution around which all workers could be based, e.g. nursery school, was highlighted. One group discussed at length what a health need could be.

For the following workshop sample members were asked to identify health needs in their area, supported by data, and begin to think about how such health needs could be met. The content of the discussions in the previous workshops was fed back to sample members for comment. After the Friday session the researcher had a clear picture of the difficulties the sample members were encountering in thinking about what they found in the profiles. A handout about

ways of thinking about the profile was sent to the Thursday group who had had the most difficulty in this respect (Appendix X).

Third group sessions

The sample members came to the series of third sessions and every group complained that building a profile was very time consuming. One member had taken fourteen hours to do the work largely in her own time, another had taken four days study leave. The problems of working in offices with the phones ringing, clients calling in and colleagues interrupting were discussed. Health visitors generally tend to see face to face client contacts as "real work" and clerical work of any sort as secondary to it. Although sample members saw the profile as important and realised there were benefits for planning, which they regarded as necessary, they still found it difficult to insist on uninterrupted time to complete the profile. Discussions about the legitimate use of work time and methods of asserting themselves arose.

In these third sessions sample members were asked to work in groups of three or four and after a discussion period of three quarters of an hour verbally produce a plan along the following lines,

- 1) Identify health needs on their patch arising from the profile.
- 2) Explain how a health visitor might tackle such needs.
- 3) Produce a plan indicating time scale and method of evaluation.
- 4) Discuss how such a plan could be presented to management.

The sample members had no difficulty in producing plans and argued vehemently from the information they had compiled why such a plan might be necessary. From these discussions arose the planning format included in the latter part of Appendix VI, which was later used in the evaluation questionnaire. In the chapter concerning the evaluation questionnaire examples of completed written plans are provided. Long discussions about priorities, given the shortage of time available, emerged. Health visitor sample members would argue the relevance of their own plan to deal with, for example, heart disease and at the same time be reluctant to give up any of the

work they were already doing. They were facing, sometimes for the first time, overwhelming health needs versus limited resources. This discussion is reflected better in the baseline interviews and in the evaluation questionnaire.

The Friday group identified an issue they were interested in as a group. The issue was that the community medical officers were attempting to change the pattern of child assessments and medicals without reference to the health visitors. They decided this was so important that they formed a group outside the research sessions, consulted other health visitors and typed letters to their management insisting that they were consulted and raising a set of associated issues. A copy of their letter to their management is enclosed in Appendix XI. They used the planning format to discuss the issues and thereby produced a plan which they then went on to implement. They appeared to gain strength from a group approach.

The context of discussions in the second session were fed back to sample members and any data they required photocopied and provided.

Meeting of the whole sample

In the final meeting of the sample members there were five main activities. These were to feedback a complete analysis of all the baseline interviews to all participants, for members to look at each others profiles, to distribute and discuss the evaluation questionnaire, to practice making written plans for health needs and to discuss the use of profiles.

Sample members fed back their ideas about the profiles and raised the following issues. Many members had found the use of ward and enumeration district data confusing as their visiting area often covered several different wards. One member had found her main electoral ward area to be "average" on most of the measures used but in fact knew it to be many small pockets of different needs which were masked by looking at the area as a whole. It was suggested that health visitors should work in wards or parts of wards so that they could use available statistical data.

The difficulties of doing group work in disadvantaged areas of the city was discussed as was the thinking required to move from individual families to group work without being distracted

by knowledge of individual families' problems. It was felt that it was in some ways easier for community workers and adult education workers to do group work because they did not have background knowledge about families. In one area of the city an Adult Education centre was closing down, one sample member saw this as a community issue on which she could campaign.

Another contribution was that profiles could be used for ordering priorities of work based on demonstrated need. One worker said she had found breast feeding and vaccination uptake rates to be satisfactory until she had actually counted rates. She now recorded these in her "birthbook" routinely and was working to increase the rates. A discussion ensued about what is recorded in records and the uselessness of present recording methods for extracting community data. Redesigned record cards with "tick boxes" for example for smoking or breast feeding were suggested.

One member who had access to a very developed age-sex register on computer described how she had approached assessing uptake rates of vaccines, taking each age group year by year. A discussion arose about how frequently and how long each visit to a client should be. Members found they had completely different approaches based on perceived client need. Another member asked how it was possible to see what motivates clients to change their health activities and all commented that attitude changing was a very time consuming activity.

Having drawn health data together for the profile one member felt it was important to communicate her findings to the other caring professionals in the same area. Sample members regarded the profile as "invaluable" for teaching student nurses and health visitor students about the area. It was also seen to be very useful for handing over a caseload to a new health visitor, particularly to those just starting a health visiting career. The need for policies and guidelines to be clearly spelt out was raised so that health visitors knew on which tasks they could change priorities if they chose. Sample members had identified a lot of preventable disease in different age groups and felt it was now difficult to justify working mainly with 0-5 year olds. The profiles were seen as a tool for change and particularly useful for approaching management about new schemes of work. It was pointed out that the profile informed one about health need but not about how to address these needs. Another use of the profile was to review work perhaps annually. As

one member put it "It gives you a chance to reflect on what you have and haven't done. Sometimes we may set our objectives too high or needs in an area change". It was added that duplication could be avoided if certain health needs were covered by other sorts of workers in the area. Ideas about setting up quality circles were discussed and one sample member fed back what she had learned from participating in a Korner working party about ways of documenting visits by coding activities.

In summary the main uses of the profiles were seen to be:

- 1) To communicate with other caring professionals in the area.
- 2) To teach students.
- 3) To plan and prioritise work having identified need.
- 4) To hand over the caseload to another health visitor.
- 5) To negotiate with management about planned change.
- 6) To review work annually.

Group members wanted to know if they had to hand in their profiles, but the researcher pointed out they were for their own use. One commented "I can't part with my profile I need it for next week".

Sample members had begun to use their profiles to negotiate changes in practice with their management. A good example of this is demonstrated in the memorandum of one sample member to her management, included in Appendix XII. The analysis of baseline interviews was distributed and sample members read these, looked at each other's profiles to gain more ideas, received the evaluation questionnaire and any questions were addressed. Members practiced identifying health needs and making written plans which are included in the chapter on the evaluation questionnaire.

CHAPTER 6

EVALUATION QUESTIONNAIRE RESULTS

All health visitor sample members were asked to complete an evaluation questionnaire (Appendix VI). This represents a response rate of 70.97% of the original sample and 91.67% of the sample available by the end of the study due to sick leave, ceasing employment as health visitors, or promotion. Those who attended the final meeting of the whole sample were given a copy of the questionnaire, others were sent a copy through the post.

The questions were based around assessing the usefulness of the project and questions concerned whether anything new had been learnt from the project, whether new health needs or client groups had been identified and whether information provided confirmed health visitors' expectations. Three further questions expressed whether information had been of the appropriate kind, in the right format and whether information provision could be improved in any way for health visitors.

Sample members were asked to indicate any problems and benefits the study had caused and to add any further comments they chose. Finally members were asked to compare a plan of work indicating the ways they might address identified health needs, providing data about their planning abilities. The resulting questionnaires were posted back to the researcher and analysed by content analysis. The results are provided here, and will be discussed in Chapter 7.

1. DID YOU LEARN ANYTHING NEW ABOUT YOUR AREA FROM PARTICIPATING IN THE PROJECT?

Most participants felt they had learnt new information from the project. Only three felt they had known all the information before hand, but one of these said the project had made her think more deeply about existing problems. Many went on to say what had been new to them such as the incidence of preventable disease, the incidence of post-natal depression, small number of breast feeders, the high incidence of dental caries, and high numbers of elderly, single parents and more about different age groups.

Sample members felt the project had made them think more objectively about their area, viewing the community as a whole, realised concerns about caseload were shared by colleagues and that their records were poor for extracting community data. Individual sample members identified particular problems on their area, for example unemployment, mobility, high stillbirth and infant mortality rates, high incidences of cerebro vascular disease and carcinoma of the cervix, asthma, psychiatric illness and young mothers smoking. One worker reported a high

number of women over 45 years with a low uptake of cervical smears, another was surprised at the ratio of Caucasian to West Indian to Asian families in her area.

2. IN PARTICULAR DID YOU IDENTIFY ANY NEW HEALTH NEEDS? IF SO WHAT WERE THESE HEALTH NEEDS?

Sample members identified the need for health education and screening programmes, the need to promote breast feeding, to encourage people to stop smoking, dental caries in children, low incidence of cervical smear uptake linked with high incidence of cervical cancer, poor clients and large numbers of single parents. One member notes "a total health need in the area". Asthma and allergies, speech problems, high infant mortality, high incidence of road traffic accidents, and accidents generally in the pre-school age children were all noted. The need for ante-natal and post-natal classes, occupational health needs, e.g. deafness, post-natal depression, behaviour problems in children, isolation of different groups, post-natal depression among West Indian mothers, the needs of 40-60 year olds and a heightened awareness of heart and chest disease were all mentioned. Members suggested that the project had made them focus on particular groups of clients for example one member had decided to campaign for more day nurseries. Another member had recognised the need for better liaison with other services.

3. HAVE YOU BECOME AWARE OF ANY NEW CLIENT GROUPS YOU WOULD LIKE TO CONTACT? WHAT GROUPS ARE THEY

Clients in the age groups 30-60 years were most frequently mentioned, especially women in this group. Elderly clients came next and one member said she would only see them if there were more health visitors. First time mothers, non-English speaking Asians, men, particularly unemployed men, ante-natal parents, pre-conceptual parents and 15 and 16 year old boys and girls were mentioned. Three sample members felt they would not contact any new group. One member felt she would like to run "granny classes" to teach grandparents new childcare methods.

4. SOMETIMES CONCRETE INFORMATION CONFIRMS WHAT YOU KNOW
ALREADY. DID THIS HAPPEN TO YOU? WHAT INFORMATION CONFIRMED
YOUR VIEWS?

Three sample members felt that almost all the data confirmed what they already knew. Other members said that years of life lost from preventable illness, smoking related illness, rates of unemployment, and people with social and relationship problems not receiving help, were all as they expected. One commented it was useful to know sources of information and how to obtain it, another remarked that she was now "counting as opposed to guessing".

Factors the sample members felt were confirmed included high incidences of post-natal depression, dental caries, pre-natal deaths, large number of single parents and gastroenteritis admissions. Sample members noted issues in their area, for example, 8% of elderly lived alone, social class mix, high birthrate, good immunisation uptake rate, good breast feeding rates and "people living in disadvantaged housing have poor health". One member had a very busy clinic and found this was reflected in the clinic attendance figures. Another noted striking differences in different parts of her visiting area, one area having few housing problems, another having high unemployment. Members felt there were no surprises from the Profile of Health and Disease, population age breakdown, client numbers from the G.P.s computer and information taken from the health visiting records. Another noted "it's nice to have facts confirmed especially when teaching students".

5. DID PARTICIPATION IN THE PROJECT PROVIDE YOU WITH THE
INFORMATION YOU WANTED?

Six sample members answered "Yes" to this question. Others commented as follows:

"It gave me unexpected information which was of great interest." H.I.

"Also gave me a new approach with time to look at information available and determine what factors were important and relevant to caseload and working methods. Discussing with other health visitors gave additional viewpoints, which could be adapted or adopted to fit my caseload." I.T.

"The Sheffield Profile of Health and Disease was useful." D.T.

"I keep wanting to know more and more." D.T.

"It made you analyse what you had got. Should be very useful in future." Q.X.

"Yes it provided more information about the work and showed you how to go about planning further projects and how to present them to higher authority for approval." X.X.

"It made me do something more constructive about my work in this particular area I find I am still adding to the information or changing it slightly." Y.Y.

"Regular updates and useful statistics re local health issues, to help promote health care and use of services in a way that can be made more meaningful to the general public would be very helpful to health visitors." S.T.

"Yes and no. I found it rather overwhelming." T.C.

"Partly. Can make a better case for providing services for other client groups but no information on evaluation of what we are already doing. Therefore if we change direction in health visiting rather than add new directions we might lose some of the health." K.H.

"Yes. It helped put abstract ideas into something to work on." K.C.

"It helped a great deal in the production of a profile for my caseload." B.D.

"I found the information provided both useful and interesting. Rather difficult to interpret at times, e.g. my visiting area incorporated three different wards." K.N.

"Yes. I sometimes felt there was too much to wade through and so little time to study it sufficiently." M.P

"Yes. So much in fact it was hard to sift out what was most important - it was all relevant." Z.Z.

"Some." C.Q., N.G., K.N., K.C.

6. **DID BOTH THE INFORMATION YOU COVERED AND THAT WHICH WAS PROVIDED APPEAR IN A FORM THAT YOU COULD USE?**

Seven of the sample members felt information was in a form that they could use. Many had some difficulties with census and ward data because it related only to parts of their areas. For example:

"Yes. But still difficult to break down general figures to specific areas." K.C.

"I feel it is a shame our areas are not split up in the same way as the enumeration districts as then it would be so much easier to interpret the futures." M.P.

"Information relating to electoral wards and polling districts, etc., was not always easy to relate to my geographical area which included many enumeration districts and their boundaries. Other specific information re local health problems/issues was enlightening and motivating." S.T.

Others had difficulties with different sorts of data:

"The information I had recorded in the past was too fragmented to be easily used. It took a lot of hard work to collect together the simplest information into a meaningful form." B.D.

Other comments included:

"Information like this is rather like being given a 1000 piece jigsaw without a picture of the finished puzzle." T.C.

"A G.P. with a computer would help in this situation, but if not geographical, visiting makes more sense for compiling priorities for visiting." K.H.

"The information given was an average for the whole of the area whereas some parts of the area are better/worse than others." X.X.

"The information was in an unfamiliar form but nevertheless was valuable because it pushed our ideas and encouraged us to think of previously neglected areas." H.I.

7. **ARE THERE ANY IMPROVEMENTS YOU WOULD LIKE TO SUGGEST IN THE PROVISION OF INFORMATION FOR HEALTH VISITORS?**

Participants complained about delays in receiving existing information concerning for example hospital admissions and vaccine and immunisation data. As one member put it:

"Our own bureaucratic organisation doesn't hand on its own data to us." K.C.

It was thought that morbidity data could be sent automatically to health visitors by the Health Authority Information section. Some members felt it was not a dearth of information that caused difficulties but getting access to it and using it.

"Information is there. It's knowing how to get at it and how to use it in a meaningful way." Q.X.

Specific requests were for more information when caseloads were handed over, that all caseloads should have a profile and that information needed constant updating. Ways of doing this included

running small in-service training sessions on updating or that information could be collated geographically by a continuous working party. One member commented:

"I think health visitors need an information technologist." D.T.

It was suggested, as in question 6, that health visitor areas could be aligned with electoral wards, and that health visitors could record more information in their birthbooks. The point was made that city wide figures were needed with local figures so that comparisons could be made, perhaps on an annual basis. One member highlighted communication difficulties with other services, especially the local Housing Department of the Council. Another suggested that health visitors needed a reduction in paperwork to provide time to handle relevant data. Question 8 concerned completing health plan forms which will be discussed after the results of question 9.

9. HAVE YOU LEARNT ANYTHING FROM THE PROJECT - WHAT BENEFITS OR PROBLEMS HAS IT CAUSED? PLEASE ADD ANYTHING YOU WOULD LIKE TO SAY.

Above all sample members had found the project required a lot of time to complete, and that lack of time was their main difficulty in planning. Several members thought that they were facing overwhelming health needs in the face of limited resources. It was thought that there should be regular meetings to discuss information and its use, and many commented on the benefits of meeting and discussing work with other health visitors. It was thought that statistics provided necessary evidence for planning work and could eventually be used for long term evaluation of the service. Conflict between seeing health visiting as a community activity versus a family orientated activity was again mentioned.

Many sample members commented that the project had given them job satisfaction, time to think, confidence, enthusiasm, time to analyse and a new perspective. Comments were as follows:

"Getting together in the workshops has been of great value. Health visitors seem to work quite differently from each other and by getting together it helps to generate ideas." M.P.

"Work can be more rewarding and more meaningful when time and background information and statistics, etc., can be drawn together and you look at your own caseload and the health needs." S.T.

"Dawning awareness of how to use statistical information to prove a health need and therefore need for resources, e.g. health visitor time." K.H.

"Thanks for yet again giving us some hope. You've given me new enthusiasm to get on and do something - and the confidence and wherewithall to do it!" K.C.

"Participating in this project has helped me be more objective. It has enabled me to consider the needs of my families in terms of health in a more general way, i.e. to consider a community rather than a collection of individuals. I think this helps to keep a perspective on roles and aims when working in the field.W I.T.

The sample members were asked to complete a health plan for the area in which they worked, identifying particular health needs they had found by participating in the project. The layout of the plan of work sheet was devised in the workshop phase. One of these plans is shown here. Twenty are included in Appendix XIII.

PLAN OF WORK

Educating of professionals to improve health in the community for Chronic Heart Disease.

A. HEALTH NEED

B. TARGET GROUP G.P.s Health Visitors.
District Nurses.

To get together and discuss and learn from each other the health problems of the community. Take lessons learnt to toddler groups - mothers, Ante-natal mothers support groups, elderly meetings. etc.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS Premises G.P., surgery. Open university course - cost of videos, etc.

E. TIMESCALE 1-1½ hours every 2 weeks - working hours and time to discuss with further groups.

F. EVALUATION Number of people improving on diet, exercise, visit to G.P.s with heart disease over a period of time (long term).

CHAPTER 7

DISCUSSION

Chapter 7 is divided into five sections as follows:

1. The use of Community Profiles

In this section the main uses of community profiles are explained with the purpose of filling identified information gaps currently present in the health visiting service.

2. Health Visitor information : moving towards a system

The provision of information for health visitors is explained and four factors identified which would need to form part of an information system. These are willingness of management to support these activities, a regular accessible supply of information, personnel involved in the provision of information and educational support for using information.

3. The role of the health visitor : information in perspective

This research has examined information in the context of the work role of health visitors. This section examines the complexity of that role, coping mechanisms used by health visitors and difficulties experienced in the existing organisational setting. The section concludes by indicating some of the new movements in community nursing.

4. Implications for the organisation and the wider context

Changes in the organisation during the research period are noted and factors identified which will enhance the use of information and the planning function of health visitors. Those factors include classification of policy statements, implementation of appraisal systems, provision of an information policy and an information system. In addition a participative administrative management style, increased funding for the health visiting service, negotiation with bodies outside the service and new concepts of planning are discussed.

5. Evaluating the method

Section 5 examines the effectiveness of the method chosen and explores some suggestions for further study.

1. THE USE OF COMMUNITY PROFILES

It is clear from the workshops and the evaluation questionnaire that there are specific times when a community profile is of use to a health visitor. These are the times when there is an information gap. Profiles could be used to fill these gaps in the following ways.

- 1) To make priorities of work.
- 2) To handover caseloads from one health visitor to another.
- 3) To teach students.
- 4) To provide the basis for an annual review of working practices.
- 5) To form the basis for innovation.
- 6) To negotiate work with managers.
- 7) To negotiate work with other workers, both in the primary health care team and the other local workers.
- 8) To provide evidence for fact centred work, demonstrating the shifting needs for allocation of health visitors.
- 9) To communicate with clients in the community.
- 10) To inform the planning process.

1) To make priorities of work

A community profile does not tell a health visitor what work priorities she should have but it can form a factual basis on which decision making about priorities can be based. It can be used to identify health facts from which health needs can be derived. A health visitor can ask what are the health needs in this area and what can a health visitor do about them? In short it forms the basis for planning. It is difficult to maintain that health visitors should continue with a traditional child centred pattern of work when many other health needs seem more urgent.

In a letter to the Nursing Times, Mark Jones said the following (1988) (100),

"As a health visitor I have responsibility for the health of about 2000 people in my geographical patch, yet I spend time with only 200 families - those with children under five. I am qualified to deliver a service to the whole community but I provide only a paediatric service because that is the traditional way health visitors are deployed in my area, and because there are too few of us even to attempt to establish the health needs of other age groups.

Assuming then that I am serving only a small proportion of my potential caseload why is it that there are no articles in newspapers or journals, no hassle from my managers or no public outcry, about the middle-aged men or women for whom I am technically responsible, who may be dying of heart disease, breast, lung, or cervical cancers and so on because I have not had the time to help them reach those health-enhancing decisions or help them utilise available health resources?"

In the original interviews in this research health visitors and their managers agreed about the main causes of ill health in Sheffield; depression, poor nutrition, smoking, poor housing, stress, poverty, poor education, heart disease, unemployment, accidents, cervical cancer, alcoholism and the present political system, among others. In their individual casework health visitors undoubtedly try to tackle these questions focussed on the families of children under five for which, as Mark Jones points out, they are technically responsible.

The existence of a community profile encourages a review of the wider picture and the potential for programmes of work addressing the issues identified by the health visitors themselves. It also counters "intuitive" knowledge, for example one respondent felt she had not known facts about the families she was visiting until she actually counted up indices of for example breast feeding, clinic attendance and vaccination rate.

2) To handover caseloads from one health visitor to another

When a health visitor takes over a caseload from another, managers and health visitors are agreed that there should be a broad base of information available about the community, that there should be input from the immediate manager and the previous health visitor. However it is clear that there are long gaps at handover, often many months because of the recruitment policy that the job cannot be advertised until it is vacated. Health visitors remarked that they spent little or no time with their manager at handover and one said her main information source was rumours. Another said she had had to give up holiday to ensure a reasonable handover, and another said her

main information source was living on the area previously. Managers felt that a community profile would to some extent improve communication at this point and health visitors were very clear about the content of such a profile. A health visitor must waste considerable valuable time rediscovering information familiar to her predecessor, or in the worse case, never move beyond an intuitive understanding of her new community.

The kind of information health visitors seek at handover covers such issues as local facilities and amenities, housing, employment, age structure, class, ethnic minorities, single parents, isolation of parents, mobility, other workers in the community including the primary health care team, and geographical and environmental considerations. These are specified in the answer to questions 8 and 9 of the health visitor interviews and question 3 of the senior nurse interviews.

3) **To teach students**

Health visitors carry a considerable burden in educating many kinds of students for example medical, nurse, health visitor and social work students (Harrison (1986) (81)). Part of this education is to orientate students to a community approach, and an analysis of the local community is vital for this function. Nurse education is rapidly moving towards a health centred model of nursing and courses often require placement in the community at the start of nurse education. A community profile would allow health visitors to communicate with clarity about their area.

4) **To provide the basis for an annual review of working practices**

It is important to evaluate the effectiveness of programmes of health visiting activity so that locally relevant practice can develop on the basis of plans. It is also important for health visitors to know whether they are achieving their aims and goals, not least for their own job satisfaction in addition to communicating with managers. Most health visitors when interviewed said they did not know whether they were doing their job well. It would be a help to the profession on many counts to make their work explicit and an annual construction of a community profile would enable evaluation. If an accident prevention programme has been launched during the previous year an assessment of admissions to casualty following accidents would inform the health

visitor about how effective that campaign had been. Update figures for services such as vaccination, cervical smear, and hypertension screening are other examples which could be used for education. Trends in dental caries in five year olds, figures which are actually collected already, could inform health visitors about dental health education and its effectiveness. There are many such examples.

Health visitors made the point, particularly in workshops, that community data is dynamic and constant updating would be needed as a basis for planning services.

5) **To form the basis to innovation**

It is very easy for a health visitor to continue to practice as she has always done. It was only when the evidence of changes in the health needs of society was demonstrated that the health visitors began to question their practice. The health visitors had retained concepts of being a service for the whole population but in actual practice produced traditional patterns of work. The health visitors also felt that there was no "atmosphere of innovation" provided by managers and indeed managers provided a very mixed response when asked how they would react to a new plan of work from a health visitor, one remarking "I wouldn't like it at first". A community profile could provide the evidence a health visitor needs to justify new working patterns in both qualitative and quantitative terms.

6) **To negotiate with managers**

This is perhaps the most important of the potential functions of a community profile if we are to move towards community diagnosis, as defined by Rosen (1986) (163) in Chapter 1, and if we are to involve practitioners in policy making at an early stage then the information about health needs must be derived from local hard data. As Cumberlege pointed out, nurses must know their patch and demonstrate need from it in order to secure funding from government "of whatever political hue" (1987) (43). Repeatedly in this project health visitors have mentioned poor communication and support from managers. Perhaps the place where discussion can begin is

about the nature of health visiting practice in a given community. This question is discussed in more depth in the section "Implications for the organisation".

Managers also have an important gatekeeper function in supplying data to health visitors which is patchily applied at present. For example one manager remarked that she received information of use to health visitors but found difficulty in circulating it to all her staff, logistically.

7) **To negotiate work with other workers, both in the primary health care team and other local workers**

Even when a health visitor has identified local health needs she may not be the appropriate person to act on them because other workers possess better skills for addressing that particular issue. Health visitors are well aware of the need to network with other workers both from the point of view of identifying skills and resources and to enhance local information and for mutual support. The health visitor however has a role in making others aware of identified health needs both at the individual worker to worker level and also politically. A health visitor for example could help to influence local housing policy or the placement of benefit advice centres or indeed the focus of a community worker's approach. Increasingly nurses of all kinds are being required to be advocates for clients needs and health visitors have been, and need to be more in the forefront of this movement. A community profile would provide the source of advocacy issues. Different health and social services workers tend to have a particular approach to their work derived from their particular theoretical background and between these approaches clients needs may be lost. A community profile could provide a more comprehensive approach. Indeed health visitors mentioned the importance of community fora for gathering information about a community. These fora could also provide a means of acting on that information with a team approach.

A frustration mentioned several times by health visitors was poor communication with general practitioners, for example receiving inappropriate referrals, G.P.s failing to comply with developmental checks and vaccine times in line with local health service policy, or G.P.s refusing to communicate at all. In the researcher's view a community profile could not necessarily overcome

personality and organisational conflicts but might help to make the health visitor's role more explicit to other workers.

8) To provide evidence for fact-centred work, demonstrating the shifting needs for allocation of health visitors

As one of the senior nurses remarked "health visitors are not all in the right place". An allocation policy based on need-led health care could be formed on evidence from community profiles. As populations of clients with health needs increased or decreased, allocation could be altered. Managers and health visitors could together decide on target groups in different localities and alter working practice to meet those needs. A less deprived area of the city might require fewer staff and a different pattern of work, e.g. groupwork-centred health education, where a more deprived area demanded an individualistic home based approach. Community profiles could also be used to demonstrate the need for more health visitors where there was a shortfall. Currently such policies are as the General Manager said "By guess and by God".

9) To communicate with clients in the community

In the workshops health visitors began to see that they could both derive information from people in the community they served, about health needs, and use the information they had derived to inform the local community about itself. Health visitors could for example display statistics about local health needs in their clinics and use data for individual teaching about health. This would form the basis for co-operating with a community about what that community saw as its health needs and what the health visitor identified from statistical evidence. For example recognising a dearth of child minders in an area could be used to encourage clients to apply to be child minders. Informing the health visitor about hazards on local roads or play areas could be used to campaign for changes in the environment. This is in a sense networking with individuals and groups in the community.

An important reason for this is that communities have themselves resources which could be tapped to improve health. This implies a "giving away" of skills and knowledge by the health

visitor to the community instead of the "professionalisation" of knowledge. A community profile could begin to identify positive strengths in a community which the health visitor could enhance and form the basis of communication with and about the community.

10) To inform the planning process

Essentially then community profiles could be used to make health needs explicit and inform the planning process. This research has demonstrated that health visitors can produce plans on the basis of data from a community profile. Examples of these plans are shown in Chapter 6 and Appendix XIII. In addition sample members began to negotiate about their plans with their management, taking the use of information past "use" to actually demonstrate productivity on the basis of received information. These plans included costing, resources and timescale information essential for management to assess the practicality of plans. This could be taken much further with an overall plan for the caseload/community providing the data for an annual review of direction and purpose which appears to be lacking in the health visiting service at the moment. It is in a sense the nursing process on a different level. The stages of assessment, planning, implementation and evaluation are here applied to the health needs of a community, identified groups within that community and identified individuals within those groups.

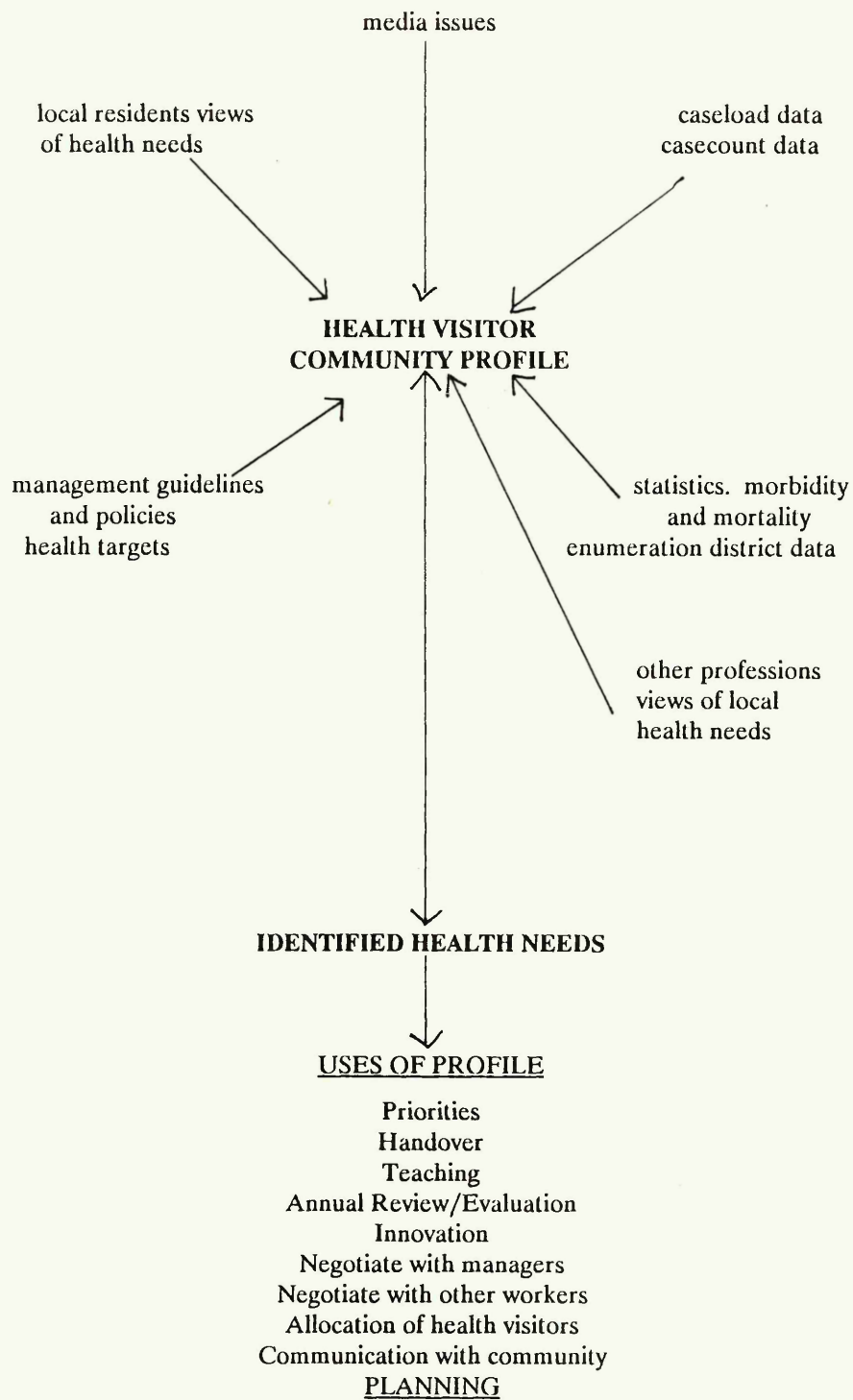
It provides an alternative to the current planning process vividly identified by the health visitors in the interviews conducted. They based their planning procedure on fixed points during the week derived from policies and guidelines about which there was considerable confusion among health visitors and managers. Managers were unsure whether health visitors considered "routine work first" or "looked at problems first". Only one health visitor respondent said she measured her activities against priorities she set herself. Health visitors did not consider that their "received visiting pattern" dealt with the health needs of their community and many said they felt overwhelmed by the health needs in their area. The use of community profiles could help to identify specifically the direction health visitors in each community should take.

Finally it would be helpful to mention some features of building community profiles. The health visitors found making community profiles time consuming and difficult because they were constantly interrupted at work and because they found it difficult to see it as a legitimate use of work time when faced with constant client demands. They identified far more needs than they could hope to meet and felt they were "only scratching the surface". They felt they would have to ignore traditional needs in order to deal with newly identified ones. They criticised poorly developed age-sex registers and their existing methods of record keeping as holding them back from collecting community data. These factors would call for management requiring community profiles to be produced and therefore legitimising the use of work time. The provision of time and space for the work to be completed, and support because of the stress produced by uncovering new areas of work, would have to be addressed. Development of age-sex registers and different records would enhance the production of community profiles.

The implementation of the recommendations of the Korner Report (1984) (184) will help to provide much caseload data which health visitors require but it will only provide information about the clients health visitors are already seeing and not about the whole local population. This means there are implications for a health visitor information system as discussed in another section of this chapter. Two further aspects of community profiles are firstly that a profile could be built by a team of community nurses at a particular worksite rather than by the health visitor alone. This would complement the concept of a neighbourhood nursing team. Secondly there are training implications as health visitors had some difficulty understanding how to use ward and enumeration district data. This research provided education in the workshops about how to use the literature but it could be that in-service training about information use would need to be considered. Again this is discussed in more detail in the section on health visitor information.

Figure II shows a flow diagram of information sources used in the production of community profiles in this research and the subsequent uses of the profile which were identified.

Figure II information sources and subsequent uses of community profiles



2. HEALTH VISITOR INFORMATION : MOVING TOWARDS A SYSTEM

The kind of information explored in this research is information about the community which would be of use in the planning of health visitor activity. It is precisely the kind of information which Gilbert (1976) (71) dismisses as

"local community information they have to build up themselves".

This project has demonstrated that,

- 1) Health visitors can state the community information they want, need and are prepared to use.
- 2) Such information can be collected together and used as a source.
- 3) If education about literature use is provided health visitors can and will interpret initially unfamiliar data.
- 4) Health visitors will assemble data and from it produce plans of work thus taking information provision through to use and productivity.

In this section features of information provision for health visitors are explained and suggestions made as to how information could be systematically supplied to health visitors to promote future competence in the client system.

The health visitors in this study demonstrated many of the features of practitioner research discussed in the Information Science Literature (Chapter 1). They used oral communication in interviews, workshops and Harrison (1986) (81) showed that they communicate orally frequently and for long periods of time. They discussed delays in communication of for example children's admission to hospital or with G.P.s, they had difficulty identifying priorities, and different perceptions of the job were clearly evident between health visitors and the general manager (Wilson (1985) (206)). They often mentioned their isolation and clearly enjoyed contact with other health visitors as expressed in the evaluation questionnaire. They expressed the fragmentation of their working day, particularly when trying to write community profiles. Many of the sources supplied by the researcher were new to the health visitors although they were available in the city prior to the research, but health visitors had not known they were available. They

complained of lack of time and lack of knowledge as to how to use statistical data, particularly the enumeration district data. Great confusion existed about policies, and guidelines and even the managers had conflicting views about whether these were available to health visitor practitioners (Question 6/7, senior nurse interviews).

There was no policy statement about information in the community unit during the research period, although there was an information officer employed. The job description of the information officer clearly links his function to the needs of senior managers and the provision of computer services. There is no mention of practitioners at all as information users supporting Wilson's claim that information staff tend to gravitate towards the information needs of middle managers where no policy is stated.

Barriers to information use by the health visitors included psychological, physical, hierarchical and accessibility aspects. Health visitors saw information seeking as secondary to their service role, information sources prior to the research project was scattered, managers felt unable to supply health visitors with relevant information and some of the data itself was initially unintelligible to the health visitors (Beevers (1979) (15)).

The health visitors appeared to identify more closely with their visiting area than with the role of health visitor as evidenced in questions 25 and 26 of the initial interviews demonstrating Streatfield's (1982) (185) point that workers on the boundaries of organisations may identify more with the client group than the organisation. There were also worse attitudes towards management, with more dissatisfaction expressed among fieldworkers than among managers themselves (Wilson (1985) (206)).

If all the advantages of community profiles are to be reaped by the organisation then it is clear that there needs to be a regular supply of information to health visitors and a support network to enable them to use that information. Let us then examine what factors would fulfil these conditions.

- 1) A willingness by management to support these activities. This is discussed further in the section on "Implications for the organisation", Chapter 7, Section 4.
- 2) A regular accessible supply of information.
- 3) Personnel involved in the provision of information.
- 4) Educational support in using information.

A regular accessible supply of information

Information sources need to be gathered together. It has been noted that community information rapidly changes and new reports constantly appear. There needs also to be a movement to collect data not yet available which the health visitors are saying would be of use to them. The location of information sources could be based at health visitors worksites, or in a central library. One of the features of information that health visitors require is that data be selected on a geographical basis so that they receive only that which is relevant to their particular practice. Information sources could be focused either on particular health visitors, or on the community nursing team for a given area or on the primary health care team. In addition to psychology, sociology, government information, preventative health policies, health education and social services information, health visitors require reports from census data, morbidity and mortality statistics, local handbooks of statutory and voluntary agencies, health data already collected by the community health unit but not supplied to health visitors, and feedback from local authority reports. Among these could be included Environmental Health, Housing, and Family and Community Services data. Health Authority and Regional Health Authority plans together with updates from conferences, health service unions and relevant journals are obvious sources. A full list of the sources used in this research is supplied in Appendix VII and could form the basis of an information collection.

As Bransom (1973) (19) suggested a circulation system of relevant journals, a scanning service, a rapid service for providing specific facts, bulletins and a selective dissemination of information service, would benefit health visitors. During the current research the researcher has requested that bulletins from the Health Authority library be circulated to health visitors.

Such a service as suggested could be based on existing libraries within Sheffield. For example the Royal Hallamshire medical library, the Health Authority library at Westbrook House, the Sheffield City Polytechnic or University libraries, the Family and Community Services Information Service or alternatively it could be based as a new Community Unit library. The advantages of a new library are that it could be tailored to the needs of the community unit and focused on the particular peculiarities of community health work.

The presentation of material for isolated workers in fragmented working conditions could be examined. Short up to date reports would benefit workers in these conditions, indeed the Assistant Directors of nursing services who appear particularly overburdened with paper work would especially benefit from summarized material as they voiced in interviews. The tasks of health visitors, the urgency of their needs, their need to interact with information providers, the short periods of time available to them for information seeking and their need to browse would have to be taken into account. On certain issues, for example the health visitor proposing to do hypertension screening, packages of information of use in responding to identified need could be formed (Ford (1977) (62)).

There would be tremendous advantages for two information-needy groups, students and health visitors newly qualified, in providing such a service. Without an adequate information system the health visitors are working in the dark. A major problem in the current research was that census data came from the 1981 census which was already out of date. A library service could be formed ready to prepare the 1991 data for immediate use.

Personnel involved in the provision of information

Ideally health visitors require, as one interview respondent remarked, their own "information technologist" to support the planning function of health visitors. This could be someone with community nursing experience and library skills. The focus would need to be on the provision of an innovative outreach approach and the information officer would need to be visible to the health visiting staff. He or she could regularly attend unit meetings to discuss new information available and reassess information needs at regular intervals. The form, location and

timing of information provision could be reviewed. Links with Health Education, the education of health visitors at Sheffield City Polytechnic and foreseeing trends in service provision would form part of his or her role.

Educational support in using information

In this research the constant feedback and communication with the health visitor sample was an important feature. It became clear that understanding a particular set of information could be dependent on for example identifying which electoral ward the health visitor was working in, or how a percentage was derived in a given case. It is not enough simply to supply information, there also needs to be an educational input. This could be done by in-service training, by an information officer or by providing printed leaflets and guidelines and might be done either on an individual or groupwork basis. Education staff could approach this by forming quality circles in which practice is discussed and using education about information as a secondary tool. Such education could be conducted with a team of community nurses at a worksite, or by withdrawing staff for study days. The experience of this research is that health visitors encouraged each other to examine the implications of data provided in groupwork and had the benefits of, as they said, giving them, time to think, enthusiasm, confidence, a new perspective, time to analyse, see the community as a whole, and realise their concerns were shared by colleagues (Evaluation questionnaire, Chapter 6).

In order to evaluate practice, or indeed select pieces of information, health visitors needed to be able to make comparisons, for example local data with city-wide data, city data with national data and so on. From this it is clear that they required education about what statistics could and could not be compared. They found a similar problem when defining categories of information they wanted to collect locally and agreement about, for example, the definition of a single parent family became important. These and similar issues would need an educational input.

3. THE ROLE OF THE HEALTH VISITOR : INFORMATION PROVISION IN PERSPECTIVE

Health visiting is a complex and difficult job. In the answers to questions 6 and 7 of the health visitor interviews and questions 1 and 2 of the senior nurse interviews respondents were asked to define the purpose of the health visiting service and the client groups who should be in receipt of it. There was hardly a group in society for whom this service was irrelevant. It is interesting to compare these answers with that of the General Manager who had a far more limited view of the service, but did not feel he needed more information in order to represent it. It is probably relevant that all respondents except the General Manager had health visiting experience.

It is clear that health visitors have defined for themselves a nearly impossible job. They complained that the existing visiting pattern that they use does not address health needs, and that the work organises them. They mentioned three coping mechanisms they used in order to contain the overwhelming nature of the work.

Firstly they decided on the priority of visiting 0-5 year olds and their families. They seemed to do this because they were informed about this group by initial referrals, because Management guidelines and policies, confusing as they seem, refer to this group and because they felt skilled with this group. Secondly they indicated a specific limited planning approach to try to "pin the job down". They mentioned fixed points in the week, e.g. clinics, case conferences, unit meetings around which they structured their work and then secondary mechanisms such as seeing the youngest children first or frequent visits to breast feeding mothers or responding to clients' calls for help. Other factors, whether they had a student with them, reducing mileage costs, altered their working day. A third coping mechanism appeared to be "doing something that interested them". Indeed it seems quite justifiable that where needs are overwhelming the health visitor should approach some tasks because they provide job satisfaction.

But it can be seriously questioned whether this forms an adequate basis for planning a preventive health service. Health visitors and managers did not lack vision about other groups in

society requiring the service and there was considerable agreement about the main causes of ill health in Sheffield. Clearly funding was an important consideration, as one manager pointed out "I just don't think the health visiting resources are there to cope as we should do". This view was not shared by the General Manager who considered the service well resourced and that if health visitors had complaints about resourcing it was up to them to lobby, he did not consider it part of his role. Surely then he was failing to take account of his aim that,

"The aspirations and professional needs of health visitors are embraced in overall plans." G.M.

Information cannot replace adequate funding, but even in the current inclement financial climate the researcher's point is that health visitors and their managers could define their task more clearly in specific localities based on accurate information and they would benefit by stating tasks they could tackle rather than being overwhelmed by unreachable goals. Using community profiles as the basis of planning would not only "contain" the job but also allow them access to a higher level of planning where such needs could be demonstrated to the General Manager and the Managers above him. In simple terms the health visiting services has to produce plans which make sense to Managers higher in the hierarchy. The service needs to be visible and explicit about its aims.

This research found that many of the factors mentioned by West and Savage (1987) (200) to be present in the organisation:

1. The need for a better and more supportive management.
2. The need for clerical support.
3. The need for better training, particularly in-service training re for example counselling, assertiveness and bereavement.
4. The need for an appraisal system.

In addition the health visitors in this study wanted:

5. Better information.

- Including:
- population, morbidity and mortality data.
 - caseload and caseload data.
 - media issues, especially local ones.
 - the views of local residents about health needs.
 - the views of local professionals about health needs.
 - policy, guidelines and health targets.

6. More time.

7. Lower caseloads.

8. Orientation programmes for workers returning after a break in service.

9. Recognition of health visitors as working mothers reflected in hours of work and possibly workplace nurseries.

10. Less stress.

11. An atmosphere of innovation.

12. More pay.

13. Better record systems orientated to community data.

Nearly all these requirements demand improved funding for the health visiting service and all of them require an attitude change among managers who do not appear to be representing these issues to the General Manager. The managers are experienced health visitors who are sympathetic to the needs of health visitors, it is possible that better information would increase their power to argue for increased funding. But, as with the health visitors it is not simply providing information, but using it that may have an effect.

The researcher would argue that the health visiting service should respond to the demonstrated health needs of the Sheffield population taking into account the new movements in community nursing. Such movements include advocacy, identifying good practice, reconnecting

with the population, communicating with other agencies and the population itself, moving to health visiting as a research based profession and emphasising the role of health visitors as a teacher and health educator rather than as a direct carer. Information forms the basis to all these movements. Advocacy involves representing individuals and groups in a wider political setting concerning their health needs. Identifying good practice is based on evaluating a predetermined set of goals and aims. Reconnecting with the population means providing health care in the places, times and by means that are understood and welcomed by the public. In short that health care is seen as relevant to the population especially to the poor, ill educated or "out groups" of society who are alienated by the formality of the existing health service. Communication with other agencies must be based on an explicit statement of the health visitors role and clarification of their skills. The call for a research based profession demands that teaching be factually based and knowledge shared among health visitors. The role of health visitors as relevant health educators and teachers requires that health visitors address the health needs of society as they are.

It would be naive for the researcher to imply that all health visitors' problems would be relieved by good information sources and community profiles but these resources would inform and empower the health visiting service to deal with both its internal difficulties and the external demands that society places upon it.

4. IMPLICATIONS FOR THE ORGANISATION AND THE WIDER CONTEXT

Changes during the research period

During the research period the organisation of health visiting in Sheffield has undergone changes. These include an increase in the number of first line managers from three to four, thus reducing the number of health visitors for which a manager is responsible. These managers have been organised so their areas are contained within electoral ward boundaries which means they can interpret data from census and Local Authority reports. There have been discussions aiming to combine Local Authority, Family Practitioner Committee and Health Authority computer services so that there is a shared data base. Issues of confidentiality have been the main

obstructions to these discussions but such an amalgamation could improve health visitor information.

A senior nurse has been placed in post to implement the Korner (1984) (184) information recommendations as discussed in Chapter 1. This activity will result in casecount data being readily available to health visitors and numbers of vaccinated children, clients with handicaps, frequency of visiting and many other relevant data sources will be available which would aid the construction of one aspect of community profiles. The Director of Nursing Services, new in post at the commencement of the research, has indicated that she wishes the service to be based on consultation between health visitors and managers. This does not in fact provide the health visitors with more real power but does indicate that managers are more prepared to listen to fieldworkers. The number of staff providing in-service training has been increased and that department has surveyed the health visitors opinions asking them to suggest topics for in-service training study days. Senior nurses have been allocated to improve the child abuse service and the continence advice service. School nurses have been "patch based" instead of school based to improve their communication with health visitors but there have also been cuts in service in school nursing. Health visitor fieldwork teachers have been provided with the equipment they needed for teaching and there has been an increase in the number of health visitor students in training. An experimental neighbourhood nursing team has been established, linked with local authority workers and known locally as the Manor Project.

The General Manager interviewed in this research has retired and been replaced, with a period of three months elapsing before the new incumbent was able to take up his post. No doubt this will result in further changes in the health visiting service.

Among the health visitors, those taking part in the research have reviewed their practice in the light of community profiles and have begun to negotiate practice with the managers (Chapter 5). It would need a longer period of study than this research can provide to assess the long term effects of this intervention. However the setting is favourable for negotiation to begin and certain factors will enhance the effect of using community profiles for planning purposes.

These factors include:

- 1) Clarification of policy statements
- 2) Implementation of appraisal systems.
- 3) Provision of an information policy and an information system for health visitors.
- 4) A willingness by managers to have a participative administrative style and a risk-taking attitude.
- 5) Increased funding for the health visiting service.
- 6) Negotiation with other bodies and agencies about the environment of health care provision.
- 7) A different concept of planning.

1. Clarification of policy statements

This research has demonstrated that health visitors and their managers are confused about what is policy for the health visiting service. Indeed the policy book, a red file kept by all the first line managers, covers such issues as what size of earrings a health visitor may wear. The problem arises because this "policy book" is based on recommendations applicable to hospital nurses which are policy for the city. It does not indicate what a health visitor is required to do to fulfil her role and does not assist in planning the service. It is important that health visitors are clear about what is and is not policy for several reasons. Firstly, as one respondent put it, "you don't know which of your practices you can alter without recourse to management approval". The health visitors creativity is hamstrung by being unable to distinguish between policies, guidelines and oblique references to health visiting practice by managers. The researcher would suggest that there should be a statement of philosophy for health visiting, an indication of broad aims and responsibilities and a specific list of those relatively few activities which must be regarded as policy. These policies must be drawn up in negotiation with health visitors, agreed by health visitors and managers and recorded in a policy book available at every worksite. It is reasonable that a health visitor should be supplied with information about her work derived from an agreed job description. The researcher would see this as a freeing rather than a restricting exercise.

2. Implementation of appraisal systems

As West and Savage (1987) (200) have indicated no appraisal system is better than a bad one. Health visitors and their immediate managers need to communicate about a health visitors' aims and objectives within the work setting. They need to assess the health needs of a community, plan an approach to meeting those needs, implement activities and assess their outcome. The researcher would suggest that a health visitor could base her aims and objectives on a community profile and the discussion with the manager would entail delineating the means whereby those aims and objectives could be attained. They would need to be within policy, relevant, possible, and after an agreed period of time the health visitor and manager would evaluate their effectiveness. The manager would be in a position to represent that health visitor, and advise on a basis of clinical objectives and values. At the point where higher management questioned a health visitor's practice the immediate manager would be able to have an informed response.

A second function of the appraisal would include the job satisfaction aspects of health visiting. It is constantly a problem that health visitors do not know how well they are doing their work as amply demonstrated in the interviews (Question 27 Health Visitor Interviews). The appraisal could form the basis of mutual assessment between the manager and the health visitor. With such a creative, experienced, motivated work force as health visitors form the control aspect of management is considerably over emphasised at present, possibly a relic from the poorer aspects of hospital nurse training.

The other benefits of appraisal such as career development, the need for further training, recognising and using specialist skills, early recognition of stress and supervision in relation to difficult work conditions would also accrue to the service.

3. Provision of an information policy and an information system for health visitors

The need for an adequate information system has been discussed in another section of this chapter. An information policy needs to be based on the concept that the health visitor workforce must have the information within the workplace which it needs to produce a high

standard of service. This is not currently the situation. Health visitors are for example expected to read widely outside the workplace in order to maintain a high standard of practice. Many courses of advantage to health visitors are not provided within the NHS structure. Health visitors have in the past, for example, been told to "visit the elderly" without any effort being made to inform them of where those same elderly live. The information aspects of health visiting work needs to be addressed prior to alterations in policy. The information flow within the service has many faults at present, for example a slow and inaccurate internal postal system, inaccurate tracing of records, vast numbers of forms that need to be completed when records are transferred, tracing another health visitor visiting a child with a particular handicap is impossible, the telephone system is grossly inadequate causing enormous delays in communication. Records of children's attendance at clinic may be reproduced as many as three times and delays in receiving health education material constantly frustrate health visitors in the field.

Prior to this research health visitors were not even informed about data collected in other departments of the community unit itself, though efforts to communicate speech therapy and dental data during the research period have been made. Health visitors could not be sure about the vaccination state of each child they were visiting. There are many such examples.

This project has focused on "community information" and the kinds of data and the nature of its provision have been explained. Health visitors are clear about what information they want. An information policy would pave the way to ensuring they have it.

4) **A willingness by managers to have a participative administrative style and a risk taking attitude**

A workforce who are all doing the same thing are easier to control and administrate than a workforce who are experimenting with different ways of working, different approaches. It could be very threatening to a first-line manager to have a truly creative establishment of health visitors. The public have come to expect a consistent though limited service from health visitors and it would be difficult for a manager to "allow" health visitors great flexibility in their approach. The managers themselves would be forced to think about the nature of the work and what

approaches would be effective in different communities. They would have to take risks in encouraging creativity among the health visitors. Such a step rests on a participative administrative style, sharing the responsibility with the health visitors, tolerating and supporting the occasional misjudgment. Managers who have for a long time been under so much pressure as the senior nurses have, would need to step back from the field to reassess their role. It seems essential that they should receive a high standard of management training in such an approach and also take part in appraisals with their own managers.

To provide the health visitors with information at field level without any change in the style of management is unlikely to result in long term changes in the organisation (Clark (1976) (34)).

5) Increased funding for the health visiting service

In 1988 the Health Service is in crisis and the funding of the whole service is being questioned. It would therefore be extremely unlikely that there will be a massive increase in the funding of the health visiting service. There are however two possibilities for increased funding. The first is that mentioned by the General Manager, that there could be joint Local Authority and Health Authority funding. As local authorities perceive health as an important community issue joint projects could be put forward for, for example, Inner City Partnership funding.

The second source, that of increased direct government funding could rest on the service making adequate plans based on demonstrated need - the community diagnosis approach. There is clearly an emphasis on the "community" as a focus of care and as opposed to increased funding for technological medicine, "preventive care" is now the current vogue. A rapid increase in the elderly population of Britain, and indeed especially in Sheffield which has one of the highest proportions of elderly in the country, means that funding is to some extent following initiatives for work with the elderly. Politically speaking this is not the time for health visitors to limit themselves to the care of the under-fives and their families. But the care of the elderly, in prevention terms

rests with the care of the middle aged. Firstly because they will soon become the elderly and secondly because they are often the carers of the elderly, especially women. These are strong arguments for widening the scope of health visiting to include the elderly, the middle aged and carers because they have health needs and because such work is more likely to receive funding for the service as a whole.

6) **Negotiation with other bodies and agencies about the environment of health care provision**

As Katz and Kahn (1966) (102) put it,

"Programmed planning can be implemented through two auxiliary or staff functions, one to develop alternative courses of action for anticipated changes in the environment, the other to gather intelligence about environmental changes and reactions to organised programmes. Both these functions are generally combined in a single staff group, to the great neglect of the intelligence function. Guesswork replaces exact knowledge of environment trends."

It is important for the optimal functioning of the health visiting service that there is feedback from the health care environment, that is the community. Community profiles could form a part of this process. In addition it is essential to make

"Organisational boundaries more permeable" Katz & Kahn (1966) (102)

so that bodies such as Family and Community Services, the Environmental Health Department, the Family Practitioner Committee, the Community Health Council, Voluntary bodies and consumer representatives have an input into the planning process of the service.

Traditionally community nursing services have been planned on the basis of government directives and funding available, that is top down planning rather than taking account of the needs and wants of the communities served. These two functions of anticipating trends and assessing reactions to programmes have been missing. Partly this will be improved by better management information but it is the form of this that the researcher questions. It is not helpful to know simply how many people in a given category have received community nursing attention, there are other

questions. Was the care in the right form, to the right group, were they satisfied with the care, to what standard was that care delivered? Managers could in conjunction with health visitors review care priorities on a more locally relevant basis than a government directive.

The work of community workers, adult education teachers, social workers and other members of the primary health care team all need to be considered in planning the service. There has been too much professional isolation in the health visiting service and this could be mitigated by negotiation with other bodies and workers. This needs to happen in the field, at management levels and also from an overall picture of the health needs of the city. Again, as discussed in Chapter 1 the role of the medical officer of health's annual report is now missing for this useful function. We need to move towards community diagnosis resting on locally based information. The planning of services and therefore other factors such as the new acquisition of skills by health visitors need to follow community health needs rather than be imposed upon them.

7) **A different concept of planning**

"Any organisation that does not have a four -, five - or ten-year plan is risking destruction or a series of continuing crises in its operations Of all the functions of central management, this responsibility to think ahead is perhaps the most important." Katz and Kahn (1966) (102)

One of the problems of planning in the Health Service currently rests on the inability of managers to predict what budgeting restrictions will be placed upon them. Planning can only take place on a year by year basis. Although the Regional Health Authority produces ten-and five-year plans these are so vague as to be unhelpful to the managers responsible for direct care.

The only rational response seems to the researcher to be to plan as if budgeting will be available and to justify recommendations on the basis of factual data about the community. It seems also that when there are severe financial constraints the need for detailed and specific plans and the formulation of priorities is more acute. Where monies are so restricted that only very basic service provision is possible then the only room to manoeuvre available to managers is to improve how that care is delivered. The managers could be aided in this process by relinquishing some power to the field workers for the planning process in the ways that have been discussed.

The morale of health visitors has been low because they have been excluded, as Ali Mazrui put it "Powerlessness corrupts" (1987) (132). Michael Barrat Brown repeats the same message (1978) (23),

"The reason why your knowledge is so often ignored is that if management gave it proper attention you would be likely to gain more shop floor control".

It is time in the health visiting service that senior managers gave power away to field workers for the benefit of the community's health. By doing so they would improve the information base on which services are planned.

As White (1987) (201) put it,

"They (the nurse managers) should seek to gain professional authority through an improved knowledge base".

And finally as Cumbelege was quoted - in Chapter 1 (1987) (43),

"We felt that change is quicker and more successful when it comes from below I think there are three aims for the next year, more power to the people, more power to the team and more power to the community nurse".

5. EVALUATING THE METHOD

"In the applied field the criterion must be does it work : that is, are the decisions made and the practices initiated, improved in the light of the information, or would they have been much the same in the absence of the information?" Brittain (1970) (21)

In this section the researcher argues that the intervention used in the research process provided health visitors with information they wanted and needed, educated them about possible uses for that information and that the health visitors subsequently proceeded to use the information to alter their planning mechanisms. Many other benefits accrued to the participants including the enthusiasm and confidence they developed in handling community data, benefits from contacting each other in groupwork, and a new awareness of their possible role in the overall planning process of the health visiting service.

As one health visitor commented;

"It provided more information about the area and showed you how to go about planning further projects, and how to present them to higher authority for approval."

The collaborative "action research" style of the study enabled health visitors to encourage each other, hear of other discussions and led to more innovation than would have been likely with a more isolating approach. Because the interview analysis was fed back to all participants including all the managers taking part, managers appear more open to the use of community profiles and several managers have approached the researcher to discuss how such profiles can be further developed. The circulation of the interview analysis formed a new kind of communication in the organisation.

In selecting a sample the researcher had originally thought that experience of an age-sex register would aid health visitors in understanding community data. Since age-sex registers are still in very early stages of development this was probably not as relevant as it could have been and in repeating such a study the researcher would waive this criterion. The sample of health visitors were experienced in the world, as demonstrated by the numbers of different occupations they had had, as well as experienced as health visitors. They represented approximately the same proportion of full time and part time workers as in the general population of health visitors and all but three had trained locally, the vast majority at Sheffield City Polytechnic which one might expect to have given them a uniformity of view about for example the purpose of health visiting. However what was striking about the participants was the differences in the way they described their work and the approaches they used even within the narrow sphere of visiting the under fives and their families.

The interviews allowed the health visitors and managers time to express their views - as one health visitor remarked,

"No-one has ever listened to me for an hour before",

and was probably important in forming an relationship with the researcher particularly when she was later to ask them to do considerable amounts of work for the project. The main purpose of the health visitor interviews was to derive their information needs for community data in the context of the job, on which the provision of information in workshops was based. These interviews however also furnished such data about the organisation and the way the health visitors perceived their role. The managers interviews involved the managers in the research which will be likely to make them more inclined to take notice of the research outcomes (Clark (1976) (34)). It highlighted how they saw their role and demonstrated striking differences between the view of the General Manager and the senior nurses.

The benefits of workshops have been discussed elsewhere in this discussion but one feature, that is removing health visitors from their working environment, was clearly helpful in giving them legitimised time in which to reflect on practice. The inclusion of Anne-Marie Coyne in the workshop format allowed the researcher to receive necessary support and useful discussions but also gave the health visitors access to one of the authors of the Sheffield Profile of Health and Disease (1986) (175) which was a useful information source on, for example, the derivation of statistics. The design of a planning sheet arose directly out of workshop discussions and later formed an important part of evaluating the research process. It was important not only that the health visitors took part in workshops but also produced concrete evidence of planning. The health visitors were enabled to produce both a written document, that is the community profile of their area, and plans for new ways of working which they could directly use in practice.

The evaluation questionnaire provided the researcher with feedback about the conduct of the research and health visitors appeared to have learnt new information, identified new health needs, and explored future factors in information provision from which the researcher formed the discussion on health visitor information systems.

Because of the work this project imposed on the researcher it would have been difficult in the time available to have a much larger sample of staff involved, and indeed the project was probably large enough to demonstrate its usefulness for a wider audience as it stands.

In information science it is often commented that respondents have difficulty in stating their information needs, this was not the case with the health visitors who were in any case a very verbal group. In repeating the study method with an occupational group whose oral skills are not an integral part of their work there could be more difficulties.

Response rates to interviews were 100% and to the evaluation questionnaire 91.67% of those available. The gradual reduction in sample size reflects the dynamic nature of staffing in community nursing as health visitors are promoted, on sick leave, leave the service or take maternity leave and indicates one of the difficulties managers face in maintaining establishment at norm.

In this study only the needs of health visitors and their managers were considered. An alternative focus would be to have a problem centred rather than discipline centred approach (Brittan (1970) (21)). The information needs of the primary health care team or a neighbourhood nursing team would form an interesting study and could make a community based information study more relevant to a team of workers.

Further research about information and planning could also be developed after the implementation of the Korner recommendations, after the further development of age-sex registers and following amalgamation of a Family Practitioner, Health Authority and Community Unit data base, all of which could have a profound effect on the way information is used for planning.

Finally two aspects of this research are contended. Firstly that the concepts derived from the research relate directly to the world of health visitors and would be recognisable by them, and secondly that the information provision was taken past absorption by the health visitor and through to productivity. The researcher would here argue that poor conceptualisation as discussed by Paisley (1968) (148) was not a feature of this research and that Diesing's (1972) (53) emphasis on the holistic quality of research was upheld (Chapter 1). The checking mechanisms described by Gale (1985) (66) and quoted in Chapter 1 were employed throughout the research supporting the

validity of the findings. It is for the health visitors and their managers to decide whether they will now implement the recommendations of the study.

CHAPTER 8

CONCLUSION

This research project has shown that health visitors when provided with time, education and information can

- a) produce community profiles,
- and b) plan on the basis of those profiles.

The profiles can be used for various functions which are currently problematic in health visiting practice. They can be used to set work priorities and to justify changes in working practice on a factual basis, relating health promotion activities to demonstrated need in the population. Profiles can be used to hand over caseloads from one health visitor to another. This study has identified a severe information gap when one health visitor leaves and is replaced. The health visitor sample also identified a use for the profiles for teaching students. They need to learn not only about the functions of the community health services but also about the workings of the community itself.

In order to assist the management and direction of the service, profiles can be used to inform an annual review of working practices. This could make achievements measurable, give the service direction and provide positive feedback for health visitors which is clearly currently lacking. In this way they can be used in negotiation with managers but also to inform other workers and members of the community itself about health needs. This would aid a more co-ordinated effort at addressing needs than is presently available. Positive effects for managers could be that profiles could be used to identify factually-based allocation policies related to local health need rather than the current system of relating it to a 'head count' of clients.

Finally profiles could be used to inform the planning process of the community health services on a much wider basis. If the health needs of every area in a city are identified then the senior managers have an efficient information system on which to base decision making for the

service as a whole. This would be an information system in which health visitors have a powerful voice.

The benefits of using profiles are applicable to health visiting as a whole and are not limited to the narrow field of Sheffield.

To implement the production and use of profiles certain organisational implications need to be considered. Organisational changes would need to include the production of policy statements for the health visiting service. This would free the health visitors from some of the implied policy used at present which does not allow them to experiment with different approaches to health promotion. The implementation of appraisal systems would have many benefits if combined with the use of profiles. In simple terms 'how well one was doing' would be realistically related to 'what one had to do'. In addition other benefits such as career development, the need for further training, recognising and using specialist skills, the early recognition of stress and supervision in relation to difficult work conditions could result from good appraisals.

The researcher has argued that community unit should have an information policy relating to fieldworkers, in effect to establish the principle that information should be provided within the workplace relating to identified health needs. In short that the health visitors, and all other workers in the unit, should be provided with the information they need to do their work, in the workplace. This implies a good information system based on libraries, and information officer for fieldworkers and Managers, time and educational support for information seeking by practitioners. The existing information officer in the community unit has a job description relating his work to the statistical information needs of senior managers only. It relates to the managers needs to control the system financially.

To allow health visitors to experiment in the field managers would need to develop a more participative administrative style and to do this they should probably need to undergo management training. Managers would also need to develop an enlightened concept of planning involving negotiation with field workers, other bodies outside the health service and individuals and groups in the community.

The researcher has suggested two sorts of increased funding the health visiting service could pursue. Firstly joint funding projects especially with the local council but also with other bodies such as the World Health Organisation to do experimental work. Secondly the current interest in the health care of the elderly could be interpreted as the preventive care of the nearly elderly, particularly the middle aged, carers and women. This could attract central government funding for new projects.

Finally there are implications for education both of Managers and the training of health visitors to choose a more broad based approach to their work. These concepts are already present in health visitor training, the idea of analysing a community has long been present but the benefits of this approach have not been visible in subsequent practice. This clearly has implications for in-service training. The method based in this research could also form a model for in-service training providing the resources are there to support participants.

The researcher has argued for changes which connect the aims and objectives of the health visiting service with the health needs of the population it serves. It has also been argued that higher levels of planning could derive from local data sources offering a community diagnosis approach to health care planning, informing several hierarchical levels of the health service with a bottom-up planning process. The health visitors themselves have felt undervalued in their organisation and have expressed the need for change on many issues including in-service training, better information, an atmosphere in innovation and a better and more supportive management.

Were the recommendations to be implemented a more informed, motivated occupational group could provide a relevant, more rational service to the population of Sheffield.

RECOMMENDATIONS

1. All health visitors should be required to build community profiles of their visiting area provided they have:
 - a) An adequate information system
 - b) Educational support
 - c) Time allocated to complete their studies.
2. An information policy should be prepared for the community unit to establish the principle that information necessary to doing work is provided in the workplace.
3. An information officer relating to the needs of practitioners and Managers should be employed to interpret information, provide information packs and foresee trends relating health needs to information provision.
4. Consideration should be given to either establishing a community unit library or approaching other libraries in the city to provide an information system for health visitors and their managers.
5. Action needs to be taken by managers to address changes sought by the health visitors which are:
 - a) Better information provision including
 - population, morbidity and mortality data
 - caseload and casecount data
 - media issues, especially local ones
 - the views of local residents about health needs
 - the view of local professionals about health needs
 - policy, guidelines and health targets
 - b) More time, by employing more health visitors.
 - c) Lower caseloads.
 - d) Appropriate clerical support.
 - e) Orientation programmes for workers returning after a break.

- f) Recognition of health visitors as working mothers reflected in hours of work and work place nurseries.
 - g) Better training, particularly in-service training on for example counselling, bereavement and assertiveness.
 - h) The reduction of stress by providing a counselling and group work support for working health visitors.
 - i) Producing an atmosphere of innovation.
 - j) More pay, particularly as the new grading system offers the opportunity for a locally enhanced pay structure.
 - k) Improved record systems orientated to the collecting of community data.
 - l) Appraisal systems.
6. The health visiting organisation needs to have clear statements of policy, aims and objectives and a statement of overall philosophy.
 7. Appraisal systems for health visitors and their managers need to be implemented.
 8. Management training should be implemented to encourage a more participative administrative style.
 9. The health visiting service needs to consider alternative sources of funding in particular joint funding and monies allocated for the care of the elderly.
 10. Agencies and bodies including representatives of the local community need to be involved at several levels of the planning process, not just at Health Authority level.
 11. The planning process of the health visiting service needs to begin with locally based community data, and a collaborative style of planning needs to be implemented to which fieldworkers have direct access.

REFERENCES

1. AIYEPEKU, W. O. (1982)
Mapping the Information Environment of Policy-makers: Some empirical findings from Nigeria.
Social Science Information Studies. 1982. 2. 79-91.
2. ALLAN, G. & HIGGINS, J. (1987)
A sentimental notion.
Community Outlook. Nursing Times June 1987 pp. 30-31.
3. ALLEN, T. (1969)
Information needs and uses.
Annual Review of Information Science and Technology. Vol. 4, 3-29.
4. ALLEN T. & COHEN, S. I. (1969)
Information flow in two R and D laboratories.
Administrative Science Quarterly. March.
5. ALLEN T. S. and GERSTBERGER, P. G. (1967)
Criteria for selection of an Information Source.
M.I.T. Alfred P. Sloan School of Management Massachusetts. (Working paper 97-64).
6. ALLEN, T. C. and GERSTBERGER, P. G. (1971)
Report of a field experiment to improve communications in a product engineering department : the non-territorial office.
M.I.T. Alfred P. Sloan School of Management. Massachusetts. (Working paper no. 579-71).
7. ALLEWAY, L. (1987)
Trendsetters.
Nursing Times Feb. 18 1987, p. 20.
8. ANDREWS, M., BEDALE, C., LAING, T. ED. HANNON (1984)
Jam Tomorrow
Food Policy Unit, Wellings Faculty. Manchester Polytechnic.
9. ANSHEN, M. (1960)
The Manager and the Black Box
Harvard Business Review 36 (6) 85-92.
10. ALLINSON, J. (1971)
A Handbook for Interviewers.
H.M.S.O. London.
11. BACH, S. A. (1987)
Evaluating the Health Visiting Process using a model of nursing.
Health Visitor September 1987, Vol. 60.
12. BARKER, W., PERCY, P., SUTCLIFFE, D. (1986)
The Cumberlege Report on Community Nursing Services - an innovative charter for G.P.'s?
Child Development Programme, Early Child Development Unit, University of Bristol.

13. BARNES, M. (1975)
Information in a local authority social services department : a non-participant observation study.
Unpublished MA thesis. Department of Information Science, University of Sheffield.
14. BARUCH, J. J. (1967)
A medical information system : some general observations.
In. Walker D. E. ed. Information system science and technology. Thompson. Washington DC.
15. BEEVERS, A. (1979)
The Information needs of Hospital Workers. Unpublished MA Thesis.
Department of Information Science. University of Sheffield.
16. BELKIN, N. J. (1978)
Information Concepts for Information Science.
Journal of Documentation. March. 34(1), 55-85.
17. BERGER, P. and LUCKMANN, T. (1967)
The Social Construction of Reality.
London. Allen Lane.
18. BETTS, G. (1985)
Health in Glyndon. Report of a survey on health in Glyndon Ward, Greenwich.
Greenwich Health Rights Project.
19. BRANSOM, H.E. (1973)
An investigation into the information requirements of community health service staff.
Unpublished M.Sc. Thesis. Department of Information Science. University of Sheffield.
20. BRENNER, M. (1985)
The Research Interview.
Academic Press. New York.
21. BRITTAIN, J. M. (1970)
Information and its users.
Bath University Press.
22. BRITTAIN, J. M. (1971)
User studies in Education and the flexibility of an international survey of information needs in education.
Council of Europe. EUDISED Steering Group. Strasbourg France.
23. BROWN, M. B. (1978)
Information at work.
Arrow.
24. BROWN, S. (1985)
Information World/Social World. A selective consideration of the sociological perspective in information studies research and some possibilities for its development.
Unpublished Masters Thesis. Information Science Department. University of Sheffield.
25. BULMER, M. (1976)
Concepts in the analysis of qualitative data.
Sociological Review. Vol. 27, No. 4 1979 pp. 651-677.

26. BURGESS, R. (1980)
Some Fieldwork Problems in Teacher based research.
British Education Research Journal 6, 2, pp. 165-173.
27. CAPLAN, N., MORRISON, A., STAMBAUGH, R. L. (1975)
The Use of Social Science Knowledge in Policy Decisions at the National Level; A
Report to Respondents.
Ann Arbor M.I. University of Michigan, Institute for Social Research.
28. CATER, E. A. (1982)
Changing Patterns of Information Use in Planning.
Social Science Information Studies 1982, 2, 5-21.
29. CATFORD COMMUNITY HEALTH PROJECT (1982)
Report for 1982: First year of the project.
Health Education Council.
30. CETHV (1977)
An Investigation into the Principles of Health Visiting.
CETHV London
31. CETHV (1982)
Health Visiting Principles in Practice.
CETHV London.
32. CHECKLAND, P. (1981)
Systems thinking, systems practice.
Chichester Wiley.
- 32a. CHILD DEVELOPMENT PROJECT (1984)
Child Development Programme.
University of Bristol.
33. CITY OF SHEFFIELD (1986)
Basic Information pack on neighbourhood support schemes.
Family and Community Services, City of Sheffield.
34. CLARK, A. W. (1976)
Experimenting with organisational life. The Action Research Approach.
Tavistock Institute of Human Relations. Plenum Press. London.
35. COLEMAN, J. S., KATZ, E. AND MENZEL, H. (1966)
Medical Innovation: a diffusion study.
Bobbs Merrill. Indianapolis.
36. COLLIERE, M. F. (1986)
Invisible care and invisible women as health care providers.
International Journal of Nursing Studies, Vol. 23, No. 2, pp. 95-112.
37. CONRATH, D. W. (1968)
The role of internal organisation in decision making on R and D.
IEEE. Transactions on Engineering Management, 14.
38. CONROY, M. (1975)
Information needs of local authority planners in Ireland: a survey.
Unpublished M.A. Thesis. Department of Information Science. University of Sheffield.

39. CORMACK, D. F. S. (Ed.) (1984)
The Research Process in Nursing.
Blackwell Scientific Publications. Oxford.
40. CRANE, D. (1971)
Information needs and uses. Annual Review of Information Science and Technology.
Vol. 6, 3-39.
41. CRAWFORD, S. (1978)
Information needs and uses. Annual Review of Information Science and Technology.
Vol. 12, 62-81.
42. CROFT, S., BERESFORD, P. (1986)
Cracks in the Community.
Nursing Times 25th June 1986, p. 20.
43. CUMBERLEGE, J. (1987)
One Year On. Community Outlook.
Nursing Times, June 1987. pp. 24-25.
44. DEAN, A. (1985)
Prelude to Practice. A Study of Fieldwork Teaching and the needs of the Health Visitor
Student.
R.C.N. London.
45. DERVIN, B., NILAN, M. (1986)
Information Needs and Uses.
Annual Review of Information Science and Technology. Vol. 21, 3-33.
46. DEVLIN, R. (1986)
Sold on Cumberlege.
Community Outlook. Nursing Times. August 1986, pp. 12-14.
47. D.H.S.S. (1980)
Inequalities in Health (Black Report)
D.H.S.S. London.
48. D.H.S.S (1983)
NHS Management Enquiry (Griffiths Report)
D.H.S.S.
49. D.H.S.S (1985)
Evaluation of the micro's for G.P.'s scheme. Final Report.
H.M.S.O.
50. DIAMOND, M. (1986)
Ploughing back the profits.
Nursing Times 23rd April 1986, pp. 44-45.
51. DICKSON, N. (1987)
The Conspiracy Theorists Maybe Right - could this report be the first stage towards
dismantling the NHS?
Leader. Nursing Times. October 7. Vol. 83, No. 40, 1987.

52. DICKSON, N. (1987)
At Last the Government is taking seriously the dictum that prevention is better than cure.
Leader Nursing Times. March 4th 1987,
53. DIESING, P. (1972)
Patterns of Discovery in the Social Sciences.
Routledge and Kegan Paul, Ltd., London.
54. DOBBY, J. (1986)
Project to Evaluate Health Visiting Effectiveness - summary of Progress January 1986.
Brunel. University of West London.
55. DOBBY, J., BARNES, A. (1987)
Measuring the need for, and the value of Routine Health Visiting : 1.
Health Visitor. March 1987. Vol. 60, pp. 81-82.
56. DOBBY, J., BARNES., A. (1987)
Measuring the need for, and the value of, Routine Health Visiting : 2.
Health Visitor. April 1987. Vol. 60, pp. 114-115.
57. DOUGLAS, M. (Ed.) (1977)
Rules and Meanings.
Harmonsworth Penguin.
58. DYSON, C. (1986)
Womens Centres : the theoretical and practical constraints on the development of womens information systems.
Unpublished Masters Thesis. Department of Information Science, University of Sheffield.
59. FAWCETT-HENESY, A. (1986)
Or the safe option.
Nursing Times, 30th April, 1986.
60. FIELD, P. A., MORSE, J. M. (1985)
Nursing Research. The application of qualitative approaches.
Croom Helm
61. FITTER, M. (1986)
Evaluation of Computers in Primary Health Care : The Effect on Doctor-Patient Communication.
in Peterson, E. and Schneider, W. (Eds.) (1986) Human-computer communications in health care. Elsevier Science Publishers B. V., North Holland.
62. FORD, G. (1977)
User studies an introductory guide and select bibliography.
University of Sheffield. CRUS occasional paper no. 1. British Library Research and Development Department Report 5375.
63. FOSTER, P. M. (in Clark A. W. Ed.) (1976)
Experimenting with Organisational Life.
Plenum. London.
64. FOX, D. J. (1982)
Fundamentals of Research in Nursing.
Appleton - Century - Crofts. London.

65. FRIEDLANDER, J. (1973)
Clinical Search for Information.
Journal of the American Society for Information Science. 24:1, 65-69.
66. GALE, J. (1985)
Qualitative Research Methods in Medical Education.
Paper read at the first AMEE pre-conference workshop on Educational Research,
Prague, September 1983.
67. GARRY, A. and COWAN, J. (1986)
Learning from Experience : A tutors guide to the use of small groups in continuing
professional development.
Further Education Unit.
68. GARVEY, W. D. and GRIFFITHS, B. C. (1968)
Informal channels of communication in the behavioural sciences : their relevance in the
structuring of informal or bibliographic communication, in Montgomery, E. B. (ed.)
The foundations of access to knowledge. Syracuse University, New York. pp. 129-151.
69. GAZE, H. (1987)
CommunityCare-less
Nursing Times. January 7 1987, pp.. 20-21.
70. GIDDENS, A. (1976)
New Rules of Sociological Method.
London. Hutchinson.
71. GILBERT, S. E. (1976)
The information needs of nursing staff : a survey carried out in the Salop Area Health
Authority.
Unpublished M.Sc. Thesis. Department of Information Science. University of Sheffield.
72. GINNETY, P. (1985)
Maynard : A health profile.
Maynard Health Survey.
73. GLASER, B. and STRAUSS, A. (1967)
The Discovery of Grounded Theory : Strategies for qualitative research.
Aldine Publishing Company. New York.
74. GOODMAN, C., HALL, D. (1986)
Targets and Trends.
Nursing Times. January 8th, 1986,
75. HALL, A. M. (1972)
Comparative use and value of INSPEC Services.
IEE INSPEC. London.
76. HAKIM, C. (1980)
Integrated Social Data Systems : the role of household censuses and surveys as sources
of social, demographic and manpower data in Britain.
Social Science Information Studies 1980, 1, 13-21.
77. HAMILTON, D., JENKINS, D., KING, C., MACDONALD, B. and PARLETT, M.
(Eds.) (1977)
Beyond the numbers game.
Macmillan Education Ltd., London.

78. HAMILTON, P. (1983)
Community Nursing Diagnosis.
April 1983 *Advances in Nursing Science*, pp. 21-36.
79. HANDY, C. B. (1985) (3rd ed.)
Understanding organisations.
Penguin. Harmondsworth.
80. HARRIS, C. (1981)
The travelling workshops experiment : an attempt at "illuminative evaluation".
Social Science Information Studies, Vol. 1, No. 4, 1981, 247-253.
81. HARRISON, J. (1986)
The Workloads of Health Visitors in Sheffield.
Sheffield Health Authority.
82. HEALTH VISITORS ASSOCIATION (1985)
Health Visiting and School Nursing : the Future.
H.V.A. London.
83. HEALTHY CITIES 2000 (1987)
Sheffield Health for all by the year 2000. Draft Targets.
Sheffield 2000. Chief Executive. Sheffield City Council.
84. HERNER, S. and HERNER, M. (1967)
Information needs and uses in science and technology.
Annual Review of Information Science and Technology, Vol. 2, 1-33.
85. HILDREW, P. (1987)
Cuts? What cuts?
The Guardian. Wednesday, 14 October, 1987.
86. H.M.S.O. (Cumberlege Report) (1986)
Neighbourhood nursing - a focus for care.
H.M.S.O. London.
87. HOBAN, C. F. (1967)
Survey of professional journals in field of public communication, including new media of education.
University of Pennsylvania, Philadelphia.
88. HOUGHTON, D. (1987)
Development of caseload and community profiles.
Health Visitor, September 1987, Vol. 60, p. 298.
89. HUGHES, J. (1980)
The Philosophy of Social Research.
Longman. New York.
90. HUNT, J. (1979)
Managing People at Work.
London. Pan.
91. HUNT, M. (1982)
A Critique of the Neighbourhood Study in Health Visitor Training.
Health Visitor, October, 1982, Vol. 55, pp. 521-525.

92. HUNT, M. (1982)
Caseload Profiles - An alternative to the neighbourhood study.
Health Visitor, November 1982, Vol. 55, pp. 606-607.
93. HUNT, M. (1982)
Caseload Profiles : Their implications for evaluating Health Visiting practice.
Health Visitor, December, 1982, Vol. 55, pp. 662-665.
94. HUNT, M. (1987)
The process of translating research findings into nursing practice.
Journal of Advanced Nursing, 12, 101-110.
95. HYDE, P. (1986)
Computer Speak.
Nursing Times, June 18, 1986, pp. 44-45.
96. HYSLOP, M. R. and CHAFE, H. D. (1967)
User appraisal of an information system and services through a programme of joint applied research.
In Schechter G. Ed. Information retrieval - a critical view. Thompson. Washington DC.
97. IGERSEIM, R. H. (1976)
Managerial Response to an Information System
in. Winkler S. ed. Proceedings of the American Federation of Information Processing Societies. Vol. 45. 877-882. New York. AFIPS Press.
98. JARMAN, B. (1983)
Identification of under privileged areas.
British Medical Journal 28th May, 1983, 286, 1705-1709.
99. JOLLY, C., GALE, J. (1976)
Statistical significance : its appropriate use.
Medical Education 10. 410-411.
100. JONES, M. (1988)
Health Visiting : the time has come to define the job more clearly.
Letter to the Nursing Times, January 20-26, Vol. 84, 3, p. 11.
101. KATTER, R. V. (1969)
Design and evaluation of Information Systems.
Annual Review of Information Science and Technology. Vol. 4, 31-70.
102. KATZ, D. and KAHN, R. L. (1966)
The Social Psychology of Organisations.
Wiley and Sons, USA.
103. KEGAN, D. L. (1970)
Measures of the usefulness of written technical information to chemical researchers.
Journal of the American Society for Information Science. 21, 3, 179-186.
104. KENNEDY, I.
The Reith Lecture : unmasking medicine. We must become the masters of medicine not its servants.
The Listener, 6th November 1980. pp. 600-604.

105. KERSHAW, B. and SALVAGE, J. (Eds.) (1986)
Models for Nursing
John Wiley and Sons, Ltd., Chichester.
106. KILTY, J. A. (1976)
Can nursing research learn from educational research?
International Journal of Nursing Studies, 13, 97-102.
107. KING, D. W., PALMOUR, V. E., (1974)
User Behaviour.
In: National Information Retrieval Colloquium, 10th Philadelphia Pennsylvania 3-4 May 1973. Proceedings. Changing patterns in Information Retrieval. Ed. FENICHEL C. American Society for Information Science, Washington DC, 7-33.
108. KIRKPATRICK, D. L. (1985)
How to Manage Change Effectively.
Jossey-Bass. London.
109. KLEIN L. and TOMLINSON, P. (1987)
Patchwork.
Nursing Times, July 1, Vol. 83 No. 26 1987 pp. 39-40.
110. KLEIN, L. and TOMLINSON, P. (1987)
Sharing the caring.
Nursing Times, July 8th. Vol. 83, no. 27, 1987. pp. 60-61.
111. KRATZ, C. (1986)
The Radical Solution
Nursing Times 30th April, 1986. p. 18.
112. LANCASTER, F. W. (1969)
MEDLARS: report on the evaluation of its operating efficiency.
American Documentation 20, 2, 119-142.
113. LANGRISH, J., GIBBONS, N., EVANS, E. G., JEVONS, F. R. (1972)
Wealth from knowledge.
Macmillan, London.
114. LEDSHAM, I. (1978)
Half the problem is knowing who to ask: a study of community information provision in the Heeley district of Sheffield.
Unpublished MA Thesis. Department of Information Science. University of Sheffield.
115. LEGGATE, P., SMITH, B., STOW, U., WILLIAMS, M. I. (1972)
The BA Previews Project: The Development and Evaluation of a Mechanised SDI Service for Biologists. University of Oxford, Experimental Information Unit, Oxford, England.
116. LEWIN, K. (1947)
Frontiers in group dynamics. 1. Concept, method and reality in Social Sciences: Social equilibria and social change. 2. Channels of group life: social planning and action research.
Human relations. 1: 5-41, 143-153.
117. LIN, W. D.
Information needs and views.
Annual Review of Information Science and Technology, Vol. 7. 5-37.

118. LINE, M. B. (1963)
Student attitudes to the university library : a survey at Southampton University.
Journal of Documentation 19, 3, 100-117.
119. LINE, M. B. (1971)
The information uses and needs of social scientists: an overview of INFROSS.
Aslib. proceedings 23:8 414-434.
120. LINE, M. B. (1974)
Draft Definitions. Information and library needs, work, demands and uses.
ASLIB Proceedings 26 no. 2. pp. 86-87 (1974).
121. LINE, M. and TIDMARSH, M. (1966)
Student Attitudes to the University Library: A second survey at Southampton University.
Journal of Documentation 22, 123-135.
122. LIPETZ, B. (1970)
Information needs and uses.
Annual Review of Information Science and Technology. Vol. 5, 3-32.
123. LIPPIT, R. (1959)
Dimensions of the consultants job.
Journal of Social Issues 15. 5-12.
124. LOEWENSTEIN, P. (1984)
A Testing Case. State Incorporation of Community Work.
Community Development Journal 19(3) p. 158-165.
125. LUKER, K. and ORR, J. (Eds.) (1985)
Health Visiting.
Blackwell Scientific Publications.
126. LUND, A. B. and CHRISTENSEN, J. M. (1986)
Future Workshops in Health Care - a Social Experiment?
Paper presented at the CEC FAST international conference on Social Experiments with Information Technology, Odessa University 13-15 January 1986.
127. MACLEOD CLARK, J., HOCKEY, L. (1979)
Research for nursing. A guide for the enquiring nurse.
H. M. & M. Aylesbury.
128. MARTIN, T. H. (1973)
The user interface in interactive systems.
Annual Review of Information Science and Technology,, Vol. 8, 204-219.
129. MARTYN, J. (1975)
Information needs and uses.
Annual Review of Information Science and Technology, Vol. 9 3-23.
130. McNALLY, C. E. (1985)
A community information unit: the development of support services to community information provision in Sheffield City Libraries.
M.A. in Librarianship Unpublished Thesis. Department of Information Science. University of Sheffield.

131. McWILLIAMS, B., WELLINGS, A. (1985)
The Nurse and Research : concepts and constraints.
Studies in the Education of Adults 17 (2) 1985.
132. MAZRUI, A. (1987)
Thinking Aloud.
BBC2 26.11.87.
133. MENZEL, H. (1966)
Information needs and uses.
Annual Review of Information Science and Technology, Vol. 1 41-69.
134. MERTON, R. (1968)
The Matthew Effect in Science.
Science 159, 5.1.68, 56-63.
135. MINTZBERG, H. (1973)
The Nature of Managerial Work.
Harper & Row, New York.
136. MOSER, C. A. and KALTON, G. (1971)
Survey Methods in Social Investigation
Gower. Aldershot.
- 136a. MUNHALL, P. L. and DILER, C. J. (1986)
Nursing Research, A Qualitative Perspective.
Norwalk. Appleton-Century-Crofts.
137. MYERS, S., MARQUIS, D. G. (1969)
Successful industrial innovations : a study of factors underlying innovation in selected firms.
National Science Foundation publication NS69-17. US Government Printing Office, Washington, DC.
138. NEILL, S. D. (1987)
The Dilemma of the subjective in information organisation and retrieval.
Journal of Documentation, Vol. 43, 3, 193-211.
139. NELSON, J. (1973)
Faculty Awareness and Attitudes towards Academic library Reference Services : A Measure of Communication.
College and Research libraries 35:5, 268-275.
140. NORMAN, A. (1987)
Divided we fall.
Nursing Times, April 29, Vol. 83, no. 17, 1987, pp. 16-18.
141. OATES, J. F. (1968)
Convention theme : levels of interaction between man and information.
American Documentation 19: 3: 290-294.
142. O'BROLCHAIN, D. (1973)
Information for planning : an initial study of data collection by the Department of Education in respect of primary schools in Ireland.
Unpublished M.Sc. Thesis. Department of Information Science. University of Sheffield.

143. O'GARA, P. W. (1968)
Physical location as a determinant of communication possibility among R and D engineers.
S.M. Thesis. Alfred P. Sloan school of Management, M.I.T., Massachusetts.
144. ORR, J. (1980)
Health Visiting in Focus.
R.C.N. London.
145. ORR, J. (1983)
Is health visiting meeting today's needs?
Health Visitor. June 1983, pp. 200-203.
146. ORR, J. (1987)
Never mind the quality.
Nursing Times, April 15th, 1987.
147. ORTON, H. (1986)
Ward sister development project. Proposal for Research.
Sheffield City Polytechnic.
148. PAISLEY, W. J. (1968)
Information needs and uses.
Annual Review of Information Science and Technology, Vol. 3, 1-30.
149. PALMOUR, V. E., BELLASSAI, M. C., DEWATH, N. V. (1980)
A Planning Process for Public Libraries.
American Library Association. Chicago.
150. PARKER, E. B., LINGWOOD, D. A., PAISLEY, W. J. (1968)
Communication and research productivity in an interdisciplinary behavioural science research area.
Institute for Communication Research, Stanford University.
151. PARLETT, M. (1981)
Illuminative evaluation. pp. 219-226 in Reason P., Rowan, J. (Eds.) Human Inquiry. A source book of new paradigm research.
John Wiley. Chichester.
152. PATRICK, K. C. (1977)
Information systems for legislators : research and information services.
Unpublished MA Thesis. Department of Information Science. University of Sheffield.
153. PETERSON, D. R. and THOMAS, D. B. (1978)
Fundamentals of Epidemiology
Lexington Books, Lexington, Mass.
154. PELZ, D. C. AND ANDREWS, F. M. (1966)
Scientists in organisations: Productive climates for research and development.
Wiley, New York.
155. PILGRIM, C. (1987)
Processing clients and colleagues.
Nursing Times, January 7, 1987, pp. 44-45.

156. PRICE, D. J. S. (1970) Citation measures of hard science, soft science technology and non science.
In Nelson, C. E., and Pollock, D. K. Eds. Communication among scientists and engineers. Health Lexington Books, Massachusetts.
157. REASON, P., ROWAN, J. (Eds.) (1981)
Human Inquiry. A sourcebook of New Paradigm Research.
John Wiley & Sons, Ltd. Chichester.
158. ROBERTS, H. E. (Ed.) (1981)
Doing Feminist Research.
Routledge & Kegan Paul. London.
159. ROBERTS, N. (1976)
Social considerations towards a definition of information science.
Journal of Documentation, Vol. 32, 4, 249-257.
160. ROBERTS, N. (1982)
A search for information man.
Social Science Information Studies 1982, 93-104.
161. ROBINSON, J. (1982)
An Evaluation of Health Visiting.
C.E.T.M.H. London.
162. ROGERS, J. (1987)
Limited Opportunities.
Nursing Times, September 9, Vol. 83, no. 36, pp. 31-32.
163. ROSEN, M. (1986)
Community Diagnosis. An epidemiological approach for planning to primary health care.
Swedish Planning and Rationalisation Institute of Health Services.
164. ROSSENBERG, K. C. (1969)
Evaluation of an industrial library : a simple minded technique.
Special Libraries 60:10. 645-638.
165. ROWBOTTOM, R. and BILLIS, D. (1977)
The stratification of work and organisational design.
Human Relations, Col. 30, no. 1, 1977, pp. 53-76.
166. ROYAL COLLEGE OF NURSING (1986)
A Manifesto for Nursing and Health.
RCN, London.
167. RUFFLE, H. (1987)
Training for Health.
Nursing Times, February 11, 1987, pp. 59-60.
168. SADDINGTON, N. (1984)
The Körner Report Five: Putting Körner into practice.
Nursing Times. May 30th, 1984, pp. 53-55.
169. SALVAGE, J. (1985)
The Politics of Nursing.
Heinemann Medical Books. London.

170. SANDERS, I. T. (1975)
The Community.
Macmillan, New York.
171. SCHERER, J. (1972)
Contemporary Community. Sociological Illusion or Reality.
Tavistock Press.
172. SCRIVENS, E. (1985)
Policy Power and Information Technology in the National Health Service.
University of Bath, Bath.
173. SHEFFIELD CITY COUNCIL (1983)
Areas of Poverty in Sheffield. Report to the Urban Strategy Panel 13th September 1983.
Department of Planning and Design. City of Sheffield.
174. SHEFFIELD CITY COUNCIL (1987)
Healthy Cities 2000 : Sheffield Targets.
July 1987, Sheffield City Council.
175. SHEFFIELD HEALTH AUTHORITY (1986)
Health Care and Disease, A Profile of Sheffield
Sheffield Health Authority
176. SHEFFIELD HEALTH AUTHORITY (1986)
Providing a Personal Service.
Sheffield Health Authority.
177. SLATER, M. and KEENAN, S. (1967)
Results of a questionnaire on current awareness methods used by physicists prior to
publication of "Current papers in physics".
American Institute of Physics Report. AIP/CPP/I.
178. SLATER, M. (1968)
Meeting the users' needs within the library.
In Burkett, J. Ed. Trends in special librarianship.
Clive Bingley. London.
179. SMITH, A. C. (1966)
Communication and status : the dynamics of a research centre.
University of Oregon, Centre to the Advanced Study of Educational Administration.
Eugene Oregon.
180. SMITH, D. C. (1978)
The information needs of physiotherapists.
Unpublished MA Thesis. Department of Information Science. University of Sheffield.
181. SMITH, L. (1987)
Doctors rule, O.K?
Nursing Times, July 29, Vol. 83, no. 30, 1987, pp. 49-51.
182. SPENCER, L., DALE, A. (1979)
Integration and Regulation in Organization : A contextual approach.
Sociological Review Vo. 27, no. 4, pp. 679-702.

183. STEERING GROUP OF HEALTH SERVICES INFORMATION (1982)
A report from Working Group E.
London. DHSS.
184. STEERING GROUP ON HEALTH SERVICES INFORMATION (Draft 1984)
Fifth Report of the Secretary of State.
London. DHSS.
185. STREATFIELD, D. (1982)
Community Workers and Information: from national resources to neighbourhood advice.
Social Science Information Studies 1982, 2, 23-37.
186. STUFFLEBEAM, D. I. et al. (1971)
Educational evaluation and Decision Making.
F. E. Peacock. Illinois.
187. TAGLIACCOZZO, R., KOCHEN, M., EVERETT, W. (1971)
The use of information by decision makers in public service organisations.
American Society for Information Science. Annual meeting 34th Denver Colorado 7-11 November 1971. Proceedings Vol. 8 : Communication for decision makers. Greenload Publishing Corp. Westport Connecticut 53-57.
188. THUNHURST, C. (1983)
Poverty and Health in the City of Sheffield.
Environmental Health Department, Sheffield City Council.
189. TOWELL, D. (1979)
A 'social systems' approach to research and change in nursing care.
International Journal of nursing studies, vol. 16, pp.. 111-121.
190. TREECE, E. W., TREECE, J. W. (1977)
Elements of Research in nursing.
Mosby. St. Louis.
191. TUCKER, W. J. (1979)
The nature of a community, in Fromer M. J. (Ed.) Community Health Care and the Nursing Process.
Mosby. St. Louis.
192. TURNER, B. A. (1981)
Some practical aspects of qualitative data analysis: one way of organising the cognitive processes associated with the generation of grounded theory.
Quality and Quantity IS (1981) 225-247.
193. TURNER, B. A. (1981)
The use of grounded theory for the qualitative analysis of organizational behaviour.
Journal of Management Studies 20, 3, 1981, pp. 333-348.
194. TUSHMAN, M. L. (1977)
Special Boundary roles in the innovation process.
Administrative Science Quarterly 22, pp. 587-605.
- 194a. UNITED KINGDOM CENTRAL COUNCIL FOR NURSING MIDWIFERY AND HEALTH VISITING (1986)
Project 2000, a new preparation for practice.
UKCC

195. VERNON, C. (1984)
An investigation into the information needs of probation staff in the South Yorkshire Probation Service.
MSC Information Studies. University of Sheffield .
196. WALKER, R. (1980)
Making sense and losing meaning.
in Simon, J. ed. Towards the science of the singular. University of East Anglia Centre for Applied Research in Education, pp. 224-235.
197. WARNER, E. S., MURRAY, A. D. and PALMOUR, V. E. (1973)
Information needs of urban residents : final report
US Department of Health Education and Welfare, 1973.
198. WELLS PARK HEALTH PROJECT (1984)
Wells Park Health Survey.
Wells Park Health Project.
199. WEST, M. A., RUSHTON, R. (1986)
Nurse learners : In at the deep end.
Unpublished paper. MRC/ESRC Social and Applied Psychology Unit, University of Sheffield.
200. WEST, M. A., SAVAGE, Y. (1987)
The Experience of Health Visiting
MRC/ESRC Social and Applied Psychology Unit. University of Sheffield.
201. WHITE, R. (1987)
Health Visitors : The Willing Horses
Health Visitor, May 1987, Vol. 60, pp. 163-168.
202. WHITEHEAD, D. (1987)
The Health Divide : Inequalities in health in the 1980s.
Health Education Council, London.
203. WILLIAMS, S. C. (1984)
An investigation of information service in the probation service to assist developments in the library and information unit, South Yorkshire Probation Service.
Unpublished Masters Thesis. Department of Information Science. University of Sheffield.
204. WILSON, H. (1986)
Caseload Profile.
Health Visitor, February 1986, Vol 59, p. 40.
205. WILSON, T. O. (1984)
The Cognitive Approach to Information Seeking Behaviour and Use.
Social Science Information Studies 4 197-204.
206. WILSON, T. D. (1985)
Information needs and the design of information systems.
in Research and Information in the Probation Service : Papers from Course (Midlands Regional Staff Development Office of Probation Service 7-11 January 1985. University of Sheffield.

207. WILSON, T. D., STREATFIELD, D. R. and MULLINGS, C. (1979)
Information needs in local authority social service departments : a second report on project INISS.
Journal of Documentation Vol. 35, 2, 120-136.
208. WOOD, D. (1969)
Discovering the user and his information needs.
Aslib Proceedings 21:7. 262-270.
209. WOOD, F. E., THOMAS, S. (1985)
How occupational health nurses gather information : some results of a study.
Department of Information studies, University of Sheffield.
210. WOOD, J. and RONAYNE, J. (1972)
Scientific and Technical News Periodicals.
University of Manchester, Department of Liberal Studies in Science, Manchester, England.
211. WRAGG, G. C. (undated)
Rediguide 11. Conducting and analysing interviews.
Nottingham University School of Education.
212. YOUNGMAN, M. B. (undated)
Rediguide 12. Designing and Analyzing Questionnaires.
Nottingham University School of Education.
213. ZALTMAN, G. (1968)
Scientific recognition and communication behaviour in high energy physics.
Thesis. American Institute of Physics. New York.

APPENDIX Ia

INTRODUCTORY LETTER TO HEALTH VISITORS

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

*Telephone Sheffield
(STD Code 0742)*

PLEASE REPLY TO: Joan Harrison, Research Nurse

9th April, 1986.

Dear

I am planning a new piece of research about the information and planning needs of field level health visitors. I am looking for a group of about thirty health visitors for whom the main part of their caseload is on a GP's age/sex register. I am then going to interview those health visitors who wish to take part, all about their caseload, the area where they work, and how they plan their work.

After that I'll hold discussion groups and give those health visitors information sheets about their areas - providing things like census data, and adult health information which is locally relevant. There should be about three discussion groups all together. Then I'll interview all those health visitors again to see if there are any alterations in the way they would like to plan their work. The health visitors themselves would contribute information such as the number of people in a particular age band, or local neighbourhood resource information. Interview information would of course be confidential.

You are quite free to refuse to take part - but I think it may turn out to be very interesting. It does not compete with the research on stress, which will be going on, as the information and planning research will be starting as the stress research finishes.

Of the thirty health visitors taking part I would like to draw a group of nine or so to form a working party to help run the project. The health visitors on the last working party very much enjoyed the involvement, do talk to them if you want to know more about it. If you are on the working party you are in an advisory capacity to me and I do the work! It would probably mean five or six meetings over the next twelve months.

Any input into the research for health visitors would be within working time, I have management approval to say this. I have high hopes for the outcome of the research. I think we might make our voices heard and I think we could generate ideas about creative health visiting. It is certainly going to be lot easier on health visitors than the last study and I hope that you will find that taking part supportive.

The study will not start until July/August but what I need to know at the moment is whether you would like to take part and whether you would like to join the working party. My intention is to support your work and not to cause unnecessary additional work.

I was asked at a recent unit meeting what is being done about the findings of the work-loads study. Although you already have the findings, the managers in charge of resources do not yet have their copies. This is because I agreed to bring it back to you first. The workloads study will be going, not only to our own nursing managers, but also to people like Miss Dargue and the District General Manager, Mr. Harper. When they have read it our managers are in a position to argue for changes in resources and conditions.

I enclose a reply slip for the information and planning study. I would be grateful if you would let me have it back by Friday 18th April, 1986. I am willing to answer any questions, come out to your health centres or you can find me on Tel: 685323.

I understand that in 18th Months time a population register of the whole of the city will be held jointly by the Family practitioner Committee and the Health Authority - if this piece of research works, all the Sheffield Health Visitors could have really good community profiles so we can plan and demonstrate our need for further resources and maybe influence policy from the field.

Interested?

Thank You.

Yours sincerely,

Joan Harrison,
Research Nurse.

Joan Harrison,
Research Nurse,
Johnson Memorial Home.

Reply slip; The Information and Planning Needs of Health Visitors.

- | | | |
|----|--|--------|
| 1. | Is most of your caseload on a GP's age/sex register? | YES/NO |
| 2. | Would you be happy to take part in the research? | YES/NO |
| 3. | Would you like to be on the working party? | YES/NO |

Name:

Health Centre:

APPENDIX Ib

SECOND LETTER TO HEALTH VISITORS

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

Telephone Sheffield
(STD Code 0742)

PLEASE REPLY TO: Joan Harrison, Research Nurse

9th April, 1986.

Dear

Thank you very much for offering to take part in my new study "The information and planning needs of Health Visitors". Between June and September, I will be asking you for an appointment so that I can come and interview you for an hour, after that there will be a series of workshops about Health Visitor information. Finally I will interview you again.

So that I can explain more about the study, I would like to arrange for all of us taking part to meet together, I would therefore be grateful if you would tick the sessions in the week that are generally best for you to attend meetings. (Paper 1)

Secondly, so that I can get tailor made information for you about your Health Visiting patch, please could you send me a list of all the roads and streets where you visit clients at the moment. If you know the post code please fill it in, if you do not leave a blank, and I will look it up. (Paper 2)

You may wonder if there is a separate working party. After due consideration with my supervisors, because of the method I am using, all the people in the study are the working party as well. It means that everyone has an equal say and there is no elite.

Please could you return Paper 1 and Paper 2 to me by Friday 4th July 1986. I will arrange a meeting as soon as I can, when I know which are the best days for everyone.

Thank you for your help

Best wishes,

Joan Harrison
Research Nurse

JH/EMP

PAPER 1

The sessions during the week which are best for you to attend meetings. Please tick the sessions you are generally available.

| | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|------|--------|---------|-----------|----------|--------|
| A.M. | | | | | |
| P.M. | | | | | |

NAME:

Work Telephone Number:

PAPER 2

Health Visitor's Name:

G.P.'s Names and Addresses:

Please would you provide me with a list of roads/streets on which you visit clients. If you know the postal code please fill it in, if not leave a blank.

| Name of Road/Street | Postcode | Electoral Ward |
|---------------------|----------|----------------|
| | | |

APPENDIX IIa

INTRODUCTORY LETTER TO MANAGERS

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

PLEASE REPLY TO: Joan Harrison, Research Nurse

Telephone Sheffield
(STD Code 0742)

9th April, 1986.

Dear

As you are aware, I am commencing a new research project about the information and planning needs of Health Visitors. In order to get the widest possible understanding of some of the relevant issues, I would like to discuss them with you and tape record your responses. This would form part of the research.

Confidentiality will be maintained in the summarising report and only I will hear the tape recording.

I think your input into this research could be very valuable, and I would be grateful if you assist me. I envisage that the discussion would take about an hour and would take place wherever is most convenient for you, with the provision that we be uninterrupted for that period. I anticipate that I would ask your co-operation for a second discussion towards the end of the research. I am asking all those in direct management of the Health Visitors to take part.

Please could you let me know whether you would be willing to be involved.

Thank you.

Yours sincerely,

Joan Harrison
Research Nurse

JH/EMP

APPENDIX IIb

LETTER TO GENERAL MANAGER AND DIRECTOR OF NURSING SERVICES

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

Telephone Sheffield
(STD Code 0742)

PLEASE REPLY TO: Joan Harrison, Research Nurse

Tel. No. 685232

Community Headquarters
12 Lyndhurst Road
Nether Edge

9th July 1986

Dear

As you are aware, I am commencing a new research project about the information and planning needs of Health Visitors. In order to get the widest possible understanding of some of the relevant issues, I would like to discuss them with you and tape record your responses. This would form part of the research.

In view of your position in the organisation, although I will not use your name in the summarising report, it will be more difficult than is normally the case to ensure complete confidentiality. However, I can assure you that only I will hear the tape recording, and if you wish, I could provide you with the partial transcript of the discussion, which you could edit prior to analysis.

I think your input into this research could be very valuable, and I would be grateful if you assist me. I envisage that the discussion would take about an hour and would take place wherever is most convenient for you, with the provision that we be uninterrupted for that period, I anticipate that I would ask your co-operation for a second discussion towards the end of the research. I am asking all those in direct management of the Health Visitors to take part.

Please could you let me know whether you would be willing to be involved.

Thank you.

Yours sincerely,

Joan Harrison
Research Nurse

JH/EMP

APPENDIX III

INTERVIEW SCHEDULE FOR HEALTH VISITOR SAMPLE

I am going to ask you some questions about your work. Altogether it will take about an hour. I do not think there are any right answers, I would just like to hear what you really think. I want to tape record it so that I can remember in detail what you say. I am interviewing 31 Health Visitors like this, and then I will summarize what everyone says. No one but me will listen to this tape recording, so no-one one can link you with the summary I write when I have finished. Is that all right?

Is there anything you would like to ask before I switch the tape on?

INTERVIEW SCHEDULE

1. How long have you worked as a Health Visitor?
2. Which college did you train in as a Health Visitor?
3. Have you done any work other than nursing, midwifery and health visiting? What other work have you done?
4. How many different caseloads have you worked on since qualifying as a Health Visitor?
5. Do you work part time or full time?

If part time, how many wholetime equivalent hours?
6. Quite often people who do not know much about health visitors say they do not know what they do. Could you explain to me what you think the purpose of health visiting is?
7. What groups of clients should be contacted by Health Visitors?
8. When you start work in a Health Visiting job, what do you need to know about the community you visit before you start?
9. What information were you given when you took over this caseload, by the previous Health Visitor, Senior Nurse or colleagues? Did you overlap with the previous Health Visitor?
10. There are many possible sources of referral of clients, would you tell me how or from whom you get the names and addresses of clients that you then visit?
11. What groups of clients do you contact on your patch? Can you identify any other health needs?
12. What groups of clients would you like to contact?
13. What are the preventable causes of ill health on your patch? Can you identify any other health needs?
14. How do you know there are the health needs on your patch?
15. The previous study I did, showed that there is one Health Visitor to about 5½ thousand people in Sheffield, with an average caseload you might contact up to a thousand individuals, including the immediate relations of your clients. How do you know the health needs of the other 4½ thousand people in your patch?
16. Are there any policies or guidelines laid down by management about which clients you should see?

If YES what are these policies or guidelines?

If NO researcher describes visiting pattern, asks if it is familiar.
17. Is the visiting pattern I have described, relevant to the needs of the people who live on your health visiting patch? Could you tell me a bit more about that?
18. Do you keep this pattern, or do you have a personal set of guidelines which you use?

19. Do you plan your work?
Tell me how you do that, what do you bear in mind?
20. Is there any information you would like that would improve the way you plan your work?
What sort of information is that?
21. Do you use your G.P.'s age/sex register?
What do you use it for?
22. If you viewed your caseload as the whole population on your G.P.'s age/sex register, what information would you want from it?
23. If you had twice as much time, what would be the best health visiting use of it you can think of?
24. Since you trained, have you done any reading, training, received teaching or had any incident happen to you that has made you alter the way you organise your work?
Tell me about it.
25. Do you enjoy being a Health Visitor?
26. Do you enjoy working on this caseload?
27. How do you know when you are doing the job well?
28. What would help you to be more enthusiastic and effective in the job?
29. Is there anything else you would like to tell me?

Traditional Visiting Pattern of Health Visitors in Sheffield

Ante-natal visit.

Newbirth visit (10-11 days post-natally)

4 week survey (for the sudden infant death study)

6 week medical

3 months developmental assessment

6 months medical

7-9 months hearing test

9 months developmental assessment

18 months developmental assessment

3 year developmental assessment

4 year developmental assessment

Pre-school visit

In addition children are seen in infant welfare clinics whenever the parent wishes and attend for vaccination to either their G.P. or the infant welfare clinic.

APPENDIX IV

INTERVIEW SCHEDULE FOR SENIOR NURSE SAMPLE

INTERVIEW SCHEDULE - SENIOR NURSES

1. What is the purpose of the health visiting service?
2. What groups of clients should be contacted by health visitors?
3. What information should health visitors have before they commence work on a patch?
4. What do you consider to be the main causes of preventable illness in the area of Sheffield you cover?
5. How do you know?
6. Are there any policies or guidelines laid down by management about which clients health visitors should see?
7. What are these policies or guidelines?
8. Can you distinguish between policy and guideline?
9. Are they written down in a place accessible to the Health Visitors?
10. Are these relevant to the most important health needs in Sheffield in your view?
11. How do you think Health Visitors plan their work?
12. Is there any information, which, if it were readily available to field workers would improve their ability to plan their work?
13. If you had twice as much time available, what would be the best use of it for the health visiting service?
14. What information would you like in your own job which you lack at the moment?
15. How do you think this could be provided?
16. How do you know when you are doing your job well?
17. How do the Health Visitors know when they are doing their jobs well?
18. What would help you to be more enthusiastic and effective in this job?
19. What would help the Health Visitors to be more enthusiastic and effective in their jobs?
20. When a Health Visitor brings you a plan of a new way of working they would like to try, how do you react?

21. Is there any way in which we could use planning or information to improve the service that you can think of?
22. What power and responsibilities do you have in the planning process of the health visiting service?
23. Is there anything else you would like to add?

APPENDIX V

INTERVIEW SCHEDULE FOR GENERAL MANAGER

INTERVIEW SCHEDULE - GENERAL MANAGER

1. How do you see your role in relation to the health visiting service?
2. What do you think the health visiting service is there to do?
3. How do you think health visitors find out where their clients are?
4. How do they decide which clients they will visit?
5. If health visitors can demonstrate that they are understaffed in relation to client need and the job they are trained to do, what do you think they should do about it?
6. Is there any way that you feel you could contribute to an improved health visiting service?
7. How do you think the regional recommendations about applying morbidity figures and health indicators to the improved prevention of illness in Sheffield could be achieved?
8. Do you foresee any alternative forms of funding for health visiting?
9. Do you think the setting up of a jointly held FPC/Health Authority client information system for the health visiting service is a feasible proposition?
10. It has recently been suggested that all immunisations should be done by G.P.'s. What do you see as the future role of the Child Health Clinic?
11. Do you feel you can adequately represent the health visiting service with the information you have now, or would you like more information?
12. How do the managers of the health visiting service know when they are doing their job well?
13. Is there anything else you would like to add?

APPENDIX VI

EVALUATION QUESTIONNAIRE

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

PLEASE REPLY TO: Joan Harrison, Research Nurse

Telephone Sheffield
(STD Code 0742)

Dear

Re: Health Visitor Evaluation Questionnaire

Thank you for taking part in the Information and Planning Project. This brief questionnaire is to evaluate the effects, problems and benefits of this project. I would be grateful if it could be returned to me at Johnson Memorial Home by Thursday 6th October. Because the project is drawing to a close it is important that the replies are in by this date at the latest. I have greatly appreciated your support for this work and hope it will contribute towards improved health visiting practice and working conditions for health visitors.

Best wishes,

Joan Harrison
Research Nurse

HEALTH VISITOR EVALUATION QUESTIONNAIRE

1. Did you learn anything new about your area from participating in the project?
2. In particular did you identify any new health needs? If so what were these health needs?
3. Have you become aware of any new client groups you would like to contact? What groups were they?

7. Are there any improvements you would like to suggest in the provision of information for health visitors?

8. Please would you write a brief plan of work for your area on the form provided.

Notes for completing the form

- A. Identify a health need, supporting it with reasons why you think it is a health need. e.g. post natal depression, the need for some form of health education.
- B. A target client group, e.g. teenage mothers, men of 65 years.
- C. A plan of activities, e.g. series of groups, clinics, or a new visiting pattern appropriate for that client group. You might want to add time of day and venue.
- D. Resources or costs. e.g. your own time, equipment, other personnel.
- E. Timescale, e.g. 6 months project, one year, six weeks.
- F. Describe how you would evaluate the effectiveness of your programme, e.g. reduction in gastro-enteritis admissions, feedback from clients.

9. Have you learnt anything from the project - what benefits or problems has it caused?
Please add anything else you would like to say.

APPENDIX VII

WORKSHOP INFORMATION PROVIDED FOR HEALTH VISITOR SAMPLE

BETTS, G. (1985)

Health in Glyndon. Report of a survey on health in Glyndon Ward, Greenwich.
Greenwich Health Rights Project.

CARR, G. (1982)

Making a Health Profile of an Area.
Health Visitor June 1982, Vol 55, p. 309.

CATFORD COMMUNITY HEALTH PROJECT(1982)

Report for 1982: First year of the project Health Education Council.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1986)

DHSS Performance indicators for the NHS. Sheffield Health Authority.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1987)

Analysis of Age Group Attendance Patterns by Family Planning Clinic 1986.
Sheffield Health Authority.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1987)

Analysis of Contraceptive Methods by Family Planning Clinic. 1986.
Sheffield Health Authority.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1987)

Child Health Clinic Statistics for 1/86 to 12/86.
Sheffield Health Authority.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1987)

Dental Disease by Age and Postal District.
Sheffield Health Authority.

COMMUNITY UNIT, SHEFFIELD HEALTH AUTHORITY (1987)

Doctor Session/Attendance Analysis by Family Planning Clinic 1986.
Sheffield Health Authority.

CHILD DEVELOPMENT PROJECT (1984)

Child Development Programme.
University of Bristol.

DAUNCEY, J. (1986)

Community Profile: Example to be tested.
Oxford Health Authority.

D.H.S.S. (1986)

A Guide to Health and Social Services Statistics.
D.H.S.S.

DRENNAN, V. (1985)

Working in a different way.
Community Nursing Service, Paddington and North Kensington Health Authority.

GINNETY, P. (1985)
Maynard: A Health Profile.
Maynard Health Survey.

HEALTH VISITORS ASSOCIATION (1985)
Health Visiting and School Nursing: the Future.
HVA. London.

HUNT, M. (1982)
A Critique on the neighbourhood. Study in Health Visitor Training.
Health Visitor October 1982. Vol. 55, pp. 521-525.

HUNT, M. (1982)
Caseload Profiles - An alternative to the neighbourhood study,
Health Visitor Nov. 1982, Vol. 55, pp. 606-607.

HUNT, M. (1982)
Caseload Profiles: Their implications for evaluating Health Visiting practice.
Health Visitor. Dec. 1982, Vol., 55, pp. 662-665.

KNIGHT, A. (1985)
Community Profile. Unpublished project for Sheffield City Polytechnic Fieldwork Teachers
Course.
Department of Health Studies. Sheffield City Polytechnic.

LUKER, K. and ORR, J. (Eds.) (1985)
Health Visiting.
Blackwell Scientific Publications.

OPCS (1986)
Vital Statistics for Wards 1981, 1982, 1983, 1984, 1985. Office of Population Censuses and Surveys.
Crown.

OPCS (1985-86)

Including:

General Household Survey 1985.
Legal abortions 1985.
Rubella associated terminations of pregnancy 1986.
Hospital in-patient enquiry 1979-1984.
Adoptions in England and Wales 1984.
Live births during 1985, and first half of 1986.
Fertility Trends in England and Wales 1975-1985.
Births by birthplace of mother 1985.
Trends in conception 1974-1984.
Births by birthplace of parents 1985.
Mid 1985 population estimates for local government and health authority
areas of England and Wales.
Deaths by birthplace of deceased 1985.
Deaths by cause 1985.
Infant and pre-natal mortality 1984: birthright.
Cancer survival 1978-80 registrations, and 1980-81 registrations.
Deaths from accidents and violence 1985.
Annual review of communicable diseases 1983.
Infectious diseases March quarter 1985.

Office of Population Censuses and Surveys.

PEOPLE'S CAMPAIGN FOR HEALTH (1986)

Sheffield's Health. Could we care less?

People's Campaign for health, c/o 46, Blayton Road, Sheffield.

SHEFFIELD CITY COUNCIL (1981)

Census Report 1-21.

Central Policy Unit. Sheffield City Council.

SHEFFIELD CITY COUNCIL (1981)

Constituency Profiles: Hallam, Hillborough, Brightside, Central, Attercliffe, Heeley.

Central Policy Unit. Sheffield City Council.

SHEFFIELD CITY COUNCIL (1981)

Map of Sheffield : Electoral Wards and Enumeration Districts.

Sheffield City Council.

SHEFFIELD CITY COUNCIL (1983)

Areas of Poverty in Sheffield. Report to Urban Strategy Panel, 13 September 1983.

Department of Planning and Design. City of Sheffield Metropolitan District Council.

SHEFFIELD CITY COUNCIL (1983)

Enumeration District data.

Department of Planning and Design. Sheffield City Council.

SHEFFIELD CITY COUNCIL (1983)

Review of Priority Areas of Deprivation - Methodology.

Department of Planning and Design. City of Sheffield Metropolitan District Council.

SHEFFIELD CITY COUNCIL (1984)

Environmental Health. Report for the City of Sheffield.

Department of Environmental and Consumer Services. Sheffield City Council.

SHEFFIELD CITY COUNCIL (1985)

Environmental Health. Report to the City of Sheffield.

Department of Environmental and Consumer Services. Sheffield City Council.

SHEFFIELD CITY COUNCIL (1985)

Services for under fives in the Fox Hill/Parson Cross/Grenoside areas of Sheffield.

City of Sheffield Education Department.

SHEFFIELD CITY COUNCIL (1985)

Services for under fives in the Hillsborough/Stannington/Worral areas of Sheffield.

City of Sheffield Education Department.

SHEFFIELD CITY COUNCIL (1985)

Services for under fives in the Woodside/Burngreave/Southey/Longley areas of Sheffield.

City of Sheffield Education Department.

SHEFFIELD CITY COUNCIL (1986)

Environmental Health. Report for the City of Sheffield Department of Environmental and Consumer Services.

Sheffield City Council.

SHEFFIELD CITY COUNCIL (1986)

Family and Community Services Information leaflets.

1. Services to voluntary and community groups.
2. Guide to services : Urdu Bengali, and Arabic.
3. Holiday accommodation for elderly people.
4. Facts about elderly people in Sheffield.
5. Areas covered by teams.
6. Population change.
7. Elderly persons support units.
8. Racial equality.
9. Places of birth.
10. Pensioners living alone.
11. Demand for short term care.
12. One parent families.
13. Staff and sites.

Sheffield City Council.

SHEFFIELD CITY COUNCIL (1986)

Putting you in the picture. Sheffield City Council 1980-1986.

Sheffield City Council.

SHEFFIELD CITY COUNCIL (1986)

Sheffield Council Handbook. A guide to the Council and how it works.

Sheffield City Council.

SHEFFIELD CITY COUNCIL (1987)

Tinsley Corporate Group Meeting 20th January 1987. Progress Report.

Department of Environmental and Consumer Services. Sheffield City Council.

SHEFFIELD HEALTH AUTHORITY (1986)

A food and health policy for Sheffield Health Authority : A report to the District Executive Team.

Health Promotion Strategy Group. Sheffield Health Authority.

SHEFFIELD HEALTH AUTHORITY (1986)

Health Care and Disease a Profile of Sheffield.

Sheffield Health Authority.

SHEFFIELD HEALTH AUTHORITY (1986)

Health Care and Disease a Profile of Sheffield : Supplement.

Sheffield Health Authority.

SHEFFIELD HEALTH AUTHORITY (1986)

Information : vaccine uptake rates 1973-1985. Occasional Paper 7

Information Section. Sheffield Health Authority.

SHEFFIELD HEALTH AUTHORITY (1987)

Information : Monitor 87. 2nd April 1987.

Information Section. Sheffield Health Authority.

SHEFFIELD HEALTH CARE STRATEGY GROUP (1985)

Progressive Strategies for Health 2.

Sheffield Health Care Strategy Group.

SHEFFIELD CITY POLYTECHNIC (1986)

Health Visitor Course 1986-87. Neighbourhood study incorporating a caseload profile.

Department of Health Studies, Sheffield City Polytechnic.

THUNHURST, C. (1983)
Poverty and Health in the City of Sheffield
Environmental Health Department. Sheffield City Council.

TRENT REGIONAL HEALTH AUTHORITY (1986)
Better Health for Trent - a Plan for Action 1983/84 - 1993/94.
Trent Regional Health Authority.

UNITED KINGDOM CENTRAL COUNCIL FOR NURSING MIDWIFERY AND HEALTH
VISITING (1986)
Project 2000, a new preparation for practice.
UKCC

WELLS PARK HEALTH PROJECT (1984)
Wells Park Health Survey.
Wells Park Health Project.

WEST, M. A. AND SAVAGE, Y. (1987)
The Experience of Health Visiting.
MRC/ESRC Social and Applied Psychology Unit. University of Sheffield.

WILSON, H. (1985)
Morley : Caseload Profile.
Leeds Western Health Authority.

WILSON, H. (1986)
Caseload Profile.
Health Visitor Feb. 1986, Vol. 9, p. 40.

APPENDIX VIII

HANDOUT - LOOKING AT THE CASELOAD

After the workshop on Friday several people felt they would like an outline of what I was asking for, for the next workshop.

1. Firstly think through what are the special features of your caseload.

e.g. lots of very young parents

 lots of gastro-enteritis

 very articulate people

2. Make a list of the things you collect and record in your records but you never usually pull together. Choose the ones that you think would tell you the most about health in your patch.

e.g. What sort of employment/unemployment do the adults in your caseload have?

 How many babies are breast fed at 3 months?

 How old are the parents of first babies?

 Completed immunisations at 2 years.

3. As you do this you may think of things you can't get out of the records,

e.g. how many people smoke or take tranquillisers. Write these on another bit of paper for later. You might want to consider recording some of these in future.

4. Make a list of about 10 or 20 categories of information you want to collect from your records. I enclose a list of suggestions in case your mind has gone blank!

5. Look through all your records and count the features you are looking for. You could total them up and write them down.

6. Ask yourself, have I learnt anything new about this caseload, anything surprising, are all my old ideas confirmed is there an amazing new discovery?

Please write down your findings so they are readable by someone else, but they don't need to be in sentences or anything.

File them in the red binder.

Come to the next workshop.

Some ideas for categories

Number of individuals or caseload

Age range of parents/adults

Size of households

Numbers of children per household (preschool and 5-16 years)

Number of one parent families - supported or unsupported?

Employment/unemployment of women and men

Number of expectant mothers

Children/adults with disabilities

Children attending day nursery or child minders

Removals in the last year

Breast feeders at newborn and 3 months

Vaccines completed at 2 years

Hospital admissions for accidents

Hospital admissions for gastro-enteritis

4 year olds who have received all their assessments

Types of contraception used, if any.

Proportion of caseload in different geographical areas/housing, e.g. old cottage areas versus council estate new "Barratt" type housing versus old established village

Number of families/children with certain infections, e.g. ear infections, scabies.

Antibiotic use in under 2's.

The important thing is to choose what you think would be important on your caseload.

Examples of things you may not yet collect:

Number of ante-natal attendances

Family history of heart disease

Use of contraceptive pill and smoking

Attended for cervical smear in last 3 years

Relatives within a 5 mile radius

How long householders have lived locally

No inside toilet and bath

No telephone

Proportion of caseload who have ever contacted the health visitor

Obesity - apparent overweight by height (Diet)

APPENDIX IX

USING ENUMERATION DISTRICT DATA

When you are trying to interpret these figures please remember:

1. For each enumeration district there are two lines of figures.
2. All the figures except the very last one need one decimal point in, e.g. 111 should read 11.1, these figures are percentages.
3. The very last figures is the number of people in that enumeration district and is not a percentage.
4. I enclose a list of definitions of the headings. It is important to check whether each heading is a "person" or a "household".
5. These figures are from the 1981 census.
6. The figures for social class 4 and 5 are "10% sample". This means that only one in ten of the population was assessed to discover what social class they were. Of this sample the percentage in social class 4 and 5 are shown. All this means is that they are not as accurate as they would be if all the population was assessed.

*** REMEMBER THE DECIMAL POINT!**

Do not worry if you get confused, we can cover it again at the next workshop if you wish.

JOAN HARRISON 20/2/87

APPENDIX X

LETTER TO "TUESDAY GROUP" HEALTH VISITOR SAMPLE

Sheffield Health Authority

4 Endcliffe Crescent,
Sheffield, S10 3ED.

Telephone Sheffield
(STD Code 0742)

PLEASE REPLY TO: Joan Harrison, Research Nurse

Tel: 685323

Johnson Memorial Home
4th March 1987

Dear Folks,

One of the disadvantages of being in the Tuesday group is that you are the first group in each set of workshop weeks, and I am learning as I go along! I thought very carefully about you and the things you have said and decided to write and tell you the structure I am using with the Wednesday and Friday groups because of what you have taught me. You may find it useful.

You will remember we talked of three sources of information caseload, outside statistics and community forums or contacts. You have extracted alot about your caseload (or are doing so at the moment). I have given you lots of statistics about your area. If you are thinking, well what sort of local contacts - I enclose a sheet headed "OTHER WORKERS" - this is a summary of what all the HVs taking part answered to the question,

"When you start work in a health visiting job what do you need to know about the community you visit before you start?"

It is the kind of background data you have got in your head and could form part of a profile.

When you have got all these things in your file, what I want you to do for next time is to ask yourself,

"WHAT ARE THE HEALTH NEEDS ON MY PATCH?"

All you have to do is read what you have already and think about it.

If you are feeling blank about health needs - I enclose a lot of the answers HVs taking part gave to the question,

"What are the preventable causes of ill health on your patch?"

You could look at this list (you will probably be able to add to it now) and decide what is relevant on your patch.

Don't worry about the current working situation and your Managers, etc., we must ask ourselves the question "what are the health needs?" before we talk about time/priorities, staffing levels, etc.

If you feel unclear or upset (or indeed full of joy!) feel free to ring me up. I hope I have made things a bit clearer. I look forward to seeing you in two weeks time.

Best wishes,

Joan

CASELOAD

+

STATISTICS

THINK

COMMUNITY

PROFILE

THINK

HEALTH

NEEDS

+

LOCAL CONTACTS

OTHER WORKERS. AGENCIES. FACILITIES.

CABworkers

Social workers

Doctors

Community workers

Youth leaders

GPs

Social services

Voluntary agencies

Adult education

Groups for older people

Home helps

School nurses

Clinic nurses

Luncheon clubs

Meals on wheels

Launderette

Schools for handicaps

Vicar

NSPCC

Dentist

Optician

Interpreter

Community liaison if ethnic minority

Schools

Libraries

Shops. Post Offices.

Chemists

Nursery schools, education nurseries

Transport/bus services

Playgroups, toddler groups

Self help groups

Swimming baths

Facilities for supporting and strengthening
parenting.

Health services available

School teachers

Police

Housing managers

Community centres

PHCT

ACQUIRED WISDOM

PREVIOUS HV.

Previous HV

Who you are going to be working with

Information sources about area.

What are the main health problems and health needs.

Pressures people are under.

Who is influential in that community.

Is PHCT working in that area.

Problem families

High risk.

n/o psychiatric problems.

? contacted by phone or door knocking.

Keys to the filing system!

How many times does the phone go.

Where are your managers based?

Does this particular "client" group need me?

Should spend the first week going out on the area.

THE PEOPLE

STATISTICS, SOCIAL GEOGRAPHY and DYNAMIC INFORMATION

Need to live there 10 years

Population Age sex
 mortality
 Morbidity
 Census data

Sort of people Their history. Where have they come from. Do relatives live nearby. Mobility. Isolation. Facilities for supporting and strengthening parenting. Are needs of area met within the area. Single parent families? Students? Young families? Handicapped? Employment situation. Unemployment rate. Population of non-whites. Social mix - does not necessarily categorise people there's a stigma attached to any social group.

Crime rate

Cultural mixes

What people themselves see as being deprived.

Where old tend to be in relation to others.

How people live - pubs, eating places, shop selling fresh fruit.

THE PLACE

GEOGRAPHY. ENVIRONMENT.

Housing - type of tenure
 structure - high rise
 mobility of population/for sale signs.

Position in relation to countryside or industry.

Pollution

Hazards e.g. roads. Play areas. Built up.

Names of roads, boundaries of area.

Terrain - mobility of population. Do people at top and bottom of hill communicate.

History of environment.

PREVENTABLE CAUSES OF ILL HEALTH

Q13

All diseases we are immunising against and notifiable.

Measles

Whooping cough

Cervical cancer

Hypertension

Depression. Anxiety. "smiling depressives"

Heart disease

Failure to thrive

Diet/nutrition - anaemia in women/Especially in 60+/overweight/very thin/ poor diet undermines health.

Smoking.

Cancer of breast.

Isolation.

Post natal depression.

Ca. lung.

Bronchitis/chest infections.

Damp flats.

Accidents in home.

NAI - support of families under 9 months - 3 year child. Unmet of childrens needs.

Unwanted pregnancy.

Sexually transmitted disease.

Stress - break up of families.

Psychological health.

Loneliness in elderly.

Gastroenteritis.

Deafness from rubella.

Handicap from intermarriage.

Bad housing.

Poor expectation of health.

Motivation to get treatment.

Poverty.

Communication.

Employment. (Change of employment to unemployment Health)

Lack of exercise.

Womens emotional health - total responsibility for kids.

Lack of space - stress.

Inadequate supervision of children.

Homeless families rehoused in a depressed area. psych. problems in children.

Smoking.

Alcohol.

Financial problems.

Eczema and skin disorders. Asthmatic kids? Corporation tip

Low resistance to infection.

No prospect of a job.

No self respect.

Mental health interrelated with relationships

Lack of knowledge about child care

don't recognise early signs of illness

not knowledgeable about rashes

Dental decay

Living lunchtime to early hours. Kids awake mornings.

Gastric and duodenal ulcers in men. Smoking and stress.

Squints - treatable?

Ear infections?

Preventing feeding poses.

General care and hygiene, e.g. preventing nappy rash.

Lack of general education.

Single parents - young, immature.

Unknown diabetes.

A lot of elderly do not see any h/c professional.

Over dependence on "the book" - latest child care book.

Tension among elderly.

Budgetting.

Lack of family support.

Pre-menstrual tension

Bereavement - losing spouse - lack of motivation (smoking and obesity in elderly and really to do with loneliness.).

Failure to attend appointments, e.g. speech therapy.

Stress in self employed.

Alienated by the system.

Health in schools especially attitudes to parenthood, roles and responsibilities, contraception.

APPENDIX XI

MEMO FROM "FRIDAY GROUP" HEALTH VISITOR SAMPLE TO MANAGEMENT

SHEFFIELD AREA HEALTH AUTHORITY (TEACHING) – MEMORANDUM

From Health Visitor,
 Health Centre

To Acting Senior Nurse
 Health Visiting

Date

Ref.

Tel. Ext.

Ref.

During our discussions on Health Visiting/Health Needs of the area, we heard that a re-evaluation of assessments on the under-fives was taking place. We discussed the issues from this and many suggestions were brought forward. We would like to be involved in the planning stage of a programme regarding assessments, and wondered if this could be discussed by all health visitors at a Unit Meeting, considering all aspects, before a decision is made?

We enclose a sheet with some of the comments which could be used as a stimulus for further discussions.

We are sure that our colleagues will have more to offer from their varied experience and areas.

Thank you for your consideration.

Health Visitors

Names supplied

EXAMPLES FROM DISCUSSION ON ASSESSMENTS

1. We would like to know how many handicaps are being admitted to schools - have many not previously been discovered?
2. What are the main ages handicaps are referred?
3. We feel that handicaps are being referred earlier to hospitals by hospital baby clinics and G.P. baby clinics, and there may be less in total.
4. We would like to hear more about ophthalmic, audiology and speech therapy referrals and their outcomes.
5. Stycar Vision Testing - suggest 3 years to 3½ years, depending on ability of child - varying with the area.
6. Co-ordination with Nursery schools over 4 year medicals and vision testing to avoid duplication.
7. It may be necessary when looking at health needs of our areas to consider other priorities of equal importance - e.g. middle age group, pre-retirement screening, well man and woman clinics, prevention of coronary heart disease, and the follow-up of problems found.

APPENDIX XII

MEMO FROM HEALTH VISITOR NEGOTIATING WORK WITH MANAGEMENT

SHEFFIELD AREA HEALTH AUTHORITY (TEACHING) – MEMORANDUM

From Health Visitor,
Health Centre

To Acting Senior Nurse
Health Visiting

Date

Ref.

Tel. Ext.

Ref.

Following attendance at Joan Harrison's (Research Nurse) Workshops - regarding "The Information and Planning Needs of Health Visitors". I have produced my case load analysis/community profile.

The following information is a result of this.

Case Load Analysis

Pre school children - 168

Adults (includes both parents) - total - 618

11.5% Households with expectant mothers

10.3% One parent families

34.2% First time parent households

58.9% Breast feeding mothers - 50% of these continuous up to six months or over.

Higher than National and Sheffield Average uptake of Immunisations

Full Prophylaxis - 82.8%

Demography - 54.3% aged 16 - 50+

44.8% 22 - 45 years

16.9% No full time wage earner

28.4% Households have working mothers -
mostly part time

Hillsborough 1985 - highest overall incidence of dental caries in five year old children.

80% cervical cancer occurs in women over 40 years. Women in South Wortley and Walkley Wards 35 - 64 years of age lower than expected smear rate uptake.

50% of Sheffield smearing resources taken up by 19% of women. Many older women in high risk groups never have a smear.

South Wortley women have higher than Sheffield average incidence of invasive Ca.cervix registrations. i.e. 11.7 per 10,000 women.

Hillsborough ward - high rate of ischaemic heart disease 1981 - 41 - S.M.R.122.

Value rank 20, in a scale 1 to 27. South Wortley ward has a high death rate from diseases with a large preventable component.

Hillsborough and Walkley wards have moderately high rates. This analysis has high-lighted many preventable health issues.

The three issues I wish to give priority to are:

1. Reducing the death rate of diseases with a large preventable component.
2. Improving the cervical smear uptake of women 45 years + .
3. To provide group support to "first time mothers".

To achieve this I am planning to utilise the age-sex register at Far Lane Medical Centre, to invite all women aged 45 to 60 years for "Health Screening" i.e. A weekly session on Fridays 1.30 p.m. to 3.30 p.m. at Far Lane Surgery - allocating 30 mins per client.

To: Take history of relevant health issues i.e. - smoking, alcohol, tranquilisers, anti-depressants, Family History heart disease.

Check Blood pressure and urinalysis and weight. Encourage cervical cytology. Discuss prevention of heart disease - relevant factors.

Refer to G.P. for follow up where appropriate.

Refer to other agencies where appropriate, i.e. -

Area Health Authority Cytology clinics

Relaxation groups

Provide resource for other information as appropriate

- Evaluate
- Uptake
 - Referrals
 - Responses to have cervical smear
 - Health Education in-put

To evaluate after one year.

I have approached the G.P.'s at Far Lane and they are in agreement with providing "accommodation" and back-up support.

Regarding "First time mothers". I plan to organise a post natal support group for first time mothers with children from birth to six months of age. An informal group, to meet alternate Monday mornings 10.00 a.m. to 11.30 a.m. to offer mutual support and to discuss any relevant health issues. Maximum size of the group to be 20.

Invitations will be extended to any first time mothers in the Hillsborough area in order to maintain a viable number within the group.

The difficulty of finding suitable, appropriate premises has yet to be resolved.

Appraisal will be carried out after six months by comparing the attendance rate, with the result of a questionnaire given to mothers before the final "meeting".

Future issues for consideration will be to:

1. Inaugurate the organising of a "Community Forum" involving all statutory and voluntary bodies working in the Hillsborough area, with the aim of:
 - i) Improving understanding of each others role.
 - ii) Improving communications
 - iii) Providing a platform to examine local health/social issues.
 - iv) To examine how the Forum may then respond to these.
 - v) Better use of all local resources.
2. To examine the possibility of helping local "one parent families", to organise their own support group.
3. To attempt to make better use of "local" resources to improve awareness of local health issues.

Taking time to plan a community profile and case load analysis has been demanding, and exciting, in clarifying local health issues and motivating a way of widening a Health Visitors Preventive Role in a meaningful and satisfying way.

Name supplied
Health Visitor

APPENDIX XIII

HEALTH PLANS

PLAN OF WORK

| | |
|------------------------------|---|
| A. <u>HEALTH NEED</u> | Providing more support for families with multiple social problems; in such a way that both physical, emotional well-being of such families is promoted. |
| B. <u>TARGET GROUP</u> | Young single unsupported mothers/families with 'relationship' problems. |
| C. <u>PLAN OF ACTIVITIES</u> | A new visiting pattern I feel would be beneficial and appropriate. Increase contact with such families particularly during the first 12 months of baby's life. Antenatal visits to such families is important. Gaining confidence of such families so that they are more receptive to advice given. |
| D. <u>RESOURCES OR COSTS</u> | No immediate costs in terms of finance. However, more time needed to provide greater input. To put this into practice a reduced caseload may be necessary - Therefore more Health Visitors needed, or alteration in priorities and/or pattern of working must change. |
| E. <u>TIMESCALE</u> | 12 months at least. |
| F. <u>EVALUATION</u> | Feedback from clients, e.g. improved clinic attendance: immunisation uptake: feeling able to contact HV for advice, etc.: General health of family. |

PLAN OF WORK

Integration of various social groups within the area giving rise to fragmented and divided community.

A. HEALTH NEED

B. TARGET GROUP

- 1) Mothers and babies within the caseload.
- 2) G.P.'s

C. PLAN OF
ACTIVITIES

1. Brainwash G.P.'s into setting up baby clinic within the surgery (at present two well baby clinics attended by different social groups).
2. Encouraging all mothers to attend this baby clinic therefore leading to contact and hopefully understanding of different backgrounds.

D. RESOURCES
OR COSTS

G.P. surgery already there! Need baby scales. Transfer of costs from present baby clinic to G.P. clinic. G.P.: would need to buy baby weighing scales. HV Time.

E. TIMESCALE

One year to get clinic fully established.

F. EVALUATION

1. Are G.P.'s co-operating in setting up the clinic.
2. Number of parents attending.

PLAN OF WORK

Educating of professionals to improve health in the community for Chronic Heart Disease.

A. HEALTH NEED

B. TARGET GROUP G.P.s Health Visitors.
District Nurses.

To get together and discuss and learn from each other the health problems of the community. Take lessons learnt to toddler groups - mothers, Ante-natal mothers support groups, elderly meetings. etc.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS Premises G.P., surgery. Open university course - cost of videos, etc.

E. TIMESCALE 1-1½ hours every 2 weeks - working hours and time to discuss with further groups.

F. EVALUATION Number of people improving on diet, exercise, visit to G.P.s with heart disease over a period of time (long term).

PLAN OF WORK

A. HEALTH NEED To provide nourishing weaning programmes for infants 6-18 months. General problem but specifically bad in many Asian families particularly Bengalis. Problem is Heinz - Egg custard and rice which is given in large quantities to the exclusion of all other foods except cows milk and breast milk.

B. TARGET GROUP Bangladeshi families in Darnall.

- C. PLAN OF ACTIVITIES
1. Contact Heinz and make them aware of the problem. This has been done and they're sympathetic!!!
 2. Health education and the subject in all the community groups.
 3. Contact the IMAM (Muslim Priest) - try to educate him and make him aware of the malnutrition.
 4. Participate as a consultant on the elderly research programme to be started soon in the area.
 5. Continue the personal visiting of families with the LINK WORKER.
 6. Encourage the G.P.s to mention diet at all consultations. FOOD IS OFTEN THE MOST USEFUL DRUG.
 7. Education of local Ethnic shops and availability of a variety of foods.
-

D. RESOURCES OR COSTS NONE in terms of personal HV time.
? Possibility of buying a Haemoglobometre Approximately £500 I think.

E. TIMESCALE MUST BE ONGOING AS MOST NEW IMMIGRANTS NOW SEEM TO BE FROM Bangladesh.

F. EVALUATION At least 2 years. Re-assessment of feeding pattern. Assessment of haemoglobin status of these admitted to hospital.

PLAN OF WORK

Lonely mothers. Isolated. No family, no friends.

A. HEALTH NEED

B. TARGET GROUP

1. Antenatals working up to 29 weeks (PRI'S) New mothers not already met by HV. Anyone else who may benefit.
2. Invite couples planning to have a family to similar session to discuss matters of interest prior to conception.

Invite both partners to evening group meeting at 12-20 weeks, to meet and have open discussion about health needs questions to HV etc.
To formulate plan for potential care together with families, i.e. do they want a postnatal group run by HV or do they want to have meetings in own homes, inviting HV to give talks, etc. on weaning.

C. PLAN OF
ACTIVITIES

D. RESOURCES
OR COSTS

Need for easily accessible meeting soon which can accommodate health ed. equipment and resources plus people in relaxed setting. May be possible in surgery upstairs or in local hall. (free if I chat up the vicar again!)

E. TIMESCALE

Look at antenatal list until Xmas. May also involve other HV's and their clients in the geographical area, as main subject is for people to meet to form support networks and for health ed. I see HV as the catalyst for this.

F. EVALUATION

As babies from group are born, evaluate in the light of caseload profile statistics re depression, breast feed rate, etc. Could also evaluate by recording no. of phone calls to HV re matters which might have been solved without her help or phone calls for reassurance - pre-Xmas and then after the pilot study.

PLAN OF WORK

Children living in a smoky atmosphere.

A. HEALTH NEED

Parents of new babies.

B. TARGET GROUP

Discussion of subject appropriate leaflet. 1) Ante-natal clinic. 2) Birth unit. 3) Surgery visit. 8) 8 weeks visit.

C. PLAN OF ACTIVITIES

Allocation of health visitor time. 1) Allocate more time for ante-natal visits. 2) Be aware that both birth visit and survey visit will be lengthy. 3) Make time for 8 week visit. Discussion may reveal need/advice for group work. This would add considerably to the time/cost of health visiting input. e.g. 2 hours per week for 4 weeks. Room available.

D. RESOURCES OR COSTS

6/12 January to June i.e. definite start.

E. TIMESCALE

Compile column and birth book re smoking with both visit and summary visit column - also at 3/12 assessment column this number of parent smoking at birth visit can be compared with 3/12 visit. Total eradication of smoking may be difficult to achieve so approx. no. of cigarettes smoked per day may be revealed and show a reduction or not. If not - alter approach and repeat: If no effect abandon as a waste of time or hope effect may be shown over longer time.

F. EVALUATION

PLAN OF WORK

A. HEALTH NEED The planning of second or successive pregnancies prevention of unplanned pregnancies. The promotion of planning 1st child within the area frequently not possible as many are rehoused or refused into the area during 1st pregnancy.

B. TARGET GROUP Families with first child, particularly single girls that are unsupported or with unstable relationships.

C. PLAN OF ACTIVITIES Increased ante-natal visiting both first and successive pregnancies. Increased discussion on family planning generally. Promoting the advantages of a 'planned or limited family' to their needs.

D. RESOURCES OR COSTS HV. Family Planning Clinics/G.P.s. Domiciliary family planning service.

E. TIMESCALE On going. Attempt to analyse numbers/comparison 1 year. C/f previous year.

F. EVALUATION Number of families and obvious unplanned babies.

PLAN OF WORK

| | |
|------------------------------|--|
| A. <u>HEALTH NEED</u> | Premises for social contact/health education with emphasis on <u>health</u> i.e. separate from sickness. |
| B. <u>TARGET GROUP</u> | <u>WOMEN!</u> 1) Mothers and first children. 2) mothers and toddlers. 3) women whose last children have just started school 4) The next generation of grannies. Post-natal support. To provide "time out" even if only ½ hours for mothers of tricky toddlers. General social contact and expanding horizons, etc., etc., etc. |
| C. <u>PLAN OF ACTIVITIES</u> | |
| D. <u>RESOURCES OR COSTS</u> | A warm welcoming room with space and facilities in the middle of the area. HV time. Cost of hiring room - providing refreshments. |
| E. <u>TIMESCALE</u> | Short trial period - 6/12 or so. Then on going - initially set up by HV but handed over to group with regular input to maintain interest. |
| F. <u>EVALUATION</u> | Ask clients. Keep record of number attending. Be open to suggestion/criticism generally. |

PLAN OF WORK

To promote breast feeding. Great proportion of clients start breast feeding but stop before baby 3 months old. "Breast is Best" (usually).

A. HEALTH NEED

B. TARGET GROUP Antenatals. New parents.

Antenatal advice and preparation for breast feeding, e.g. antenatal group health education. Increased A/N visiting and visiting to liaison with midwife and G.P.s.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS

Time and space in health centre for group to meet. HV time to arrange and run group. Breast pumps etc. to operate loan scheme. HV time for more intensive support visiting to breast feeders.

E. TIMESCALE

? two sessions in A/N group for each A/N client (mainly Primips.). One year project.

F. EVALUATION

Count - a) clients starting to breast feed. b) clients stopping breast feeding and when. c) questionnaire 'Why do clients stop?'
Compare statistics with pre-project figures. Questionnaire to help future planning and improvement.

PLAN OF WORK

Neglected under stimulated children who show signs of developmental delay and demonstrate behaviour problems.

A. HEALTH NEED

B. TARGET GROUP Children between ages 2 years and school entry.

Attempt to make city councillors, F and CS. Community workers and general public aware that the needs of families in this area have changed during last 5 years because of unemployment. The area of Gleadless Valley should be treated as some of the inner city areas are, and classed as an area of deprivation, so being made eligible for extra resources.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS

1. Nurseries.
2. Home teachers.
3. More social workers

E. TIMESCALE This should be a continuing process.

F. EVALUATION

1. Less families asking the health visiting service for social work support.
2. More children achieving their developmental milestones.
3. Nursery places available for children who really need them without having to wait 1-2 years or being refused a place outright.

PLAN OF WORK

A. HEALTH NEED

1. Unmet needs of visually handicapped children and their families (see report presented for publication) Bennett 1987.
2. To educate channels in the area so that they can reinforce good child health practices instead of undoing all the work HVs put in. To build up a positive relationship with grannies.

B. TARGET GROUP

1. Visually handicapped children and their families in Sheffield as a whole.
2. Grannies and "expectant grannies" who live near families with new babies in the area.

C. PLAN OF ACTIVITIES

1. Work as a member of "community vision services team" support and counselling of clients in the home. Support and resource worker to general professionals. Setting up of parents support group and toy library.
2. Weekly classes with videos, demonstrations, talks and discussion sessions.

D. RESOURCES OR COSTS

1. 8 hours per week health visitor time. Premises for support group, with attached play facilities (possibly Leopold Street) Wednesday mornings is free for the parents group and for special assessment sessions. This session is ? ? face for when money is made available.
2. Premises with electricity and facilities for making tea etc. Health visitors time - 3 hours per week approximately external speakers.

E. TIMESCALE

1. Pilot at 8 hours per week for 1 year. Evaluate at the end of this time.
2. Probably 10 week courses 2-3 times per year (different groups)

F. EVALUATION

1. Client response and compare with completed research (Bennett 1987) could also evaluate as a further piece of research. Increase or decrease service according to resources.
2. Group response at end of session. Improvement in relationships with HV. Improved child care practices. Improving child health.

PLAN OF WORK

Development of mother and first baby group. Childminding facilities for mother wishing to return to work.

A. HEALTH NEED

B. TARGET GROUP Ante-natal and postnatal mothers with 1st babies

Questionnaire to antenatal and postnatal mother to determine isolation if intending to return to work. Location of/for group NHS premises or not. Co-operation with toddler groups in area. Arrange programme. 6-9 months approx. - outside speakers including child minders. Invite Antenatal mothers to group 4 weeks prior to delivery.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS Dependent on location of group. If non NHS building mothers need to be motivated to contribute to group hire of room costs. Baby toys. Use of video equipment from Health Education. HV time during group and also preparation.

E. TIMESCALE 3-6 months to set up group then 6-9 months for group to run - new mothers introduced throughout year.

F. EVALUATION Questionnaire. Survival of group.

PLAN OF WORK

A. HEALTH NEED Support of young mothers particularly with first babies to encourage a realistic view of caring for a new baby. Being prepared or better informed may help to anticipate or avoid possible difficulties - enable parent to cope better. May help to avert some anxiety on depression caused by feelings of inadequacy or guilt after 'things' don't go according to plan.

B. TARGET GROUP Ante natal. 1st pregnancy but particularly the very young or unsupported.

Ante natal clinic to be run concurrently with well-baby clinic. Provide meeting area where clients can mix and exchange ideas. Other members of team available to answer specific queries or perhaps talk on a particular aspect if required.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS Other members of Primary Health team to be involved would be G.P. Health visitor. Midwife. Practice nurse Voluntary Worker supervising toddlers play activities. Receptionist.

E. TIMESCALE Ongoing if effective.

F. EVALUATION Feedback from clients and other team members.

PLAN OF WORK

Isolated unhappy mothers, feeling fed up at home. Most of their occupations are too poorly paid to return to work and afford childminders. Not enough nursery creches, etc. Facilities in area either.

A. HEALTH NEED

B. TARGET GROUP Mothers of children aged 6/12 - school age who want to return to work. Those mothers that previously worked full time before becoming pregnant. They don't know many people in area.

Preparing people before they have kids so expectations are more like reality - may help prevent so many lonely mums. Encourage the meeting up of home mothers, not only in mother and baby group but also in their own homes. Encourage more childminders to register in area, but cost of this is still a worry. Encouraging job sharing so mothers meet other mothers in their own homes negligible (e.g. coffee etc.) employers need to meet the cost of finding more jobsharing jobs. More education in schools to prepare for parenthood so people are better equipped at the time of birth to cope with the responsibilities and can prevent isolation occurring i.e. ? planned ? throughout pregnancies.

C. PLAN OF ACTIVITIES

Difficult to state a timescale. Encouraging mothers to meet up locally in homes immediately. Mother and baby group exists already but still mothers need more encouragement to attend - perhaps getting someone to take a new mother for first visit. Months/years before job sharing and more facilities, e.g. nursery creches.

D. RESOURCES OR COSTS

By continued visiting by HV mothers will tell HV how things have improved. Evaluation difficult as it may be long term. A lot of it may actually be too difficult to achieve i.e. more jobsharing jobs. More nursery places.

E. TIMESCALE

F. EVALUATION

PLAN OF WORK

Social isolation - causing depression and anxiety.

A. HEALTH NEED

B. TARGET GROUP

Women with small children in a defined geographical area. i.e. new housing estate.

a) Identify venue if possible for mother and baby group. or b) identify individuals in the area able to motivate others and provide facilities, e.g. own sitting room. Gain permission from individuals to give names.

C. PLAN OF
ACTIVITIES

D. RESOURCES
OR COSTS

a) HV time in looking for building or time given in encouraging (2 hours) others to do so - and then weekly input to begin with at Mother and Baby Group - 2½ hrs per week. b) HV visiting time to individuals. Perhaps 20 1 hr visits (to same area)

E. TIMESCALE

Short term approximately 6 weeks.

F. EVALUATION

Managment of contacts with HV or G.P, which will hopefully increase. More content children.

PLAN OF WORK

A. HEALTH NEED

Higher than average infant mortality. Higher than average still birth rate.

B. TARGET GROUP

Ante-natal parents.

C. PLAN OF
ACTIVITIES

To visit each (ante-natal) family at last twice during the ante-natal period. Providing information and health education, and paying special regard to the families needs and requests.

D. RESOURCES
OR COSTS

Estimating I have 70 new births each year. This could mean I need to make 140 visits to ante-natal families allowing 1 hr each visit plus preparation time and writing up 180 hrs Health Visiting time. Appeox. 25 days health visiting.

E. TIMESCALE

To take place over a 2 year period

F. EVALUATION

To measure infant mortality and still-birth rates to see if any improvement. To look for an improvement of awareness of health visitor role in families.

PLAN OF WORK

Nutrition (Diet). Dental caries in area. Heart disease in area. Hypertension.

A. HEALTH NEED

B. TARGET GROUP Young mothers with under 5's

Health Ed. in form of support group. Health education in comprehensive associated with area.

C. PLAN OF
ACTIVITIES

D. RESOURCES
OR COSTS

Team of HV in preparing and presenting use of Health Ed. resources and equipment of schools. Use of dietitian and home economics teachers. Use of dentist.

E. TIMESCALE

At least a 2 year project possibly longer.

F. EVALUATION

Assessing of dental caries in area or dental disease in general.

PLAN OF WORK

More support for first parents in 1st 6/12

A. HEALTH NEED

B. TARGET GROUP Young single mums.

Weekly meetings running for six months with each group covering use of services, home safety, feeding, etc. Target - that mums in the group will continue on their own in own premises when group finished.

C. PLAN OF ACTIVITIES

D. RESOURCES OR COSTS Available

E. TIMESCALE Each new group to run over 6/12.

F. EVALUATION Target better use of services e.g. GP HV, SU etc. More confidence in handling babies. A better gen. view of prevention. A greater trust in professionals and confidence to seek other activities in the future.

PLAN OF WORK

A. HEALTH NEED Entering middle age and young elderly with healthy mind and body. 1) Fears of unknown about this new chapter of life. 2) spasmodic employment or unemployment. Publicity and course Health Education Discussions.

B. TARGET GROUP 40-60 year old. Male and female.

C. PLAN OF ACTIVITIES To attend this age group publicity locality initiating and liaison with general Practitioners. Course. H. Ed. discussions at Health Centre or elsewhere i.e. local groups. Screening BP/Urine medical. Well person clinic at alongside.

D. RESOURCES OR COSTS Not sure re time i.e. monthly or weekly sessions possibly evening. Difficulty in persuading management or importance of evening work. No problem anticipated in access to heating Centre in evening. To involve a GP (1 or over).

E. TIMESCALE Review 6/12 of setting up. Time not appropriate immediately. There is a new surgery planned next year to consider this then.

F. EVALUATION Uptake or sessions. Suggestions of participating member. Discussion with colleagues.

PLAN OF WORK

A. HEALTH NEED

1. Health problems in women 45-60 years. i.e. ? smear uptake; psychiatric problems, stress factors. 2) social isolation of first time mothers.

B. TARGET GROUP

- 1) Women 45 years - 60 years. 2) Primips - with baby under 6 months of age.

C. PLAN OF
ACTIVITIES

1. Screening/health education for women 45-60 years using age/sex register to invite all women in the group to attend session Friday p.m. at GPs surgery. HV to provide ½ hourly appointments to see 4 women each Friday afternoon. Take health risk ? check B/P urine, wt. Discuss cytology self breast examination. Prevention of heart disease factors - Stress etc. 2) Post natal support group. stationary from area health HV time 3 hours per week and clerical time sending invitations.

D. RESOURCES
OR COSTS

Review in 1 year. Started this in july. P/N support on using facilities at Hillsborough Library. No charge. I provide tea/coffee. Self strengthening group with health education input. Meet weekly via 1½ hours HV time and travelling, and some outside speakers organised. Review after 6 months.

E. TIMESCALE

Re-screening session - after 1 year - review attendance rate . No. of successful ex. cytology appts.. Other referrals to GP or other agencies and Health Education benefit. Re P/N support group - give questionnaire for mothers to complete as group finishes.

F. EVALUATION