# Community Health Nursing
Current Practice and Possible Futures

Points of view are those of the authors

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SUMMARY

In response to the growing demands on primary and community care services, particularly with the changes in policy direction, the Department of Health Social Services and Public Safety (DHSSPS) requires a more strategic approach to planning and developing community nursing services. It was felt that practitioners need to understand the social context of illness, ensuring that healthcare becomes more culturally sensitive and that services are responsive and targeted to reach out to those who need them and are not developed solely along historical workforce allocations.

The aim of the project is:
To develop innovative models of service delivery for community health nursing (CHN) that are consistent with public health principles; workable within the developing primary care structures in Northern Ireland (NI) and have the potential to link primary care, public health, community and secondary care and other relevant interest groups. Such models will be inclusive of all community health nursing disciplines, including midwives, and grounded within the context of public health.

The objectives are:
1. to undertake a literature review of public health policy and practice;

2. to utilise a qualitative and quantitative approach to explore CHN's experiences and perceptions of the current organisation and delivery of community nursing services in NI within the context of public health;

3. to use the findings to inform a future framework for service delivery;

4. to produce a report of the findings of these studies which will inform:

    a) an option appraisal of possible models for future practice. Such models should be based on assessment of needs and be consistent with public health principles;

    b) Recommendations for piloting a model or models of service delivery that meet the identified criteria.

Main Findings

Section one: demographic data
A 15% sample of the CHN nursing workforce (2,668), in NI, was surveyed. There was a 67% response rate with proportional representation across all CHN disciplines, including midwives. Responses were received from all Trusts and Boards. Additionally, representatives from all CHN disciplines participated in focus groups conducted in two main sites in NI.

Section two: Current ways of working
The data suggests a largely reactive rather than proactive approach to public health initiatives. There is little or no emphasis on community profiling but rather a task orientated culture based on patient needs. A lack of time, inadequate staffing levels, administrative duties that are not always appropriate, a lack of

leadership and an emphasis on meeting Trust and GP goals were perceived as having a negative contribution to achieving public health policy aspirations. In addition a lack of training and an uncertainty of how to achieve public health improvements or a lack of clarity of goals might all foster a cumulative climate that is less than optimum for successful public health practice.

Section Three: Factors influencing work practices.

Education is seen to be the key to achieving improved public health practice. There is evidence to suggest a strong perception of geographical inequities with respect to the delivery and uptake of educational opportunities within NI. Nurses perceived lack of trust, lack of respect and low morale as disempowering and alienating them. Education and management policies were seen to have an influence over this situation.

Section Four: Collection and utilisation of community nursing statistics

The quantitative systems of data collection surrounding CHN activity elicited an almost unanimous antipathy towards it represented in both the qualitative and quantitative data. It was seen as time consuming and one of the more onerous of other administrative burdens. There was a distinct lack of clarity over the purposes of the data collection exercise with information going upwards into a bureaucratic 'black hole' but rarely coming back down. Nurses tended to view the completion of the data as a mandatory work requirement even though they could see very little benefit for the effort invested in the task.

Section Five: Information Communication Technology

The data showed there was an inadequate level of personal computers (PCs) although there was some evidence of initiatives to improve the situation, albeit in fairly ad hoc ways. The lack of access to research sources via the internet frequently led nurses to either work at home in their own time or to similarly travel a considerable distance to a library. Eighty percent of all staff surveyed agreed that they would need more training. Nurses were acutely aware of the increasing gap between their ICT resources and competencies and that of other professionals and many sections of the public. A climate of raised client expectations coupled with their increased access to knowledge and information was perceived to threaten their professional credibility. The qualitative and quantitative results are generally consistent in demonstrating that overall community health nurses do not have access to PCs in their work setting, although practice nurses, who are employed by GPs, and treatment room nurses, aligned to GP practices, report greater PC access.

Section Six: Introduction of new ideas to improve public health practice

Just over half of the respondents indicated they had introduced new ways of working to improve practice, over the past three years. However, the majority of the examples of good practice given were activities which would normally be considered part of the routine practice of the individual disciplines concerned. For example, several district nurses mentioned nurse led leg ulcer clinics; practice nurses cited smoking cessation

and health visitors alluded to breastfeeding support groups. In terms of factors which facilitate new ways of working 60% of nurses rated the need for strong nursing leadership to support development as important to them. The lack of time to devote to public health discussed throughout the report is endorsed in this section of data. Moreover, poor inter-agency and community collaboration is noted as is the fact that many of the initiatives are health and social care led. This perhaps points to a need for improved communication between the public, user groups and other professional organisations and institutions.

Key Recommendations

The recommendations from the report form a plan or design for Public Health Nursing that includes the following:

Vision: to create an environment which enables and empowers nurses, especially community public health nurses, to provide comprehensive health and social care to individuals and populations within the remit of their individual roles and particular cultural contexts in collaboration with relevant others to achieve improved, effective public health for all.

The recommendations to DHSSPS are:

- Support, develop, fund, pilot and evaluate innovative models of public health practice and disseminate examples of 'best practice' within the wider sector.

- Work towards establishing a clearly identified public health care nursing

infrastructure to provide professional leadership of the public health workforce at strategic and operational levels. This includes supporting the role of nurses in resource management, decision-making and policy development.

- Create appropriate education and training pathways at different levels of public health practice and support experienced community health nurses who wish to specialise in public health. This is likely to include knowledge of political skills, economic principles, budgeting, resource use and cost-effective practice.

- Support the development and evaluation of the joint QUB/UU multidisciplinary/multiagency MSc in Public Health with a commitment to DHSSPS funded places with the establishment of new and improved existing processes for community health nurses to access funding for relevant postgraduate education and scholarships.

- To address the barriers highlighted by CHNs in the report such as the need for greater access to information technology, the over-extension of role and inadequate staff resources.

- Work with community and public health nurses to develop information systems and coding mechanisms that enable the collection of data and other information for monitoring and evaluation that is actually (and perceived to be) relevant to effective practice.

- Establish evaluation processes to ensure that the governance, management and leadership of innovations are being met and to seek to improve ways of incorporating public and user groups' perception and understanding of public health needs.

- To ensure a set of reflective processes and practices are integral to cohesive future public policy decision making at strategic and operational levels.

INTRODUCTION

New health strategies have recently been launched in the UK around the twin goals of improving population health and assessing equitable health needs (Secretary of State for Health 2000). In Northern Ireland, Public Health and Primary Care are high on the national agenda, evidenced by two recent government documents: *Investing for Health* (DHSSPS 2002a) and *Building the Way Forward in Primary Care* (DHSSPS, 2000). Both these documents stress the importance of a needs led approach to care which involves service users and promotes equity of access. There is also a focus on multi-professional, multi-agency working and flexibility of provision to meet identified needs. Furthermore, *Vision to Action* (DHSSPS & DoH & C 2003) provides a nursing perspective on public health for the North and South of Ireland. It presents an action plan to strengthen nursing leadership, education and practice development for public health.

The new requirements of clinical governance are also a challenge for everyone working in public health and primary care and it is essential that it is inter-linked to political governance. The UK government's document, *A First Class Service* (DoH 1998), defines clinical governance as *a framework through which NHS organisations are accountable for the quality of care*. In Northern Ireland, *Best Practice, Best Care* (DHSSPS 2001) presents wide ranging proposals for improving quality and spreading best practice throughout

health and social services. If the quality of health and social care is to be improved, existing knowledge about effective clinical and organisational practice must be applied and new information to monitor and evaluate care must be generated and interpreted. Clinical and social care governance aims to integrate these various systems for quality improvement and professional development and to ensure that everyone in the practice team becomes involved.

An underlying challenge for clinical governance in primary and community care is to move away from professional development based on uni-disciplinary education towards multidisciplinary, team-based learning and practice. Within individual general practices and primary care teams, all staff will have a role in obtaining and using information for clinical governance whether for maintaining chronic disease registers, promoting evidence-based practice, improving the organization of services, or reporting on the outcomes of care. In primary care organizations, there will be greater emphasis on improving the health of the population and this will require the collection and aggregation of information across practices to assess health needs and health impacts, reduce inequalities, and monitor the quality of care in comparison to agreed standards.

Health impact assessment (HIA) has emerged to identify those activities and policies likely to have major impacts on the health of a population. Using this broad holistic model of health means that almost any area of public policy can have health impacts. Historically, building healthy public policy was a key component of the Ottawa Charter for

Health Promotion (WHO, 1986) so therefore the basic concepts of health impact assessment are not new. HIA builds on and collates methods familiar to those working in public health and includes policy appraisal, health collaboration and advocacy, community development, evaluation tools, and evidence-based health care. Evidence-based healthcare is defined as the conscientious, explicit, and judicious use of current 'best' practice in making decisions about the care of patients and treatment of clients. The practice of evidence-based healthcare means integrating individual clinical and community expertise with best available evidence from systematic research (Sackett, 1996).

Northern Ireland Context

Public health and primary care services are primarily delivered by community health and social care staff of which nurses make up the largest proportion. Consultation with Trusts and Boards suggests that there are approximately 2,668 whole time equivalent (WTE) community health nurses (CHN) employed in Northern Ireland. This includes health visitors (540) district nurses (433), community staff nurses (547), practice nurses (240), treatment room nurses (147), community mental health nurses (327) community midwives (100) school nurses (93), community learning disability nurses (100), community children's nurses (60) and occupational health nurses (27), plus a range of other specialist nurses (e.g. child protection, diabetes) (54). With shorter hospital stays and the management of more chronically ill patients in the community there have been calls for a shift in resources from acute hospital

services to community services. What this means in reality is the employment of more CHNs. Without an increase in CHN establishments more demand will be placed on existing staff. Alternatively managers could look at smarter ways of working, whilst ensuring value for money that does not compromise public protection and adheres to the clinical and social care governance accountability framework.

In response to the growing demands on primary and community care services, particularly with the changes in policy direction, the Department of Health Social Services and Public Safety (DHSSPS) requires a more specific approach to planning and developing community services. It was felt that practitioners need to understand the social context of illness, ensuring that healthcare becomes more culturally sensitive and that services are targeted and reach out to those who need them. Community health nurses (CHN) have a vital role to play in the creation of organisations and systems, which promote equity and health central to the goals of the DHSSPS public health agenda. Furthermore, CHNs work with communities in identifying and addressing their problems. This requires staff not only to work in partnerships but also to break down boundaries by providing integrated care within health and social care teams and participating fully in health impact assessment.

Commissioning of the Report

Against this background the Chief Nursing Officer at the DHSSPS commissioned Queen's University of Belfast (QUB) and the University of Ulster (UU) to carry out a project, which

would explore public health nursing practice with the ultimate aim of developing innovative models of service delivery for community nursing.

The research team, in consultation with the Project Steering Group, agreed that the starting point should be an exploration of current community nursing practice. It was anticipated that such an exploration would identify both innovative public health focused practice building on previous work undertaken in Northern Ireland (Lazenbatt et al; 1997; 1999; 2000; 2001; Poulton et al. 2000) and historical, structural, cultural, economic, professional, educational, epistemological, political and other contextual obstacles to achieving a more public health focussed practice.

The aim of this report is to provide an understanding of community health nurses' perceptions of their current practice in relation to public health. In order to gain both a broader and an in-depth understanding of community health nursing practice and the experience and perceptions of community health nurses both qualitative and quantitative approaches were adopted. Concurrently, a comprehensive literature review was undertaken to complement and inform the research study. A summary of this review and the process and outcomes of the research study form the basis of this report.

The Study
Aim
To develop innovative models of service delivery for community nursing that are consistent with public health principles; workable within the developing primary care structures in Northern Ireland and have the potential to link primary care,

public health, community and secondary care and other relevant interest groups. Such models will be inclusive of all community nursing disciplines, including midwives, and grounded within the context of public health.

Objectives
1. To undertake a literature review of public health policy and practice to include:
   - existing and future patterns of community health nursing service delivery in Great Britain and the Republic of Ireland;
   - an overview of public health and primary care policy in Northern Ireland;
   - public health approaches to service delivery;
   - methods of health needs analysis capable of informing workforce planning;
   - frameworks for community health nursing practice;
   - education for public health.

2. To conduct focus groups with a range of community health nurses (CHNs), across Northern Ireland, and to explore their perceptions and experience of the current organisation and delivery of community services within the context of public health.

3. To use issues identified from the focus group discussions to inform semi-structured interviews and the development of a questionnaire to collect information from a representative sample of CHNs relating to: current ways of working; factors influencing their work practices; development of new ideas to improve public health practice;

the use of information technology; and, their administrative workload.

4. To produce a report of the findings of these studies which will inform:

    •   an option appraisal of possible models for future practice. Such models should be based on assessment of need; be consistent with public health principles; and have the capacity to link primary and secondary care and develop broader collaborative partnerships;

    •   Recommendations for piloting a model or models of service delivery that meet the identified criteria.

Community health nursing in Great Britain and Ireland

From a British perspective both Scotland and Wales have reviewed aspects of their community health nursing provision in the context of public health. In Wales the review addressed only health visiting and district nursing services (Clark et. al. 2000) and concluded that whilst these services had the potential to deliver the Assembly's agenda for health in Wales both were under-developed, under managed and under resourced. The Welsh review proposes pilot studies to test out a range of options. Pilot sites would have health visitors and school nurses seconded from relevant trusts to Local Health Groups (LHG) where they would provide health visiting and school nursing services to the LHG population. Additionally, health visitors and school nurses would undertake a health needs assessment and health profile of the LHG area and in conjunction with the local community develop a Health Plan for the area. Health visiting is envisaged as carrying out three roles: generalist health visiting to children and families; generalist health visiting to particular groups identified by the health needs assessment (e.g. elderly, travellers) and public health and community development. Whether these roles are carried out independently or combined will be decided from the results of the pilot studies. After some delay there is anecdotal evidence that such pilots are about to be implemented.

Integrated nursing teams have been implemented in several areas of the UK (Burke, 1997, Hodder 1999, Owen, 1998, Cook et al 2001). A practice based teams project in Cardiff involved 12 practices. In this project groups of district nurses, general practice nurses and health visitors were designated to work exclusively with individual practices and had their own devolved budgets to organise nursing care based on patient needs (Poulton 1997). Although this was a small pilot project it demonstrated the potential for improving patient outcomes by allowing multidisciplinary teams of community nurses to work in collaboration with the wider primary care team to address the needs of specific practice populations. Such approaches encourage collaborative working among CHNs, reducing unnecessary overlap and duplication and encouraging more innovative methods of service delivery by reducing multiple levels of management and accountability.

The review of the nursing contribution to improving the public's health in Scotland (Scottish Executive, 2001) focuses on the whole range of community nursing disciplines and is far more radical in its recommendations. The review proposes the development of a public health nursing role that incorporates the roles of health visitors and school nurses. In addition the review proposes implementation of the Family Health Nurse concept currently being piloted in the Highland, Western Isles and Orkney. The WHO Ministerial Conference on Nursing and Midwifery pledged support for 'family-focused community nursing and midwifery programmes and services, including where appropriate, the Family Health Nurse' (WHO, 2000a p2).The role of the Family Health Nurse is envisaged

as involving four major types of intervention – primary, secondary and tertiary prevention and crisis intervention/direct care (WHO 1999). The Scottish Family Health Nurse pilot project is in its second year and early results are favourable (Wright 2002).

In England, the White Paper *Saving Lives: Our Healthier Nation* (DoH 1999a) and the subsequent publication *Making a Difference* (DoH 1999b) emphasised the Government's expectation that health visitors and school nurses would, in future, work differently, modernising their role to further develop their contribution to the public health agenda. To support this shift in practice the Department of Health funded a range of initiatives designed to develop the public health practice of community health nurses. These initiatives included an innovation website (www.innovate.had-online.org.uk), the development of practitioner resources packs (DoH 2001a) and the funding of innovative projects. One such project involves the piloting of a 'whole systems approach' to changing services (Rowe 2002).

This approach involves working to effect change with the various elements within the whole primary and community health care system. Four Primary Care Trusts were funded by the DoH to apply a whole systems approach to implement a change in the orientation of health visiting and school nursing services to embrace the public health agenda. Although each site provided evidence that health visitors and school nurses were keen to work differently, a range of constraining factors inhibited this. Such factors included, local policies supporting "ritualised contacts with children and families, child health promotion

assessments and family based acute need interventions." (Rowe 2002 p91). Whilst evaluation of these project sites is still in progress some early lessons have emerged in relation to the following:

- **Programme management**
  A whole systems approach requires a sophisticated level of programme management.

- **Role versus service**
  It is important to move away from defined roles in favour of skill mixed teams delivering services across the whole spectrum of public health.

- **Comparative risks and benefits**
  Prioritisation of interventions has proved problematic for staff. The evaluators concluded that peer, managerial and public health specialist support is needed to evaluate risks and agree priorities.

- **Resource distribution**
  Some pilots are attempting to redistribute staff resources to target areas of deprivation.

- **Managing the public health/primary care tension**
  The project has brought into sharp focus the difficulties of building community based programmes around practice populations.

- **Timescale**
  The planned complex changes will require an eighteen-month to two-year programme in order to develop new models of service delivery.

In keeping with the above principles the DoH (2002) propose a new framework for nursing in Primary Care as presented in figure 1.

Figure 1 A new framework for nursing in primary care

PLANNING SERVICES
IN A NEW WAY

Public Involvement and choice

Service based on need

THREE CORE FUNCTIONS

DEVELOPING CLINICAL ROLES

SECURING BETTER CARE

First contact/acute assessment, diagnosis, care, treatment and referral

Continuing care, rehabilitation, chronic disease management and delivering National Service Frameworks

Public Health / health protection and promotion programmes that improve health and reduce inequalities

Valuing Generalists

Improving the working environment

Advanced and specialist skills

Greater freedom

One service approach

Effective leadership

DoH (2002) Liberating the Talents – helping Primary Care Trust and nurses to deliver the NHS Plan, (p 11)

The public health nursing system in the Republic of Ireland is essentially based on the Department of Health Circular (1966). The core concept of the public health system is that of a nurse providing a wide range of nursing services to a district or area. The Department of Health circular of 1966 is reflective of a different era, of a time when nursing and midwifery in the community was the responsibility of a homogenous group comprised primarily of public health nurses (PHNs). In the thirty years since the publication of this circular, there have been substantial changes in the organisation and delivery of health services in the Republic of Ireland. Technological, social and epidemiological changes have also impacted on the role of the PHN. The Report of the Commission on Nursing (1998) recommended that there was an urgent need for a fundamental reappraisal of nursing services in the community as these services develop and expand in the coming years. But more importantly it stated that there was a need for the profession to develop a cohesive vision for the future direction of nursing in the community reflecting the needs of

patients / clients rather than the status of individual groups within the profession. The report further recommended the continuation of the area-based model of public health nursing. However, it recommended that the PHN should be allowed to focus to a greater extent on a health promotion and disease prevention role in the community.

A major consultation exercise is currently underway in Ireland in developing a revised strategy statement on the role of public health nursing in the community. This strategy for Nursing and Midwifery in the Community (NAMIC) is being guided by the *Primary Care Strategy – 'A New Direction'* (Dept. of Health & Children (DoH&C) 2001) launched in November 2001, as part of the Republic of Ireland's new ten-year Health Strategy "Quality and Fairness". NAMIC will build upon the existing diversity of nursing and midwifery competencies currently being provided by Public Health Nurses, Practice Nurses, General Nurses, Midwives, Community Mental Health Nurses and others. It will implement Action 20 of the Primary Care Strategy, which is to provide a plan of integration of both nursing and midwifery services within primary care.

Overview of public health and primary care policy in Northern Ireland

Public health has been defined as *"Organised social and political effort for the benefit of populations, families and individuals"* (Mason & Clarke, 2001,pp7). Recent policy documents in Northern Ireland aim to incorporate such principles. The first of these *Building the Way forward for Primary Care* (DHSSPS, 2000) proposes new structures for

primary care with the aims of:
- improving service for users;
- ensuring equity of access and service quality;
- encouraging partnerships within and beyond Health and Personal Social Services (HPSS);
- implementing a locality based approach to needs assessment;
- ensuring a strong input from local communities and users;
- minimising bureaucracy and administrative activity; and
- developing clear, simple lines of accountability.

Local Health and Social Care groups are the planned vehicle for delivering these aims and encompass the devolution of local service planning and delivery. These groups are made up of community and mainstream health and social care representatives, including nurses and are expected to work with non health departments such as transport and housing to address grass root issues pertaining to the extension of life years which are free from illness and debility in respect of a defined population (DHSSPS, 2002b). It is envisaged that service commissioners will channel resources in a fashion that promotes access and uptake of services by those in most need. Population needs analysis is suggested as a public health approach to positively targeting community groups in most need of primary care interventions. It is hoped that such an approach, will promote the most effective use of public money by providing public health focused primary care services and regulating performance in terms of evidenced-based health outcomes.

The DHSSPS public health strategy, *Investing for Health* (DHSSPS 2002a) aims to improve the health of all the people of Northern Ireland and reduce inequalities. This is to be delivered through a range of goals and targets, which focus on:

- increasing life expectancy and number of years spent free from disease and disability;
- reducing inequalities in health between geographic areas, socio-economic and minority groups;
- reducing poverty in families with children;
- enabling all people and young people in particular to develop the skills and attitudes that will give them the capacity to reach their full potential and make healthy choices;
- promoting mental health and emotional well-being at individual and community level;
- offering everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home;
- improving neighbourhoods and wider environments;
- reducing accidental injuries and deaths in the home, workplace and collisions on the road;
- enabling people to make healthy choices.

Targets and timescales are linked to these goals.

A joint vision of public health for nurses is presented by the departments of health in the North and South of Ireland in the document *"A nursing vision of public health: all Ireland statement on public health and nursing"* (Mason and Clarke, 2001). The future public health nursing framework, adapted from Holman (1992) identifies the following types of public health nursing; *"Health protection; primary, secondary and tertiary prevention; health education; healthy public policy; and community empowerment"* (Mason and Clarke, 2001pp9). A "Working for Public Health Model" is suggested. This presents collaborative input provided by various sectors, over time, responding to identified need across community, primary care and acute settings and at different levels of intervention. Within an all Ireland structure, the All Ireland Nursing and Public Health Project aims, "to build a sustainable, creative and effective contribution to public health practice in Ireland. The intention is to create change that will:

- be ongoing rather than 'initiative driven';
- be systems based rather than ad hoc;
- involve a change in thinking – setting service in the context of need;
- integrate public health approaches and thinking into ongoing nursing practice."

(DHSSPS and DoH&C 2003 page 15)

Public health approaches to service delivery in NI

A future consideration in resource distribution is to engage communities in primary care planning and commissioning of services to meet their specific needs. It demands commissioners and service planners, including nurses, to creatively employ community engagement techniques;

work collaboratively with other agencies to identify need, create locally sensitive services, evaluate effectiveness; and, to lobby for change in relation to unmet community need. The views of discrete groups of people, such as the homeless, travellers, ethnic minorities, lone parents and prostitutes are to be sought out in order to plan inclusive services (DHSSPS, 2002).

An example of this approach is *Health Action Zones* (HAZ), government funded projects that take a wide community/inter-sectoral partnership approach to addressing inequalities in health. A Northern Ireland example of HAZ *is Northern Neighbourhoods Health Action Zone* (NHSSB, 2000). Six housing estates were selected under the criteria that they were socially disadvantaged and they had an established community development infra-structure, this approach was considered to be the most effective way to use time limited funding. Information gleaned from the project sites would be shared with other socially disadvantaged areas. An important output measure will be the extent to which a community is empowered to determine its own need, plan, shape and evaluate provided services. Client evaluation is recommended as a method of informing future care delivery (Stalker, 1994; Poulton, 1999; Lazenbatt, 2002).

In relation to children's services in Northern Ireland prominent health alliance models include examples of broad based community development projects and intermediate community level interventions such as Sure Start, Homestart and Newpin. Sure Start works on the assumption that parents are the

key individuals in their child's life. By supporting parents in their caring role the Government hopes to improve the health, social and emotional development and ability to learn of all children regardless of their background (http://www.surestart.gov.uk). Sure Start projects adopt a multidisciplinary approach spanning health, social care, education and the voluntary sector to a variable extent. There are currently 23 Sure Start projects operating across Northern Ireland, resulting in over 17,000 children aged under four and their families having access to services provided through Sure Start. The most recent population figures for Northern Ireland (DHSSPS 2003) show 114,400 children in the age range 0-4, therefore Sure Start programmes cater for 15% of the targeted population group. Although there is an overall evaluation of all Sure Start projects across Northern Ireland each project is expected to carry out ongoing local evaluation.

Both Home-Start and Newpin are UK wide voluntary sector parent support organisations with a significant presence in Northern Ireland. Home-Start provides local schemes offering a home visiting and befriending service, emphasising the value of non-judgemental, non-professional help provided by unpaid volunteers. Newpin provides mainly a centre-based support approach through a volunteer befriending process, whereby those who have been helped go on to help others. Evaluation of these programmes have been carried out nationally (Oakley et. al. 1998) and a local evaluation of Home-Start has been undertaken (McCauley 1999). Further examples of projects that are aimed at addressing locally identified social need are: after school clubs, delta parenting

programmes and school aged mothers (SAM's) interventions (Fullerton D & Hayes A 2001).

Methods of population needs analysis capable of informing workforce planning

Future workforce planning in the light of needs analysis within the context of public health, is required to address holistic community health needs including the promotion of a well population (Appleton and Cowley, 2000). One of the key features of locality needs investigations is that they provide the structure to develop an in-depth profile of the designated area. Community needs assessment activities may be carried out by health professionals or voluntary or community groups all working together as a means of investigating the unmet need of that community.

Rapid Appraisal (RA) is an evaluated method of seeking community participation in health service planning and needs assessment (Murray et al. 1994). It is a multi-faceted research approach that has been applied to a number of settings and covers a variety of methods and techniques (Scrimshaw & Hutardo, 1988; Thies & Grady, 1991; Ong, 1991; Shamian & Kupe, 1993; Varkevissor, 1993). Used within the context of health it can provide an insight into a community's perspective of its priority needs which is a picture of the strength of feeling rather than a quantifiable measure of a particular problem. RA is primarily a tool for participatory diagnosis and planning, culminating in the formulation of action plans jointly with those agencies that have the resources to meet the needs

identified. The resulting improvements in a community's access to health information and services, can empower them to influence and develop services, contributing to the overall sustainable development of the population. This type of needs analysis framework supports interdisciplinary working and deals with the demand and supply of current and future services.

The use of Rapid Appraisal (RA) in defining the health and social needs of women within a deprived community to formulate joint action plans between the residents and service providers is illustrated in Northern Ireland (Lazenbatt 1999; 2001; 2002). This technique exposed the level and extent of poverty in the community, such as poor nursery provision for the under fives, lack of safe play areas, lack of education facilities, fuel poverty for the elderly person, high dependence on prescription drugs and antidepressants, as well as lack of access to specific services due to political boundaries.

Another example of assessment of needs is the Scottish *Needs Assessment Primary Care Guide* (Cavanagh, 1998) which was devised to facilitate effective local commissioning and to prioritise primary care development. Four stages were identified in the needs assessment planning cycle and are presented below (Figure 2).

Figure 2 The needs assessment planning cycle (Cavanagh, 1998 pp3)
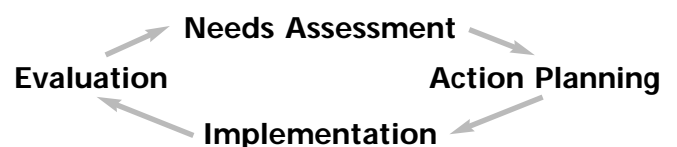
This document leads workforce planners through the needs assessment process. A team-approach with the appointment of a person responsible for co-coordinating the needs assessment trail is recommended. Decisions regarding the extent of the project, resources, public health approaches, sources of data information, methods and tools are determined at the outset of the project.

Stalker et al (1991) suggest that individual assessments could be aggregated and used to inform service planning. Furthermore that such assessments could be linked into the service planning process and used to devise national need indicators. However, it is recognised that nursing individual/caseload assessments whilst of benefit in informing the needs analysis process, are unlikely to be broad enough to stand alone in informing workforce planning.

Frameworks for community health nursing practice

Since 1998 health visitors in South Wales have been piloting the Omaha system (Clark et al 2001) to record their contacts with families with a new baby and with a variety of client groups. The system uses a standard method of recording 'diagnosis', intervention and client outcomes. In this sense diagnosis is used in its broader form to mean 'identification and labelling of the problem'. The intervention can be a treatment but also teaching or support. Client outcome, though hard to measure in the field of health promotion, can be a step towards achieving a specific goal. Because the system is available electronically it

means that practitioners can not only audit problems and outcomes at client and family level but in aggregate format for caseload profiles and community health needs analysis.

The National Service Framework (NSF) for Older People (DoH 2001b) highlights the importance of a comprehensive assessment of the heath and social needs of older people in the community. The NSF calls for services to be modernised and shaped to deliver high quality services, whatever the age of the patient, across a range of common conditions. District nurses are seen as key players in delivering this agenda. However, the Audit Commission (1999) systematic assessment of district nursing services found that whilst some district nursing services were of excellent quality, there were inconsistencies in service quality and resource allocation between different parts of the country. Subsequently a listening exercise was carried out with district nurses in England and Wales. This study (Low et al 2002) concluded that although district nurses were keen to develop they felt that to the planners and managers they had become invisible. Workloads had increased without the requisite resources and district nursing had become a 'sponge' to care services.

A review of district nursing services in Northern Ireland (Directorate of Health & Social Services Audit 2001) acknowledged that patients should have access to the same level and quality of services regardless of their geographical location. However, the findings of the study suggested that district nursing case holders generally used professional judgement to ensure

they had an appropriate balance of patients on their caseload. Whilst some Trusts were in the process of introducing more detailed caseload profiling, two main problems with caseload management were identified:

- Poor information systems
- Difficulty in agreeing a dependency model that accurately captures the range of work that district nurses undertake, and which is flexible enough to reflect patients changing needs (p11).

Whilst community health care nurses are educated to implement health need population profiles, multiple case analysis of a sample of district nurses and health visitors (n=33), demonstrated that managers do not always value needs profiling (Cowley et al, 2000). Consequently, profiling set against this backdrop may be ascribed a low priority by managers and CHN's. Furthermore, it is likely that shortfalls in determining health needs, would be most marked at times of staff under investment or long term absence. Cowley et. al criticised individualised, reactive community nursing interventions for their lack of public health focus.

Education and Regulation for Public Health

Although the nursing contribution to public health has been made explicit in numerous policy documents, there has been a lack of direction from the nursing regulatory bodies in terms of education for public health. In the mid nineties the United Kingdom Council for Nursing, Midwifery and Health Visiting (UKKC), in its review of specialist community nursing practice (UKCC 1994), designated the health visiting branch as public health. However, this was never implemented mainly because the registered health visitor (RHV) title was retained.

The Nursing and Midwifery Order 2001 whilst referring throughout to nurses and midwives, allows for a third part of the register 'for specialists in community and public health'. In the short term the RHV was retained and as its final task before its dissolution the UKCC was charged with developing new competencies for health visiting and these have now been adopted by the incoming NMC (NMC 2002). The new health visiting competencies are much more public health focused than their predecessors. In the latter part of 2002 the NMC issued a consultation paper suggesting direct entry to all three parts of the register and that the third part of the register should be for public health practitioners (i.e. those who work primarily on public health issues, such as health visitors and school nurses). As a result of this consultation the NMC has now published details of the new three part register (NMC 2003). The third part of the register will be entitled 'specialist community public health nursing' and will have no direct entry. Initially it will include health visitors on part 11 of the existing register. However, future access will be open to registered nurse and midwives who can demonstrate they meet the public health competencies.

Additional to specialist training for public health practice there is the expectation that all nurses will have a public health component within their pre registration training although the nature of this is sometimes not very explicit.

It is acknowledged that public health by its very nature is a multidisciplinary, multi-agency activity. Consequently, the Tripartite Steering Group commissioned Healthwork UK (now renamed Skills for Health) to produce a competency framework that could be used to inform all public health programmes (Healthwork UK 2001). The Tripartite Steering group is comprised of the faculty of Public Health Medicine, the Multi-disciplinary Public Health Forum and the Royal Institute of Public Health and Hygiene. Work by this group identified three levels of public health practice.

Building on this work the *Vision to Action* project expanded this framework by introducing a basic awareness level and identified levels of public health involvement for nurses as:

- general public health awareness (pre registration level)
- involvement with public health initiatives (level 1)
- specialist public health participation or promotion (level 2)
- senior level leadership in public health (level 3).

(DHSSPS and DoH&C 2003 page 28)

Methodology

The initial phase of the study used a qualitative approach as this was held to be the best method of obtaining rich, detailed data which more adequately represented the complex lived experience of the community nurses; one where they had an opportunity to discursively react to the structure of the focus groups with colleagues who shared similar experiences of the professional work context. In other words, "to describe and illuminate the meaningful and social world as prescribed by the interpretivist paradigm," and to discover what nurses "routinely, unremarkably but recognisably and readily" (Silverman, D 1993 p.21) have to do in order to perform their role in a public health context. It facilitated the generation and validation of ideas at a first stage. However, it was equally important to achieve responses from a representative sample of CHNs across Northern Ireland, a goal better achieved through the use of a quantitative approach. By using both qualitative and quantitative approaches we employed 'method triangulation' using qualitative data to inform the design of the questionnaire used in the quantitative survey (Parahoo 1997). Data from one source can be checked and validated from other sources and this allows validity to be improved.

Qualitative study

The qualitative study consisted of two methods of data collection, namely, focus groups and face to face interviews which were preceded by a pilot study of three focus groups. Twenty one focus groups were held in total across two main research sites in Northern Ireland. The focus groups comprised of separate community nurse disciplines. The face to face interviews were drawn from relevant actors identified during the course of the research.

Quantitative study

The themes emerging from the qualitative study were used to inform the design of the questionnaire. These included: level of public health activity;

involvement in community profiling; factors influencing work practices; innovative public health practice; use of ICT and collection and use of statistical information. Additionally, the questionnaire (Appendix 1) collected demographic information and explored teamwork in practice. (See Appendix II for specific details of methods and analysis).

Quantitative Sample

Accurate statistics of the exact numbers of CHNs employed in Northern Ireland have been difficult to obtain as no one agency seems to have all the information. In a previous study (Poulton et al. 2000) an attempt was made to undertake a census of CHNs and the estimated total population size was 3,000 plus. However, the response rate was low (28%), particularly among more dispersed groups such as practice nurses. The highest response rates were achieved where a key contact was used to distribute questionnaires. For these reasons it was decided to survey a 15% sample based on more accurate figures supplied by Trusts (community nurses and midwives) and Boards (practice nurses) and to use a key contact distributor. Using this process the total population of CHNs was calculated as 2,668 whole time equivalents (WTE) yielding a 15% quota sample size of 409 WTE.

SECTION ONE: CHARACTERISTICS OF RESPONDENTS

Table 1 Response rate by Trust and Board

Name of Trust	No: sent to nurses	No: returned	% Return rate
Armagh & Dungannon	22	15	68%
Causeway	23	23	100%
Crigavon/Banbridge	34	17	50%
Down/Lisburn	30	25	83%
Foyle	37	24	65%
Homefirst	59	40	65%
Newry & Mourne	19	9	47%
North & West Belfast	37	23	62%
South & East Belfast	38	15	40%
Sperrin/Lakeland	35	26	74%
Ulster Community&Hospitals	40	34	85%
Total (Trusts)	**374**	**251**	**67%**
HSS Boards(practice nurse)			
Northern	9	0	
Eastern	10	1	
Southern	9	1	
Western	7	2	
Trust/Board not specified		20	
Total practice nurse	**35**	**24**	**69%**
Overall total	**409**	**275**	**67%**

Of the 409 questionnaires distributed, 275 were returned, an overall response rate of 67%. The breakdown of questionnaires distributed to each Trust/Board and response rate is presented in table 1.

A total of 374 questionnaires were sent to community nurses employed in eleven Trusts in Northern Ireland. Of these 251 (67%) were returned. Figure 1 below shows the response rate for each Trust. For example, based on establishment figures, Causeway HSS Trust received 24 questionnaires and all of these were returned, a response rate of 100%.

Figure 1 Response rate by Trust
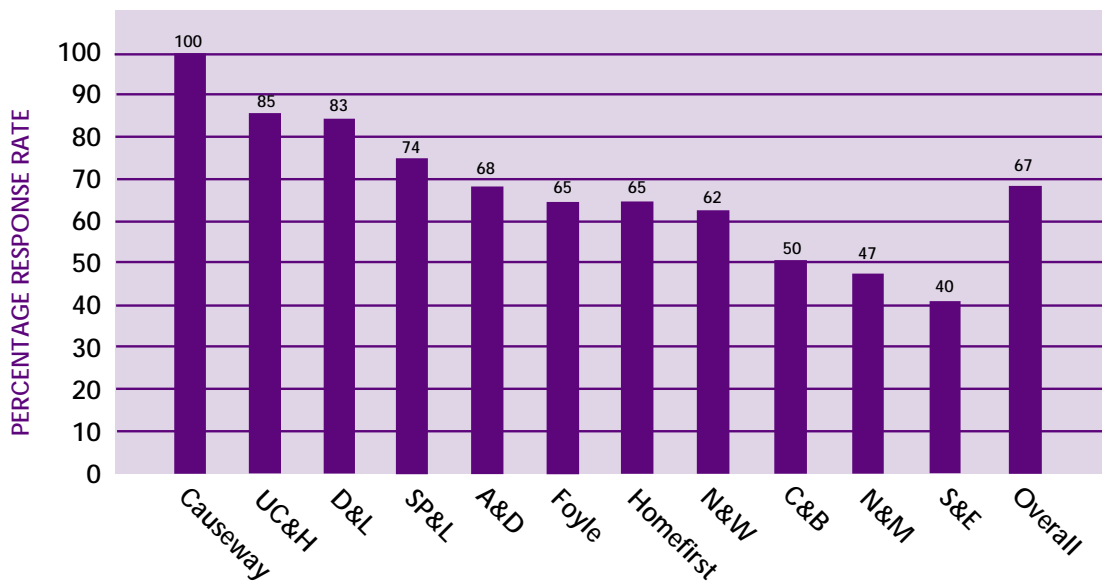
A 15% sample of practice nurses (n= 35 WTE) was generated from the 4 Boards. Based on establishment figures the number sent to each Board are presented in table 1. Although 24 questionnaires were returned from practice nurses (69%) only four of these respondents specified the Board in which they were employed therefore it was not possible to calculate the response rate per Board.

Response rate by Job Title

Figure 2 below shows a breakdown of responses by job title. The largest group represented is qualified district nurses, making up almost a fifth of the responses. District nursing sisters and community staff nurses constitute almost 37% of the response rate and combining these figures with those of health visiting (18.5%) accounts for over half (55%) of the responses. In contrast mental health nurses constituted 10% of the sample

followed by general practice nurses (9%). This representation of disciplines compares favourably with estimated community nursing numbers in Northern Ireland (see table 2).

Table 2 shows the percentage response rate for community health nurses based on whole time equivalent establishment figures submitted to the researchers by Boards and Trusts (Jan 2002). As in a previous study of community health nurses (Poulton et al, 2000), there appears to be an inaccuracy with the learning disability nursing figure as the return rate exceeds the distribution by one questionnaire.

Figure 2 Response rate by Job Title

Figure 2 Response rate by Job Title
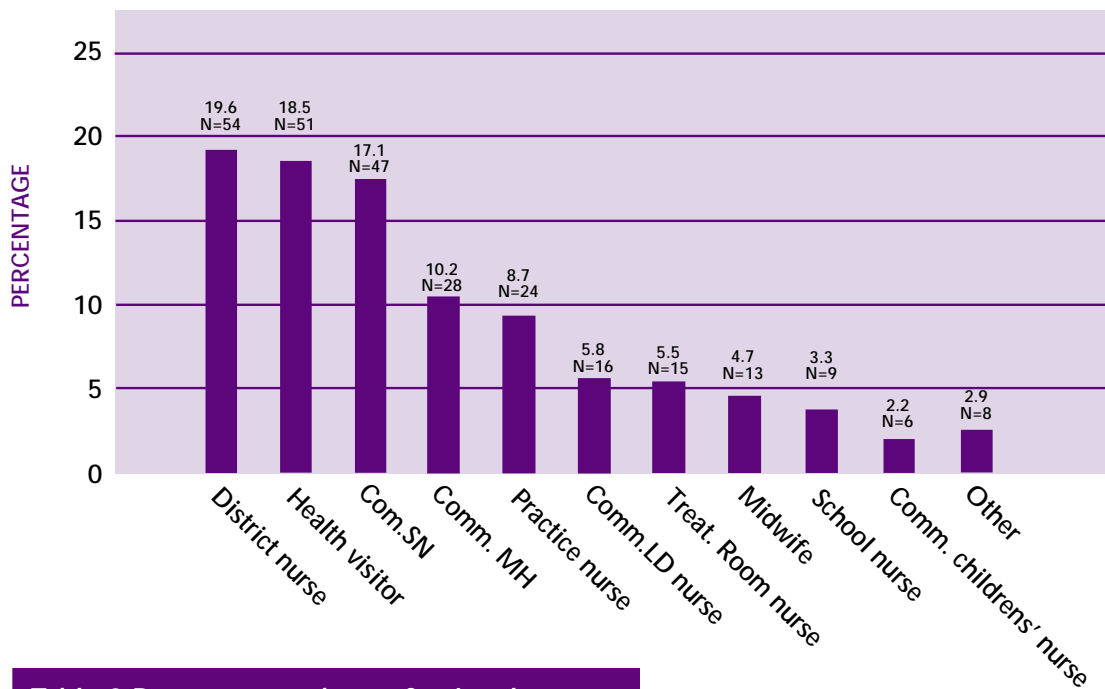
Table 2 Response rate by professional groups

Discipline	Approx no. employed in NI. (WTE)	Sample (15%)	No. of respondents	% response rate of group
District nursing sister	433	65	54	83.1%
Community children's nurse	60	9	6	66.7%
Community staff nurse	547	82	47	57.3%
School nurse	93	14	9	64.2%
Health visitor	540	81	51	63%
Community mental health nurse	327	49	28	57.1%
Practice nurse	240	35	24	66.7%
Community learning disability	100	15	16(?)	100(?)%
Treatment room Nurse	147	22	15	68.1%
Occupational health Nurse	27	4	4	100%
Midwife	100	15	13	86.7%
Other	52	18	8	44%
Total	**2666**	**409**	**275**	**67%**

Professional qualifications

Figure 3 illustrates the professional qualifications held by respondents.

Many respondents held more than one qualification.

Figure 3 Professional qualifications held by respondents

Academic qualifications

Figure 4 shows the academic qualifications (i.e. degrees and diplomas)
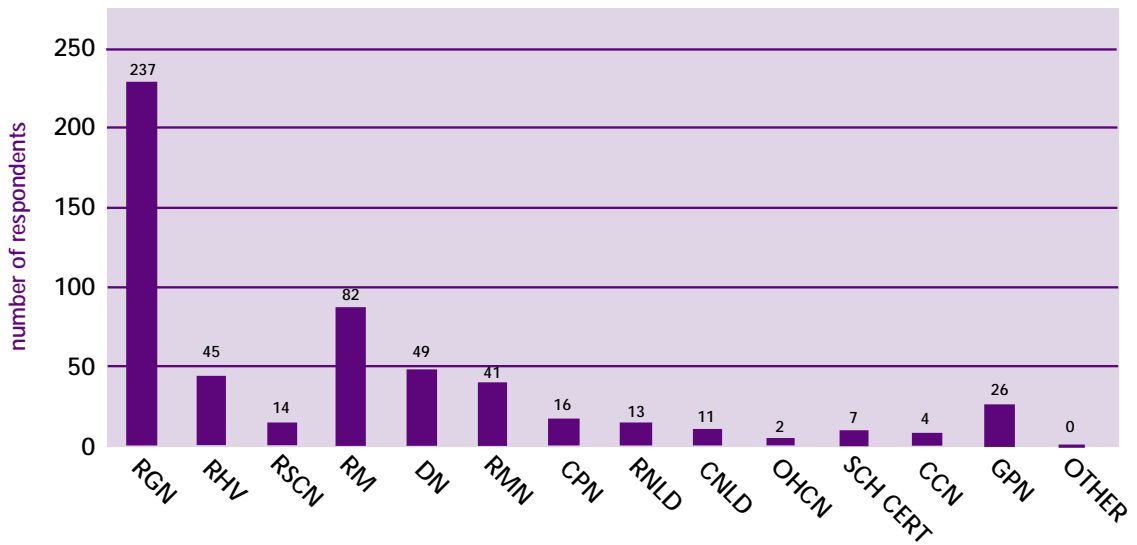
held by respondents. Please note that where a respondent holds more than one academic qualification, the highest award is illustrated.

Figure 4 Academic Qualifications held by respondents
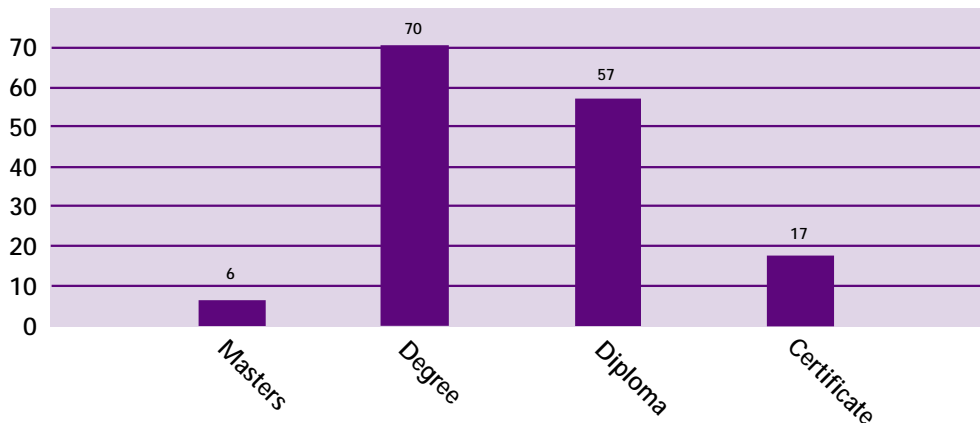
One hundred and fifty (54.5%) respondents held an academic qualification additional to their professional nursing qualification. Of these almost half (47%) had a degree, 57 (38%) had a post registration diploma, 17 (11%) a post registration certificate and a further 6 (4%) had a masters degree. These results highlighted that 76 (51%) of the 150 respondents held a degree or higher level academic qualification. In relation to the larger sample (n=275) and Northern Ireland, this would imply that over a quarter (27.6%)of community nurses in Northern Ireland hold a University Bachelor's degree or higher level qualification. In a previous study 16% of community nurses indicated that they held a University Bachelor's or Master's degree (Poulton et al, 2000). This suggests that community nursing degree level qualifications have risen by over 10% in two years.

SECTION TWO: CURRENT WAYS OF WORKING

Introduction

Although there was some evidence of public health activities the majority of accounts related to public health being reduced to health promotion activities. Much of this health promotion related to a specific form of health promotion consisting of offering advice on changing behaviour and individual lifestyle rather than seeking structural or institutional reasons for seeking to promote health. Road traffic accidents, teenage pregnancy, breast-feeding, diet, constipation and substance abuse were all included in respondent's narratives and comparable across both research sites as perceived relevant areas for health promotion. However, practice tended to be strongly described as reactive rather than proactive across the different disciplines. The stories narrated related to various possible reasons that constrained their potential to work in the public health arena. They included a lack of staff availability; a lack of other disciplines and agencies understanding of their specialist roles; a need for someone to respond to pressing client needs in the absence of other alternative agencies. A lack of time because of other priorities and administration; a lack of structural leadership in this direction to date; an institutional context which emphasised other priorities, for example, meeting Trust and GP recognised goals; an increase in role demands as a consequence of changing healthcare policies and emphasis on community care. All these points, and supplementary factors, are substantiated by evidence from the qualitative data in the form of quotes and considered in more detail in the sections below. Where appropriate, they are reinforced to a large degree by the quantitative data analysis.

Questions about community nurses approach to public health activities invoked the following responses;

An indifferent attitude really and a lack of direction really, because there is nothing specific. (Focus Group 3E)

Researcher:
So is it like you are addressing day to day………..

Respondent:
That's it. Our work is consumed with that. (Focus Group 3E)
and

More reactive than proactive. You don't have the time. (Focus Group 3E)

Another colleague questioned this statement saying;

You know I think you are down on yourself because we are proactive. I think we underestimate what we do. I mean you spend a lot of time, if you think of what you do when you are organising someone's discharge, that's all proactive work we are not only reacting to situations. (Focus Group 3E)

A further colleague commented;

We do some but we could do a lot more (Focus Group 3E)

and another;

You are constantly watching and constantly thinking how many more calls you have to do. (Focus Group 3E)

The above quotes indicate how a range of perceptions are expressed within one focus group. It is also instructive to note how notions of being proactive are framed within an individual and family care setting. This is not perhaps remarkable considering traditional educational nursing models of practice and patient needs under existing resource contexts.

We make opportunities as we can. I feel I'm reactive, acting directly on what patients want. (Focus Group 3F)

and

We're really busy, have to get through the work. It's difficult to sit down and talk. (Focus Group 3F)

and

I'm very conscious of the time and not skilled having done the course. (Focus Group 3F)

Treatment Room nurses explained;

It's very hard to treat a patient holistically in a treatment room situation under present staffing levels. (Focus Group 3G)

and

There's potential for public health but not within the present staffing levels. (Focus Group 3G)

and

We are very task orientated with the rate

of through-put and then there's budget and training needs. (Focus Group 3G)

and

It's a conveyor belt, it's difficult, if we had more staff we could do one to one' but it's down to getting them in and out. (Focus Group 3G)

One nurse asked rhetorically;

Must we work at such a pace, the treatment room is intense all the time. We would see sixty people in the morning, just two nurses.
(Focus Group 3G)
A different group, this time District Nurses explained;

We would all love the chance to do more but we are bogged down and patients always come first.
(Focus Group 2 I)

These nurses expressed interest in public health and saw it as relevant to their work. They felt that they had the potential to contribute towards it. They also said that health promotion is an integral part of their work whenever possible under the constraints outlined above. However, they felt some training would be beneficial to them in this area if they were to extend their role as indicated later under education in section three.

Turning to another discipline, one nurse manager interviewed felt that GP attachment was counterproductive to District Nurses' nurse autonomy and felt that G grade nurses needed more leadership skills. She agreed with nurses from the focus groups that finding domiciliary care for duties such as social bathing was a problem and detracted

from public health activity. She thought that School Nurses could potentially broaden their role from mainly screening activities and increase their scope for self identified public health problems but that the small numbers of staff made this difficult. (Nurse Manager Interview 4)

Quantitative data

Working on the agreed definition of public health (Mason and Clarke 2001) respondents were asked about their involvement in public health practice. Of the 267 CHNS responding to this question 241 (90%) either agreed or strongly agreed that public health was an integral part of their work

Proportion of time spent working at community and individual levels

Figure 5 illustrates the proportion of time (in an average month) that respondents estimated they spent working in various community settings.

Figure 5 Estimated amount of time (in an average month) spent on a range activities
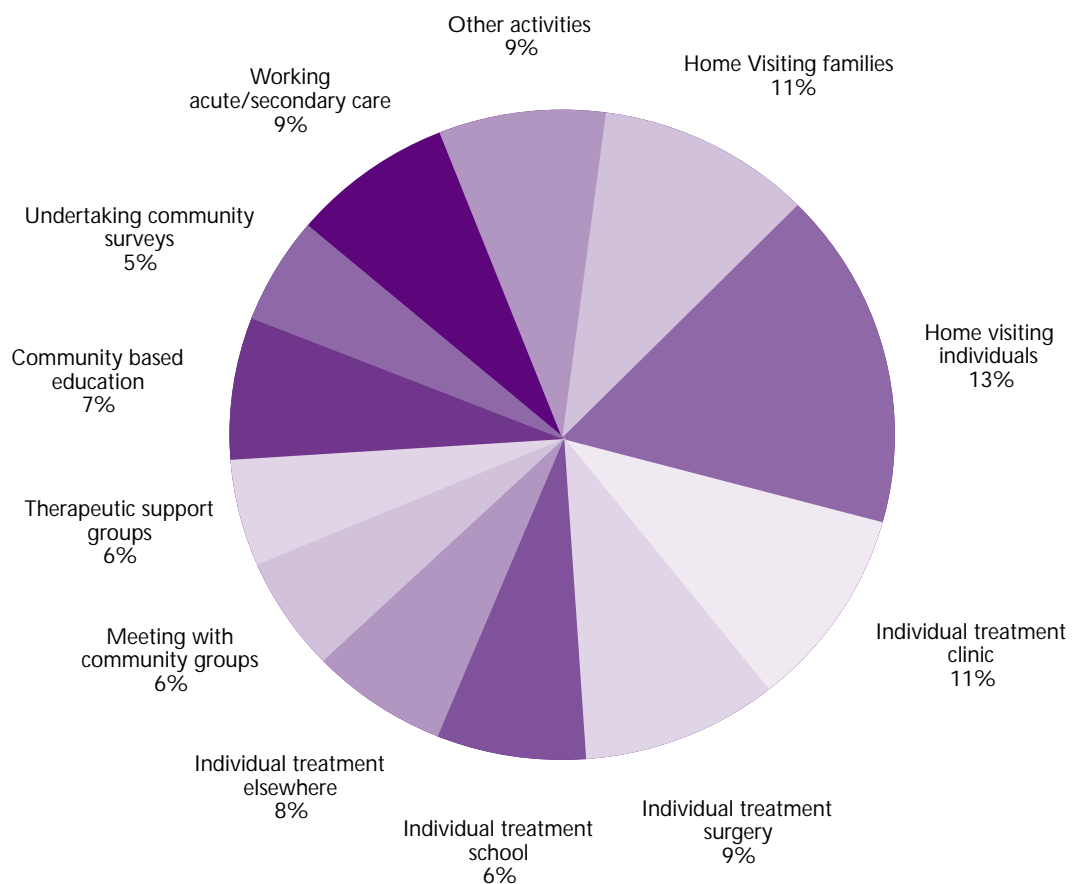
Respondents estimated that in an average month they spent 24% of their time on home visiting to individuals and families. A further 34% was spent in individual care/treatment in a ranging of settings (e.g surgery, school). In all, therefore, over half (58%) of community nursing time is spent on individual and family care and treatment in the community. Therapeutic support groups, which probably apply to specialist groups such as Community Mental Health nurses, accounted for 6% of time. Activity at a community level, which involved meeting with community groups, undertaking community surveys and participating in community based education, only accounted for 18% of CHNs time.

Involvement in population needs analysis

Population health needs analysis is a key activity in public health practice. However, of the 265 CHNs responding to the question relating to population health profiling only 24 (9%) said they had completed such a profile. Figure 6 shows a breakdown of these respondents by job title.

Figure 6 Completion of population health needs analysis by job title
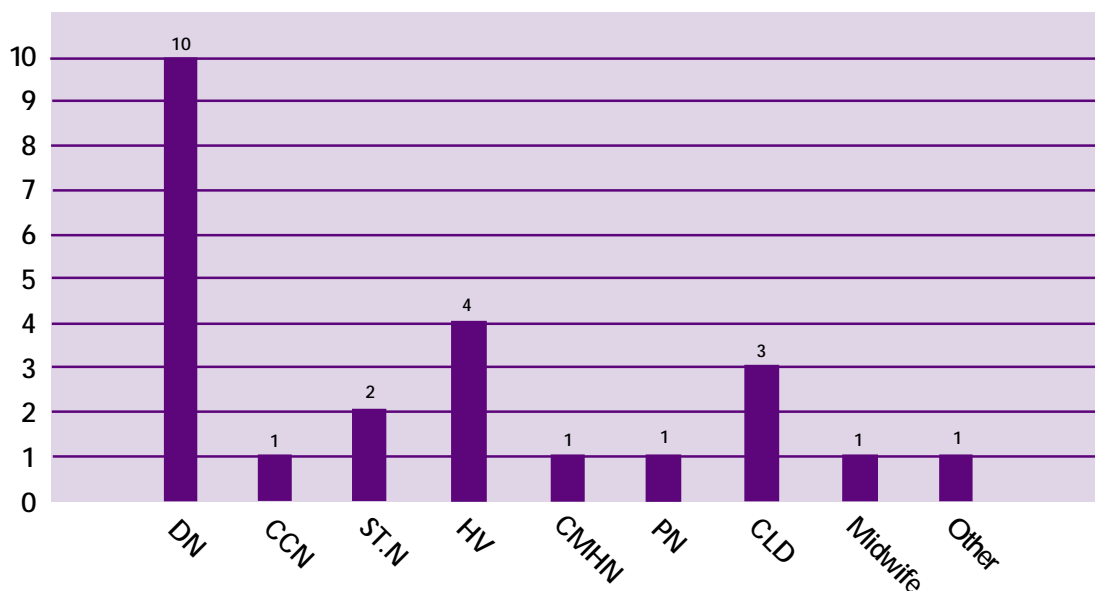
Ten district nurses said they had completed a population health profile compared with 4 health visitors. This is surprising as in a previous study the health visitors were the group most likely to work at community level (Poulton et al. 2000). However, the sample represented 83% of district nurses as opposed to 63% of health visitors, working in Northern Ireland. Of the respondents who said they had completed a population health profile 10 said they had used a needs analysis tool to facilitate identification of need. However, few gave more detail of this and of those that did there was a tendency to describe a process rather than identify a specific tool, for example, one heath visitor wrote:

Questionnaire interview of individuals living in a specific community…focus groups of interested stakeholders

In its true form population needs analysis should be a multi-professional/ multi-agency activity with full participation of the local community. Respondents who had completed a population health profile were asked to rate on a scale of 1 (not at all) to 5 (completely) the extent to which they had involved the local community; other members of the immediate multidisciplinary team; and other agencies (e.g. housing). The mean score on each of these criteria are presented in figure 7.

Figure 7 Involvement of other stakeholders in the population profile process
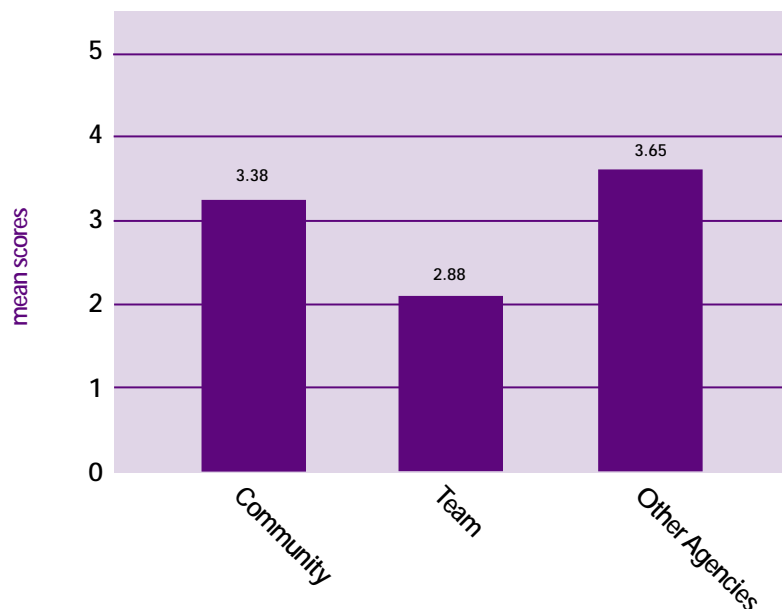
1 = not at all
2 = to a limited extent
3 = somewhat
4 = to a large extent
5 = completely

The highest level of collaboration was with other agencies where 56.5% of respondents rated the involvement of 'other agencies' in compiling the population needs analysis at 4 (to a large extent) or 5 (completely). Interestingly, the lowest level of involvement was with the immediate multidisciplinary team, and 28% of respondents rated this level of involvement at 4 or 5. There was a moderate level of community involvement reported by respondents. Fifty percent of respondents rated this level of involvement at 4 or 5.

Discussion

The data suggests a largely reactive rather than proactive approach to public health initiatives. One undertaken within a framework of individual and family health concerns, where individual and

lifestyle factors dominate thinking in contrast to identifying structural or institutional reasons for poor public health. There is little or no emphasis on community profiling but rather a task orientated culture exists based upon patients needs.

Apart from traditional nursing cultures constituting potential barriers to present and possible future public health nursing initiatives, the data evidences numerous other factors which need to be considered. At times, a lack of time, a lack of adequate staffing levels, administrative responsibilities (some of which are seen as inappropriate – (see section five) a lack of ICT – (see section four) a lack of leadership, the need to meet Trust and GP goals rather than explicit nursing goals and increases in role demands are all perceived to negatively contribute to achieving public health policy aspirations. Some of these findings are analogous with those of Cowley et al. (2000) in respect of the low priority some nurse managers view health profiling and the increased risk to public health practice posed by staff under investment. Furthermore, a lack of training and an uncertainty of how to achieve public health improvements or what indeed the goals might be all foster a cumulative climate that is less than optimum for successful public health practice. In this climate public health is frequently reduced to an understanding that it equates merely with health promotion, an area with which, nurses are more familiar and apparently comfortable. This analysis is supported by both the qualitative and quantitative data as less than ten per cent of respondents in the questionnaire claimed to have performed a population health profile. Fifty eight per cent of community nursing

time was said to be spent on individual and family care. Those who did engage in public health related accounts of a poor multi-agency and multi-disciplinary approaches.

SECTION THREE: FACTORS INFLUENCING WORK PRACTICES

Introduction

Both the qualitative and quantitative research set out to define and identify the community nurse's understanding of factors, which positively and negatively influenced their practice in relation to public health initiatives and innovations. It was recognised at the outset that nurses' individual practice, as in most employment contexts, is to a lesser or greater degree circumscribed by pre-existing work cultures and institutional structural binds (Lazenbatt,1997). A previous study of the CHN workforce in Northern Ireland (Poulton et.al.2000) found that development of a public health approach to practice was dependent on organisational support and strong leadership. Organisations which adhere to rigid policies and procedures give little scope for the development of fresh ideas and new innovations Respondents were accordingly offered a series of questions to begin the qualitative dialogue relating to their experience within the work context and what prospects existed for them adapting their practice to include more public health considerations. Their narratives and responses formed the data, detailed below and subsequent discussions.

Time and staff retention

Pressure of work was seen to have an impact on staff retention as frustrations build up.

Primary care depends on our good will, we knock our pan in every day.
(Focus Group 2I)

I think again if I was under immense pressure – I mean I am leaving, I am actually leaving because I can't work like this any longer but if you had time to step back and actually look at what you are actually doing and even identifying, this (Focus Group 2B)

Same speaker continues

In the end I just said well I'm leaving, I just don't care.(Focus Group 2B)

A different speaker related

I have worked here for twelve years now and there has never been a full quota of staff and it's worse now than it's ever been. (Focus Group 2B)

We had a member of staff who had retired who was still coming up on the system as having 100% of her work done. Who was doing it? The colleagues she left behind, we were doing it. So if mine is down as 80% because I am doing 20% of hers ………….
(Focus Group 2B)

You try to do a bit of health promotion but there's no time left.
(Focus Group 3G)

Again, it comes down to time, you're edging away while people are talking.
(Focus Group 3G)

In relation to reading to keep professionally up-dated and research

There's a lack of time, don't have time at work or at home either, it's intense with patients sitting at the door before I start.
(Focus Group 3G)

Pressure of work due to lack of time and staffing resources were discussed in terms of creating sickness which in turn created more pressure on remaining staff in an already under staffed context.

I am not prepared to do it anymore because I have become exhausted. I was up late when they went to bed and then I spent two hours in the kitchen on paperwork. (Focus Group 3E)

Same speaker:

I am not prepared to do it anymore because basically I went off work there for a week sick. My blood pressure had gone up, and it's just purely stress at the moment and then I think that I just can't cope with it anymore. I just don't think I'm able to do it. I think work has to be re-directed or there has to be more support. I think this Trust are very happy to see you do things but they won't put their money where their mouth is. But then she doesn't have the resources to put the money in. (Focus Group 3E)

This account spans the links between work pressure, lack of time, stress and consequent sickness, coupled with a recognition of the financial constraints experienced by management. The same respondent linked her discussion to the role excessive administration plays in this context and her comments are detailed in the discussion on LCID in Section Four. Thus, the data suggests that a range of factors coalesce to inhibit an optimum environment for community nurses to engage in proactive innovative public health projects in any formalised and meaningful way with some notable exceptions discussed in Section Six. These factors appear to be compounded by historical professional cultures which position nurses as mostly powerless actors within a hierarchical management system which is further constrained by a system which has traditionally been shaped to some extent by allied medical professional dominance and a health service traditionally focussed upon the sick where a medical model has been seen as the most relevant and rational one.

Management styles

Perhaps consequently, some nurses expressed frustration at not being able to have their voice heard at management level. Management style was held to be predominantly a top down one.

Our two weekly meetings are top down, being given information, mostly on pragmatic, practical things. (Focus Group 3F)

It was very much a top down management. (Focus Group 2B)

A sharing profession becomes a management led profession. (Focus Group 2B)

Sure they have their meetings without any representation from the people on the ground. They rarely ask us anything. (Focus Group 2D)

So you see that's the kind of thing that we should be wanting to look at in our professional arena rather than topics that are decided for us. Our staff meetings, where you could take a look at what is going on locally rather than a paper moving exercise because that is what it has become and it is so frustrating. (Focus Group 2 D.)

Communication is a problem, staff on the ground, though it's not always management that are at fault, sometimes it's getting time to get around to reading it. (Focus Group 3G)

You come in the morning and go home at night, unless there is a problem we don't have much communication with the manager. (Focus Group 3G)

Interestingly, the focus groups appear to have offered the community nurses an opportunity to voice their opinions in a listening environment. Most expressed this feeling in comments towards the end of each session.

The following quote is taken from a letter following one focus group with Mental Health nurses when I invited written follow up comments but reflects the common response to the focus groups.

Thank you very much for giving us the opportunity to express our opinions through the focus group on future mental health services. The general consensus seems to have been that it was good to speak frankly about the issues that are around at present. (Focus Group 2F)

There was a sense arising from all the focus groups that there was a lack of large-scale direction, one of a fragmentation of issues, where a sense of main goals was unclear. At the close of the focus groups many nurses expressed both the rarity of being given the opportunity to critically reflect on their individual practice and to hear of fellow practitioner's contexts and innovations across several areas of practice. In many senses keeping focussed upon the larger points of community nursing such as

public health appears to recede as they struggle with their own particular practice problems in less than optimum contexts which are somewhat remote from policy decision making arenas directed to an emphasis on improving public health. In other words, there is a communication gap between policy aspirations and the reality of practice which might be lessened via improved communication flows in all directions.

Role confusion

The problem associated with role confusion was a recurring one throughout the nursing disciplines (although midwives had a clearer sense of the boundaries of their practice across the research sites).This variously related to respondents' confusion over what exactly they were legitimately meant to do within their present role, how patients/clients perceived their role and how other professionals viewed their role. This confusion appeared to impact upon their morale and upon the effectiveness of their practice as indicated below.

In relation to the LCID system a respondent from the focus group said;

I would say it is more knowing our roles would be more valuable than numbers and saying that you go in and do thirty health appraisals and with that you generate x amount of hours. If they knew exactly what our role was and understood it and appreciated it then it would be more beneficial. (Focus Group 2D)

In relation to what are perceived as inappropriate roles:

We have got a School Nurse doing a travel medical clinic, which is historical – it's been going on ever since I remember and that's a full day -. It's a morning session and an afternoon session on two different days and we've been fighting about that as well. It isn't school health work. It's nothing to do with school nursing – just pulling stuff out of the fridge for them and making sure it's topped up. (Focus Group 2D)

In some cases, a lack of understanding of role by other disciplines directly influenced role status and practice:

She recently wrote up protocols and guide-lines for it and one of them was that the nurse should clean cupboards. And this is a doctor that we are working with daily but she had her doctor head on that day when she made that – it was very, very, insulting. (Focus Group 2D)

Apart from a misunderstanding of role here and elsewhere there is evidence of historical power relationships within medicine exerting a dominance and control of nursing.

Others talked of being:

A Jack of all trades, with a lack of clarification, this is what our nurses need and want to do our job.
(Focus group 3F)

I feel pressurised to do things I'm not qualified for. We need definite policy guidelines from management to give to GPs. (Focus Group 3F)

and

I don't feel I have the power
(Focus Group 3F)

The felt lack of power perhaps needs addressing via clear management strategies and nurse education which empowers nurses to act as confident professionals on a par with but different from medicine. (See also the discussion on education below in this section)

Low Morale and Feelings of Guilt

Some sections of community staff appear to have lower levels of morale than others, this appears to be particularly significant for School Nurses, Treatment Room and Practice Nurses although it was perceptible across all disciplines. Apart from the possible effects on sickness rates and performance low morale is also likely to effect staff retention levels. The quotes below illustrate some perceptions which spontaneously arose as discussants explained other facets of their work experience.

In relation to patients;

I feel guilty because the leg ulcer patients hold you back and you're always looking to the queue.
(Focus Group 3G)

In relation to management:

I think even getting recognition, management taking us on board, we are just below a certain level.
(Focus Group 2D)

They aren't interested in us, they really aren't. This is just us being realistic isn't it. (Focus Group 2D)

Well, that's what I say. If I leave the staff nurse too long I feel guilty. She can only

do a day's work on Tuesday, so what I would have done she does.
(Focus Group 3D)

And the same speaker in relation to needing more staff:

So in essence you can find, and I have actually, one thing I tend to do, I tend not to tell the GP, you try to cover up that you worry. I don't see why I should have to, but I feel ashamed that I am away from my patch, that I am seen as the designate person. (Focus Group 3D)

Here we have a perception that the nurse is unable to properly fulfil her present designated role without the further consideration of an extension of her role into public health responsibilities. She explains:

Yet District Nursing is so generic that if it doesn't fall on anyone else it's the District Nurse's. If it doesn't fall on any other professional, we take it. And no matter how much argument it still always fall back. You could bring issues up and it will end up back on your door. They think we are the waste-bin.
(Focus Group 3D)

Well, there is a reduction in OTs generally and they put them onto us, it seems to be the nurse again has fallen for that. She is now ordering more stuff. We can now order equipment that five years ago it was always the OT so again I feel other services are cutting back on what they are delivering and it is falling with us. Our remit is getting bigger.
(Focus Group 3D)

She continues to explain how her colleagues and herself have to man [sic] phones because of reductions in

chiropody services, how there is a major lack of carers. How a reduction in occupational therapists and an increase in equipment take time out of their identified role expectations. These findings are consistent with the study of District Nurses (DN) carried out in England and Wales (Low et al 2002), which concluded that DNs had become a 'sponge' for care services. This role extension maps onto issues of role confusion discussed under that specific heading and evidences the complex interaction of factors which make up the work experience and context for introducing any proposed extension of role, in this case, of public health. All these factors need careful consideration in any future planning of extension of role.

Rising patient expectations

In relation to early discharge from hospital and the package of care needed one nurse suggested that the package of care needed and the one offered may be totally different. She further argued that there are a lot of gaps to be filled, there is a difficulty getting sufficient carers and that consequently, patients are sometimes vulnerable. She explained:

The other thing is rising patient expectations - the patients are built up in hospital and told you'll get a District Nurse three times, or twice and then we go out and are the baddies because we are not providing what the hospital have said. I mean that happens all the time. The consultant will say, you will have a nurse every day and at the end of the day we have to make our own assessment and you will have social care, you need twenty four-hour care. Then we end up being called, you have wasted more time.... (Focus Group 3D)

The nurses described how people have increasing expectations because:

They know more. They know more and they know their rights, they know what they want. (Focus Group 3D)

The issue of rising expectations is pertinent to staff morale and role expectations but also maps onto other issues raised in the focus groups. For example, the discussion on ICT below in Section five.

Levels of Interdisciplinary working

An overall impression from the fieldwork data suggested a chronic lack of effective interdisciplinary working towards public health initiatives. This was the case not only within the nursing disciplines but across the broad range of respondents individually interviewed. See also the data on the final three interviews in this section under education.

On asking one GP if he ever got involved with public health his stark reply was:

No, we don't have any evidence about community needs, don't interact with public health apart from sending them immunisation statistics etc.
(Focus Group 3D)

Question:

Do you want to get involved?

Response:

No. I don't think public health is seen as very interesting, most GPs don't want to know, it's a sort of academic area, talk, but nothing gets done. If we are invited to get involved with public health as you discussed earlier, I think it will have to

be under a different banner.
(Interview 5 GP)

As stated earlier the interviews form supplementary data to the rest of the research data and do not claim to be representative of the groups in question. Nevertheless, his remaining comments may be worth considering in the light of the GPs anticipated, if currently deferred, role in the new Local Health and Social Care Groups (LHSCG) and in their potential relation to achieving improved public health.

Well, if several GPs from the same area could get together and share evidence of disease and treatment, then that would be useful but it doesn't happen. You see we tend to be scared of sharing information on practice in case we are found not to be doing the best thing. That's just the way it is. However, if we could overcome this, sharing information over a given geographical area might be useful.

Question:

So what do you see as stumbling blocks to becoming more involved with public health? Do you, for example, already work in an interdisciplinary fashion and connect up with housing, environmental health and so forth?

Reply:

One of our main problems is bureaucracy – it takes so long to get anything done, management tiers need to be cut down.

Question:

So you say you don't work in an interdisciplinary fashion?

Reply:

No, we don't connect up. We're not trained to work that way. We hope that we do good work, attain similar standards but we just hope, we just don't know what happens in other practices. If we could rid ourselves of many unnecessary tasks then we might have time to do such work. I spend much of my time chasing issues concerned with acute services, phoning up, trying to get information which could have come through but hasn't, if that level was more efficient then we could become better at that sort of thing. (GP Interview 6)

The above quote raises several interesting points worthy of further consideration and research. However, one immediate major point for consideration in relation to this report is that if other GP's work in this context then the roles of the nurses who work within their area may have an up-hill struggle in achieving effective public health practice without clear infra structural and health policy changes at operational and structural levels. Furthermore, it suggests that drawing in GPs to contribute more effectively may be a task for strategic and local governance policy makers.

An interview with a representative from a non-governmental organisation for substance abuse similarly described how little inter-disciplinary work happened in his long experience. The exceptions were liaison with community mental health, social workers and GPs. He felt that there was room for improvement both in referrals and in education in this area. (Substance abuse worker Interview 5)

Similarly, interviews with an Environmental Health Officer

(Interview 7) and three people from Public Health (Interviews 8, 9 & 10) reflected the same problems with inter-disciplinary and inter-agency working and stated that there is scope for much improvement across the statutory and voluntary sectors.

Two other areas are worthy of inclusion here. Both are related to the specific political, cultural and economic context of Northern Ireland and influence community nursing and public health in specific geographical locations. Both deserve further research as they did not form the focus of research for this study. The first issue of conflict arose spontaneously from discussions.

Conflict

The political situation makes our work and our patients totally different from other areas. (Focus Group 2I)

and

With the paramilitary organisations it's not that easy to set up community initiatives, people won't go. (Focus Group 2I)

and

People are afraid, they don't mix outside their area. (Focus Group 2I)

and

Some people who live at the top of the road won't come down to the bottom. (Focus Group 2I)

and

You have to work with what you've got. I've been asked to go home over the past

few years. I'm okay in the day but wouldn't be there at night.
(Focus Group 2I)

One nurse stressed the importance of working with the local community and posited the idea of lay advocates and workers.

One answer might be to train local people. (Focus Group 2I)

Indeed literature on democratic theory has long since championed such approaches and health research indicates that the suggestion has some merit (Johnson et. al 1993). Clearly, Northern Ireland has some unique public health problems compared to the rest of the UK but can perhaps learn from and contribute to global health and conflict evidence based research and practice in future.

Understanding cross-border public health issues

This did not form part of the qualitative or quantitative data collection schedule. It may, however, be worth noting that there was little evidence spontaneously arising from respondents from the focus groups on cross border public health policies or public health initiatives on this theme. On questioning one respondent from a cross border area on her knowledge of public health policies in the South of Ireland in light of the Irish 2001 Health Strategy Document she replied:

Well, I would have heard about it because our doctor here today actually works in 'C' and then works as a locum here so he would keep me up to date with what's going on down south but generally no, it wouldn't come through otherwise. (Focus Group 3D)

Recently two projects have been completed which have the potential to strengthen Cross Border working in public health. The first (Mhaolrunaigh et al 2003) aimed to identify and strengthen the health promotion capacity of community health nurses working in border areas. Isolation was identified as one of the key themes and has resulted in the setting up of a Cross Border nursing network which aims to 'enhance the health promotion capacity of community nurses in isolated border areas through influencing education, policy and practice'. (page 5). The All Ireland Public Health and Nursing Group has facilitated Cross Border collaboration over the past three years, culminating in the *Vision to Action Report* (DHSSPS & DoH&C 2003). This report sets out a clear action plan addressing communication, networking, practice development education, education and leadership with the aim of strengthening the public health capacity of nurses throughout the island of Ireland.

Educational factors

While some nurses appeared reasonably content with the educational and training opportunities they had been offered by their Trusts many others expressed a range of disquiet about their experience as outlined more specifically below.

On disciplinary inequity:
A perceived difference between higher educational and post registration training opportunities existed depending upon which nursing discipline spoke. For example, School Nurses tended to feel that they had low status in terms of accessing any available training, courses or conferences as compared to some other disciplines. Low staffing levels appeared to be a perceived crucial factor

in relation to being granted or refused permission to attend various events.

Being in the room nine to five means that there's a lack of flexibility, we work on a rotation basis, it makes it difficult to get cover to go on a course. There's not much staff on bank location. There are courses I'd like to go on, asthma courses and diabetic courses. (Focus Group 2G)

These same practice and treatment room nurses also commented on the poor provision of induction courses which, they argued, tended to take the form of 'apprenticeship' rather than formal training. They also felt that professional autonomy was a problem in highly medicalised environments. Others felt the pressure to keep abreast of a broad range of specialities leaving little or no time to read at work.

Public health is a whole new area, we'd need that background, some training. (Focus Group 2I)

The above succinct quote may well be a core finding of the report.

On geographical inequity and education

The geographical location of the nurses also appeared to be a significant factor with nurses from the West of the Province who expressed a perception that they were significantly disadvantaged as a result of most education and training taking place in Belfast. Consequently, attending events involved very early starts and finishes after travel time considerations, which were incompatible with commitments to family and children. This, to a lesser or greater extent, influenced their decision, enthusiasm, energy and ability to attend events which if arranged more locally would be more accessible. A posited solution offered by the respondents to the problem of marginalisation was that in future policies be directed at ensuring that education and training events are organised locally instead of Belfast automatically being seen as the centre of activity. The long quote below encapsulates some of the above problems associated with the centre and the periphery.

Yes, I could understand that and a lot of them will be in Belfast. That would be a big issue I am sure for the rural communities, the rural staff because our staff have easy access to everything. I mean you have the universities, the RCNs, whatever – most courses are within hotels in Belfast so I would say that there is a particular difficulty because you are talking about somebody maybe, our staff going off for a couple of hours at lunch time – if you were coming from the West you would have to add on another three hours travelling time to that. So I am sure that there is a problem and I think there might continue to be that sort of problem because there just isn't the push to provide the same opportunities West of the Bann. (Interview 2 Nurse Manager)

In relation to networking with people from other disciplines and sharing information one nurse from the West talked of feeling very isolated:

It would help if the Belfast, whenever they are organising – the Belfast ones are very much in touch with each other because they have meetings three to four times a year in Belfast which is a bit out of the way for us because we are so rural.

and same speaker:

we are so far away and we are just out on our own - to get away from the departments is very difficult and definitely we feel very isolated here. (Focus Group 3D)

A Nurse Manager discussed the problem of recruiting staff because of geographical marginalisation, reflecting on the fact that many nurses were only there for domestic reasons. Given the lack of 'new blood' she suggested that:

We have to train our existing staff but short term cover is difficult. We have to offer opportunity for modules in public health education and then perhaps introduce a key worker. (Interview 1 Nurse Manager)

From a manager's perspective educational and training opportunities have improved, where staff who have a real interest are given enormous opportunities when time off and financial support are forthcoming. In some cases when the demand was high some staff would be offered financial support only and others time off only. Fairness was held to be a major factor of consideration.

However, some nurses presented a different picture as indicated below:

To set you on the right track (for public health) a base-line would be needed (Focus 3 Group 3G)

I'd be interested but it's the practicalities – if there was time there would be potential. It's not realistic. (Focus Group 3G)

I applied to do the breast and cervical screening course but it wasn't funded because of cut backs. (Focus Group 3G)

Quality and relevance of courses/training days

At least one nurse had turned to users and non-governmental organisations to provide the information she needed. Her quote offers a challenge for all involved in nurse education to keep abreast of recent evidence based research, applied literatures at local, national and inter-national levels and with non statutory services.

The information I got from the voluntary agencies and one father within my case load was excellent, a great resource for anybody that talks to him. The information we had, it did not meet my needs at all. So then I went to my tutor and said look is there anything in more depth that we could be looking at. (Focus Group 2A Belfast)

Education and Training Policies

Nurses from one mental health focus group were keen to raise the point of the need to raise incentives for nurses to undertake training and education in mental health. Arguing that:

At present I feel that this is sadly lacking in Northern Ireland in particular there is a failure to acknowledge the specialist roles and to offer appropriate remuneration for some. For example, basic grade Cognitive Behavioural Psychotherapist in England is H, but in Northern Ireland it remains G. Until these inequalities are rectified people will continue with the same old attitudes, why bother? (Focus Group 2F)

His point on economic considerations may be relevant to wider concerns of recruitment and retention of qualified staff. Economic analysis was not part of the remit of this study but the need for adequate resources was a recurrent and important theme. One Nurse Manager reflected:

Getting trained staff to work in this region is difficult. The staff we have are here mainly for domestic reasons, getting new blood in is a problem. We have to train our existing staff, encourage public health training. (Interview 4 Nurse Manager)

Public Health nurse education issues

The foregoing data relating to education though interesting and important tends to be rather abstracted from public health reflecting the community nurses concerns about education before and at the time the research was conducted. Because most of the nurses' educational experience did not involve public health education the discussions tended to invoke broader concerns over a range of community health modules and courses which reflected the different disciplinary interests. However, three interviews conducted towards the end of the research with individuals currently working in departments of public health focussed more upon issues pertinent to any plans for changing public health nurse education and practice as follows:

One respondent, working in the area of public health medicine (Interview 8), set out the difference between working with individuals and families on prevention and early detection of disease at an operational level and the need to see the

big issues and challenges that population profiling poses at a strategic level. Both these activities were seen as legitimate. He envisaged that professional groups from a range of disciplines would undergo the same training and education benefiting from an understanding of epidemiology, statistics, a theoretical and practical understanding of health promotion. Within this framework each discipline would have particular skills to contribute, complementary but not inter-changeable skills. Nurses would become involved at operational and at strategic levels via a range of training in public health. He envisaged that the newly formed Local Health and Social Care Groups should take a strategic perspective about population health.

The newly organised leadership programme in public health run by The Institute of Public Health in Ireland was reported to have developed a leadership programme in public health which some nurses might wish to pursue though these would be in the minority. Others might be trained at a lower level alongside other multi-agency workers such as for example, district councillors and environmental health officers. Still others should benefit from early professional education so that medical students, nursing students and others have components of their courses which bring them together in a mutually influencing environment.

So there is something about undergraduate education, there is something about in-service education and there is something about the changing of that, all of which have to happen if we are actually going to get multi-central public health to work. (Interview 8)

We have got to work with in some cases the police, environmental health if we are actually going to get proper prevention. So I think it is the most important issue that we face because we are never going to make this population significantly more healthy until we get everybody working together on health issues. (Interview 8)

He continued by reflecting on the need to resource any new initiatives:

How you get some people involved in redirecting focus? I think some of that will have to be about putting additional money into Health and Social Services and increasing staffing. I don't think there is any way around it no matter what tricks some of our Government leaders think. (Interview 8)

A different respondent from the department but with a nursing background related how until recently membership of the Faculty of Public Health had been for doctors but was now opening up to other allied disciplines. As a result various courses, seminars and self directed learning initiatives in public health were becoming available. She related how in England there are specialists in public health who are not doctors but members and that it was likely that the same would happen in Northern Ireland given time.

She remarked that some nurses were:

just happy to trundle along and that is superb because nursing is a huge profession, you can't have everybody pushing at it, but we have also got enough people too who are really hungry for the knowledge and it is actually getting them and putting them in the right places. It's getting back to

the thing, you need to teach people how to think (Interview 9)

She continued in relation to staff retention issues, public health and fast tracking:

You have got to feed that enthusiasm. (Interview 9)

and

I would imagine that there would be quite a big interest from community nurses to do a public health masters. (Interview 9)

Although she was in a different department to the respondent in interview 8 she echoed some of his sentiments when she said:

I think we definitely within nursing need to get a really strong handle on public health and we need to get nursing and public health together. We need to get public health together as an organisation and recognise it as a family of public health within the region. (Interview 9)

Finally, she remarked:

Nurses are incredibly under-resourced and hard- worked. – That's why I think the champions are so important. It's being able to look at the whole process and why we do what we do and if you want this outcome are you going to have met that outcome and it's actually looking at the pulse points. Where do we need to gather information to know that we are doing what we want to do and forget about any other information, stop collecting, stop doing weights in pregnancy because you are told to do weights in pregnancy, you know. (Interview 9)

The above quote made to make a broad point rather than to advocate changes in weight collection data specifically strongly supports much of the data arising from the study which emphasises valuable time spent on surveillance of both staff (via LCID) and clients via many current practices in contrast for a need to, when appropriate, free up time for other public health initiatives.

The third and final contributor from a department of public health reiterated much of what has already been said by the respondents in interviews 8 and 9.

He summed this up by asking:

How do you grow someone into becoming a strategic level person unless there is a clear academic pathway that you can move from an operational focus to an organisational one? (Interview 10)

and

Whereas in medicine there is a pathway that we can then enter, it is less clear to me how you would become a nurse with a specialist public health qualification. (Interview 10)

It is encouraging to note that respondents from the departments of public health saw the potential for nurses to usefully contribute to achieving improved public health outcomes at both operational and strategic levels:

What I am thinking about is how are nurses tied into all those kinds of multi-sectoral, multi-agency…. and some are but less than might be, there is definitely potential for seeing how community based nursing initiatives could fit in with local inter-sectoral kind of initiatives. (Interview 10)

The above quotes demonstrate potential rather than actual means of educating nurses via a variety of courses for both operational and structural roles in public health. Clearly public health is something of a zeitgeist and community nursing in Northern Ireland needs to respond accordingly.

Quantitative data

Respondents were asked to rate on a scale of 1 (not at all) to 5 (completely) the extent to which the following factors influenced their work practice:
1. Northern Ireland national policy;
2. Board policy;
3. Trust policy;
4. local organisational policy (e.g. occupational environment);
5. education and training to date;
6. valid research evidence;
7. feedback from audit and evaluation;
8. feedback from service users.

The mean ratings for these categories are presented in figure 8. (see next page).

Figure 8 Factors influencing work practices
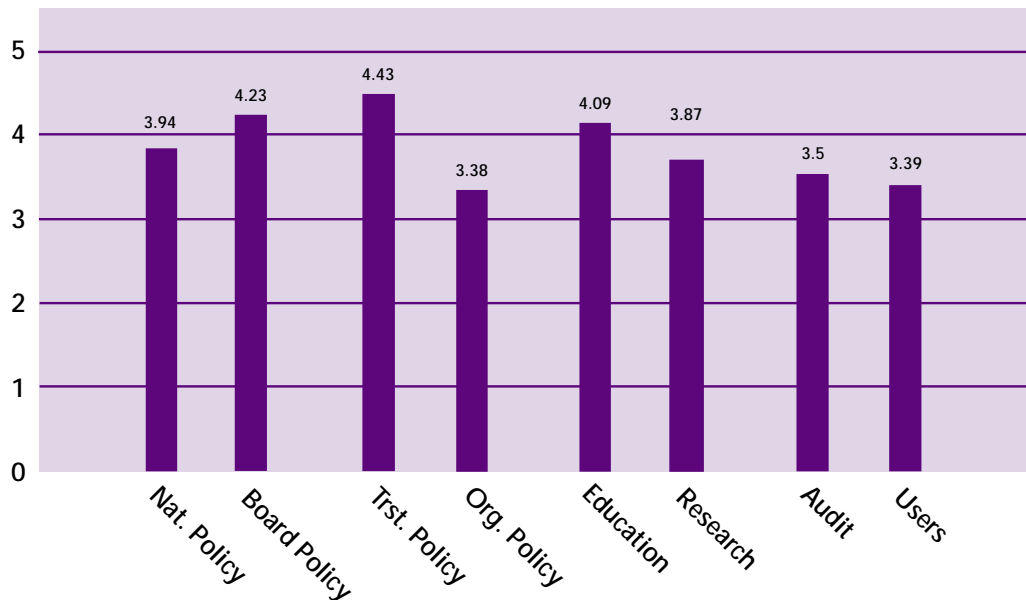
Organisational factors

A previous study of the CHN workforce in Northern Ireland (Poulton et.al. 2000) found that development of a public health approach to practice was dependent on organisational support and strong leadership. Organisations which adhere to rigid policies and procedures give little scope for the development of fresh ideas and new ways of innovative working. Respondents were therefore asked to rate on scale of 1 (not at all) to 5(completely) the extent to which National, Board, Trust and local policy influenced and shaped their practice. Figure 8 demonstrates that Trust policy had the greatest influence on practice with 92% of respondents ticking 4 (to a great extent) or 5 (completely).

The second most important influence was Board policy. As Board policy directs Trust policy, to a great extent, it is not surprising that the Board's influence on practice is perceived. National policy whilst guiding policy at Board and Trust level is perceived as having less of an influence on practice at local level. For local organisational policy respondents were given the example of occupational environment and this was seen to have the least influence on practice with half of the respondents indicating that this had little or no influence on working practices. These findings indicate a top down control of practice giving on the ground practitioners little or no power in shaping their own practice.

Education and training

Respondents were asked to rate on a scale of 1 (not at all) to 5 (completely) the extent to which their education and training to date had influenced their practice. As figure 8 indicates this was rated quite highly with 84% of respondents ticking either 4(to a great extent) or 5.

Research and audit

Evidence-based practice, audit and evaluation are key factors in NHS quality frameworks. Respondents were asked first of all the extent to which valid research evidence influences their practice. There were mixed responses, but nevertheless 75% of respondents ticked 4 (to a great extent) or 5 (completely). The rating for audit was lower with slightly less than half (49.5%) of respondents ticking 4 or 5.

Feedback from service users

A key feature of the quality agenda is the involvement of service users in shaping and evaluating services. It is therefore disappointing that this factor was rated as one of the lowest influences on practice. However, just over half (50.8%) rated this factor 4 or 5.

Teamwork

Partnership working amongst Governmental Departments, public bodies, local communities, voluntary bodies, and district councils is a key feature of the public health framework (DHSSPS 2002). From a community health nursing perspective, multidisciplinary teamwork, between professionals and/ or other agencies, has long been advocated. Therefore respondents were asked first of all if they considered themselves a member of a team and if so to select from a range of options which best described their team. Almost all (97.8%) considered themselves part of a team with only 6 respondents answering in the negative. The types of teams and the frequency of membership are depicted in figure 9.

Figure 9 Membership of a team
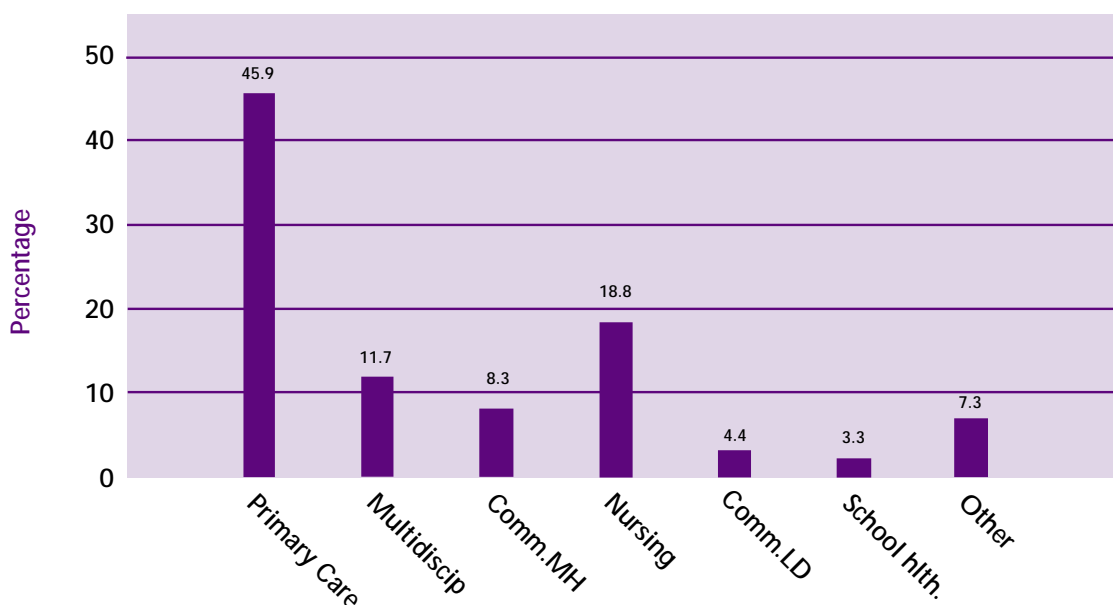
Almost half (45.9%) of respondents identified themselves as a member of a primary care team. A further 11.7% considered themselves as part of a multidisciplinary nursing team. However, almost a fifth (18.8%) of respondents considered themselves a member of a uni-disciplinary nursing (e.g. district nursing team). There were specialist teams such as community mental health (8.3%), community learning disability (4.4.%) and school health teams (3.3.%). Twenty (7.3%) respondents ticked the 'other' category and this included multidisciplinary specialist teams such as occupational health, palliative care and diabetes. Additionally, health and social care initiatives were also mentioned (e.g. Sure Start). However, there were a few respondents (in the 'other ' category) who said they were members of a health visiting or midwifery team which, in terms of the options given in the questionnaire, should have been categorised as uni-disciplinary nursing teams, suggesting that these respondents do not identify with the title 'nurse'.

Based on items used in other teamwork research (Poulton & West 1999) respondents were asked to consider their team on the basis of a range of team working factors (participation in the team, the value and achievement of team objectives) Respondents were asked to rate a series of 8 items relating to team working on a five point scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Figure 10 depicts the scores for participation.

Figure 10 Participation in the team

mean scores

14

12.1 12.45 12.09 12.3 12.08 12.78 13.4

4

Primary Care   Multidiscip   Comm.MH   Nursing   Comm.LD   School hlth.   Other
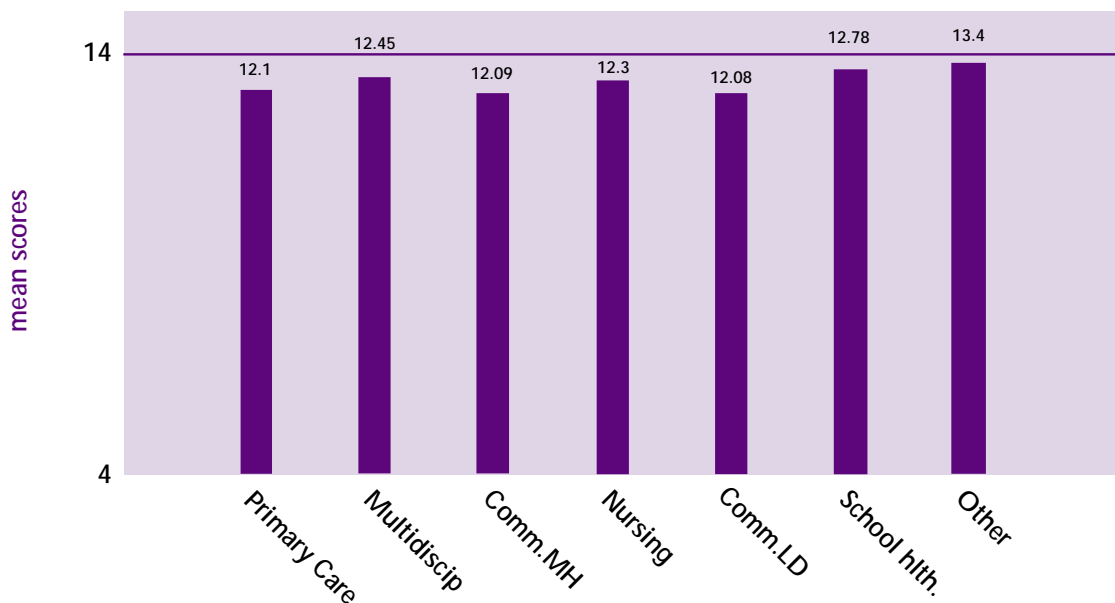
Participation relates to the extent to which team members share information; feel understood; and, feel their views are listened to by fellow team members. Whilst the highest level of participation was in school health teams and the 'other, category, there were no statistically significant differences between teams in terms of participation. There were statistically significant differences between types of teams in terms of the extent to which they set shared objectives, which were understood and committed to by all team members. Figure 11 depicts these results.

Figure 11 Team Objectives
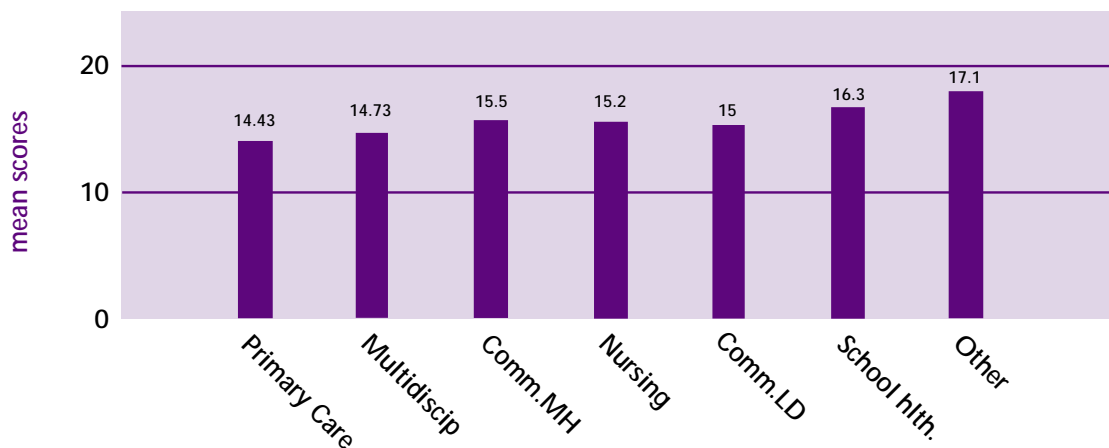
Again school health teams and the 'other' category score the highest and primary care teams the lowest. However, these figures should be viewed with caution as there were only 9 respondents rating school health teams and 115 rating primary care teams. Similarly, 18 respondents rated teams within the 'other' category. Furthermore, as the latter category included specific project teams (e.g. Sure Start) it could be assumed that such teams are working to pre set project objectives.

Discussion

The data suggests that education is a key to achieving improved public health practice. Considerations ought to include geographical parity and methods to accommodate the education of nurses across all the Trusts. The data suggests that there is a strong perception of geographical inequities with respect to the delivery and uptake of educational opportunities within Northern Ireland.

Nursing ought not to isolate itself but to embrace policy suggestions that advocate multi-agency, multi-disciplinary approaches to public health. New public health modules should consider the broad policy goals of public health, what roles in which nursing disciplines are appropriate, how inter-agency and inter-disciplinary education can best achieve

the translation of the goals into public health practice. Other disciplines will move towards meeting public health needs. Any planning perhaps ought to include inter-agency approaches from the beginning rather than as lip service after the main decisions have been made. Nurses perceived lack of trust, lack of respect and low morale appears to some extent to act to disempower and alienate them with some evidence that this affects their willingness to remain in post in some circumstances. Education and management policies have an influence over this situation.

Complex factors coalesce pointing to the need for nurses to develop professional leadership skills if they are to effectively operate with other professions who have traditionally dominated nursing practice.

Having some nurses develop skills to operate at a strategic level in public health would be advantageous to public health nurse practice generally. Work cultures and structural binds and lack of leadership in public health need addressing .

Vision to Action goes someway to addressing the education and leadership issues identified above. For example, there is a proposal for an all Ireland public health E-learning module for post registration nursing students; development and /or establishment of access to a leadership programme for nurses who are involved in public health initiatives; and, negotiation with educational organisations to further develop public health awareness in all nursing roles.

SECTION FOUR: COLLECTION AND UTILISATION OF COMMUNITY NURSING STATISTICS

Introduction

Numerous reports have highlighted the amount of time CHNs spend on administration particularly the collection and recording of activity data (Audit Commission 1999; Clark et. al. 2001). This section explored the extent to which respondents understood the relevance of the statistics they collected; whether they considered them an accurate reflection of their work; the ease with which the statistics could be accessed; and, the extent to which such statistics have been used to plan interventions at individual, family and community level.

Qualitative data

All respondents except one individual in a focus group expressed negative characteristics relating to using LCID and quantitative methods of measuring staff activity. LCID is a system of recording nursing contacts using a series of codes denoting each activity carried out and the length of time spent on each contact.

It's a very good way of showing what one does. I'm quite happy with it. (Focus group 3F)

With this exception questions relating to LCID were generally met with a strong antipathy towards it. Firstly, the activity was seen as very time consuming if undertaken properly and was frequently reported to be left until the end of the month and to a greater or lesser extent rushed.

Get your numbers, the end of the month is coming, get your numbers and should the service be falling apart, get your numbers. We take it on but we say we don't have time for this and that and the other thing, but we do it. We do it and maybe we are not militant enough about it. (Focus Group 1A)

These are put on our statistical returns and they want numbers, that's all numbers. (Focus Group 2D)

It's time consuming. Why bother with it? (Focus Group 3F)

And when home visits went down, they questioned that but there was a lot more people on the phone and we didn't have time to go out on home visits. These are put down on our statistical returns and they just want numbers, that's all that matters. If the numbers drop, they ask questions, big questions are asked. (Focus Group 2A)

It was viewed as one onerous administrative task in the context of wider problems concerning administration at a clinical level:

It's not what you do in the clinics, it's all the administration, you are sending out appointments, you are sending out discharge, you are following up. There is a massive amount of administration and I am not prepared to do it anymore (Focus Group 3E)

We would spend a good half of the day in the office every day doing paperwork. (Focus Group 3D)

Secondly, the forms were held to be inadequate for allowing an accurate representation of the actual work

performed, because of the binding structure of the forms which are seen as inflexible and not comprehensive enough to reflect the reality of practice across disciplines.

All it is going to tell you is that I visited 8 people today, or 7 people today or 4 people today, it doesn't tell you what I did with them or how long I was with them, it will tell you how long I was with them but I could have been doing their 18 month assessment and the mother is horrifically post-natally depressed and I am with her for maybe an hour and a half, but it goes down on my sheet that as an 18 month assessment with postnatal depression and what is picked up is the 18 month assessment. (Focus Group 1A)

A frequent response related to the frequency and importance of phone calls that were not recordable under present arrangements and therefore failed to reflect the reality of the work practice.

We don't put down phone calls and sometimes the phone calls you make can be long, lengthy, phone calls to remind parents to come to appointments. There is a lot of that. (Focus Group 2D)

And when home visits went down, they questioned that but there was a lot more people on the phone and we didn't have the time to go out on home visits. (Focus Group 2D)

Although the nurses had different degrees of understanding about the purpose of the forms, they generally had a less than clear idea of their function and were aware of a lack of any meaningful feedback for their regular, routine efforts of collection. This lack of

clarity over what happened to the information once they had sent it off was general throughout the disciplines.

We were putting things into a statistic that they weren't capturing you know as a specific one, but since she hasn't been around there is not really that great a feedback. We are producing the statistics and sending them to 'A' but we are not getting that much feed back.
(Focus Group 3A)

Very few nurses had ever attempted to retrieve the information as evidence for practice generally or for Public Health purposes in particular. Of those who had, some found that the system was unable to offer them the feedback that they had requested. There was only one example of a nurse who had successfully retrieved useful information.

There was a perceived mismatch of the real value of their work compared to the inability of the system to capture that value. This factor appeared to be a serious cause of frustration and resentment to community nurses across the board. Consequently, there was evidence that many nurses attempted to circumvent the system in various ways. They did this by variously filling the forms in quickly and/or by 'counting' in alternative ways prescribed by the system. For example, a contact classed as a visit may have been someone who was only seen fleetingly rather than an example of a more meaningful visit. This was seen to counter balance the instances when a particular patient had required intensive support for a longish period maybe with other people present who genuinely demanded advice or help appropriate to the nursing context but who did not fit into the structured frame

of the form and therefore didn't 'count'. This evasion of the system in this case might be usefully interpreted as a rational and professional approach to an irrational system rather than as a form of group deviancy. It was also sometimes the case that the clinical condition of the patient/client did not readily or easily fit into the dictates of the form as evidenced by the following quotes:

The busier you are the less time you have to fill it in properly.
(Focus Group 2I)

Now you would be filling in four different pages just to get that mother's postnatal visit, it is easier not to do it, so what you do you just code it in and any other code, fill in your time that you spent in that woman's house. Like do it so badly, it's unbelievable but it is quick and easy and it's the way I do it.
(Focus Group 1A)

Interviews with management tended to echo the negative assessment of contact monitoring. When one manager noted that:

We know it is disastrous, it was forced upon us a number of years ago and then we moved to a purchaser provider situation with our commissioners. It started to be used for things that it was never intended to be used for.
(Interview 2 Nurse Manager)

We know is disastrous, we had no choice, it gives only contacts and is based upon contracts. The new system needs to marry public health with it.
(Interview 3 Nurse Manager)

The choice of the same extreme adjective is noteworthy here but perhaps more

useful is the idea that any new system needs to be integrated with an overall public health policy.

The nurse manager from 'Interview 1' went on to explain that more recently commissioners were being told the length of time nurses spent with patients/clients which, more positively, was said to offer an indication that patient dependency had changed. However, it is still being reported when nurses 'fail' to reach their contact targets. The situation appears to have worsened with the advent of GP fund holding when a GP(s) monitored the number of contacts 'his nurse' [sic] made. GP fund holding officially ceased from April 2002, although contracting systems remain in place for a further year.

A new system PCIS (Patient Centred Information System) is currently under negotiation and is expected to be up and running 'within the next couple of years'. It is anticipated that this will be user friendly. This new system is discussed in terms of:

it's been very much a staff driven system.
(Interview 2 Nurse Manager)

It is envisaged that it will be outcome focussed and assist nurses in caring for their patients. It is also envisaged that it will form part of an increasingly integrated system. It remains unclear how public health initiatives will figure in the proposed system.

The CLAN system was viewed somewhat more positively by Treatment Room nurses but still had drawbacks in terms of reflecting the quality of service offered or its ability to effectively feed back data to the practice arena.

I'm reasonably happy with it, it doesn't reflect quality only quantity.
(Focus Group3G)

and

I have asked for figures and they say they are under the same pressure as us.
(Focus Group 3G)

Quantitative results

In relation to collection of statistical information, respondents were asked to rate 13 statements on a five point scale, ranging from 1(strongly disagree) to 5 (strongly agree). Nine of the statements were positively worded (e.g. *I am able to retrieve information to improve my practice*) and four were negatively worded (e.g. *The information supplied is not a true reflection of my work*).

Four factors were extracted from the data:
1. understanding and relevance of information collected (understand);
2. accuracy and reflection of work undertaken (accurate);
3. ability to access and use data (ability to use);
4. use of data in planning interventions (planning).

The mean scores on each of these factors is depicted in figure 12. The highest mean score was for understanding the relevance of the statistics collected. However, this is quite low and in fact only just over half (52%) of respondents said they understood the relevance of the statistics collected and only a third (33%) were aware of what happened to the data.

Figure 12 Attitudes to the collection and use of community data
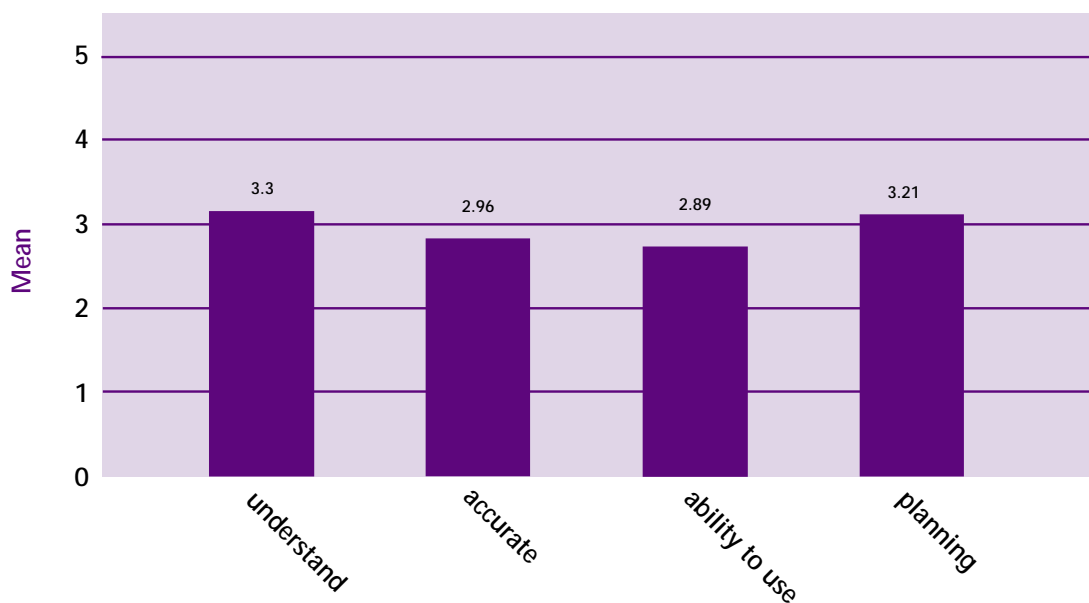
The use of data for planning interventions at individual, family or community level had the next highest mean score. Forty seven percent of respondents believed that the data was used to plan interventions for individuals, 37% families and 46% communities. There was a low rating for the extent to which respondents felt the statistics were accurate and reflective of practice with only 15% of respondents feeling that the statistics they supplied were a true reflection of their work. These results are consistent with those emerging from the qualitative data.

The lowest rated factor was the ability to access and use data. Although 49% said they were able to retrieve data only 15% said they had actually accessed the data in the last year and again support the qualitative findings.

Discussion

The quantitative systems of data collection surrounding community nursing activity elicited an almost unanimous antipathy towards it represented in both the qualitative and quantitative data. It was seen as time consuming and one of the more onerous of other administrative burdens. The forms were perceived as inflexible, thus negating both the value and the reality of practice and hence, failing to a large extent to evaluate the quality of health care offered. (This maps on to the levels of job satisfaction and morale of the staff, which in turn influences staff retention and staff sickness rates. Not least it fails to respond to outcome evaluation models of services).

There was a distinct lack of clarity over the purposes of the data collection

exercise with information going upwards into a bureaucratic 'black hole' but rarely coming back down. Nurses tended to develop a tacit response to the forms which allowed the perceived inadequacies of the forms and time demands created by the system to be minimised; thus allowing them to prioritise their workload demands over the demands of the system if it was strictly adhered to.

This contract/contact-based system arose from a policy framework embedded in a 'market' orientated system as part of the legacy of the Conservative Government Policies of the 1980s. It's relevancy and suitability to recent health policy legislation and aspirations are increasingly in question.

New evolving systems, for example, the PCIS, may offer an excellent opportunity to place public health concerns firmly on the agenda for consideration. It is imperative that public health is an integral part of the planning.

Introduction

The changing nature and importance of communication via Information Communication Technology (ICT) made this an important consideration of the research and, although the focus group schedules, individual interviews and quantitative data were all planned to include this area of concern, many of the nurses independently raised this without a stimulus question in the qualitative research.

Qualitative data

There appeared to be a general lack of PC's available to all nursing disciplines across both geographical sites. Although some nurses in several health centres did report having access to one via the GP's secretary for urgent requirements, most did not. Both nurses and their managers are aware of the patchy and inadequate availability of ICT facilities.

That's one of the things that you'll find in different health centres and there is very little consistency between them. I work in one of the bigger ones and we would have email but there is inconsistency between the centres and the Trusts, whether you get them, or whether you get those articles I was originally talking about.
(Focus Group 1A)

From a management perspective it appears that measures to address the situation at some level have begun but it was acknowledged that the focus group data represents some legitimate issues of concern.

Oh, I'm sure there is room for considerable improvement. It is only of recent times that we have been able to build up any IT infrastructure in our community.

and the same speaker:

That's not going to be sorted overnight because that is a constant battle. The one thing the Trust has tried to do is try to make sure that as many people as possible have access to the internet and we probably certainly in a number of our health facilities, we do have access to the internet.
(Interview 2 Nurse Manager)

Some nurses use the Internet at home in their free time for research purposes, others used the library ICT resources from the Trust on occasion, again in their own time. In many instances this entailed significant travelling time. Without exception all nurses felt a perceived lack of relevant computer skills and a need for further training though the degree of skills varied from no skills to some respondents being reasonably accomplished. This was recognised at management level.

Yea. So I would think there is a mega training issue around it, it's huge.
(Interview 1 Nurse Manager)

and

I wanted it to be a tailored programme that would meet their own needs rather than send them out to ad hoc courses along the way.
(Interview 1 Nurse Manager)

Nurses acknowledged the potential benefits of ICT and tended to regret that they were lagging behind the rest of the population.

It would be wonderful. We are so far behind in the IT world that it is unbelievable. (Focus Group 2B)

A few nurses expressed reservations about the prospect of becoming ICT literate but acknowledged that some skills are increasingly relevant to professional practice. Nurses frequently noted the increased use of the Internet by their patients and clients who were becoming increasingly informed and in some cases misinformed via the Internet. Nurses recognised the need for them to keep abreast of new research to both better inform their clients and to stay professionally credible in an information age.

.. and you know it's interesting in terms of all the controversy and parent's fears about the state of the MMR, people are anxious, looking it up on the internet, reading it on the internet or whatever. It tends to be people who are very anxious and we don't have the basic access. (Focus group 1A)

In answer to a question on computer literacy one nurse replied:

Wouldn't have a clue. None of us are computer literate. Well, I can only speak for myself, very illiterate really. (Focus Group 3E)

Another nurse from a different group said:

As nurses we were never trained to use this technology, at first I was afraid to

use it but had to when I started my degree. If you have it in your suite where you work its not so hard. (Focus Group 3G)

Some nurses reported using the Internet at home in their own time because of a lack of resources at work. The cost effectiveness implications of this might benefit from being drawn out:

I have to fight with my kids to get on it at home to prepare for meetings. (Focus Group 3G)

Most nurses felt that access to a computer would be multi-beneficial to their roles and would encourage increased efficiency and effectiveness. One Occupational Health Nurse represented a more positive response in this area.

We do yes. We have a specific package on the computer for occupational health and we have just changed our system from 'S' to 'C' and it's an English based company and they have come over and given us training on it. And again, it's good for statistical purposes that we can pull out our statistical information and plus it tells us to forward book appointments and things like that. So yes, we have.

Researcher: *And is that a boost?*

Respondent. *Yes, it is. Oh, definitely.*

The same nurse said that she was connected to the Intranet but not to the Internet. On asking if this would be useful to her she replied:

Yes, well we have locum doctors and they have their own laptops and they

have access to the Internet and so they are very good at sharing information. They would put it onto a disc and then we would print it out, you know, current information that is on the Internet. But no, we don't have access and it would definitely be a big help.
(Focus Group 3A)

One nurse explained how she routinely and effectively puts her PC into use in her daily practice, for example, in the context of having identified a patient with a raised blood pressure, she would:

.. print off patient information leaflets. I like to be able to hand them to patients to read later. Advice on diet, exercise, what having a high blood pressure means and so on. (Focus Group3G)

a different nurse in the same group commented:

I would love to be able to do that.
(Focus Group 3G)

In several focus groups individuals raised the issue of a possible lack of trust by their managers in relation to ICT. They felt that nurse managers might not trust them to use any organised ICT resources responsibly as they feared they might be suspected of using the PC's for non-work purposes during working hours.

I don't think they would trust us, they would be suspicious that we abuse the system for our private use
(Focus Group 2H)

Quantitative data

Respondents were asked firstly whether they had access to a computer in their work setting. Of the 273 respondents answering this question 65% agreed or strongly agreed that they had access to a computer. However, the majority of these were general practice nurses or treatment room nurses and it can be assumed that such computers were the property of the general practice in which these nurses were located (see figure 13). This confirms the findings of the qualitative data. Other groups reporting computer access were community children's nurses, community mental health nurses and occupational health nurses.

Figure 13 Access to a computer in the workplace by job title
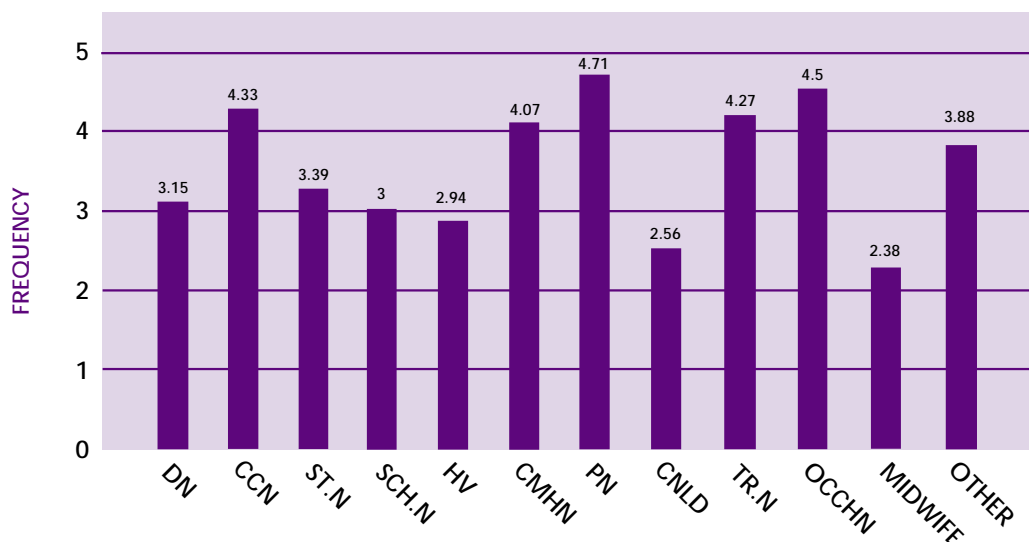
Respondents were then asked to rate the extent to which they felt they had the necessary skills and knowledge to retrieve internet/intranet information. Just less than half 49.5% felt they had the necessary skills. However, practice nurses, community children's nurses and community mental health nurses were the groups reporting the highest level of computer literacy and this follows as they were the groups reporting the highest level of computer access.(figure 14). The health visitors, district nurses and community staff nurses were the ones reporting low levels of computer literacy and as they were probably heavily represented in the focus groups this may account for the discrepancy between qualitative and quantitative findings.

Figure 14 Necessary skills and knowledge by job title
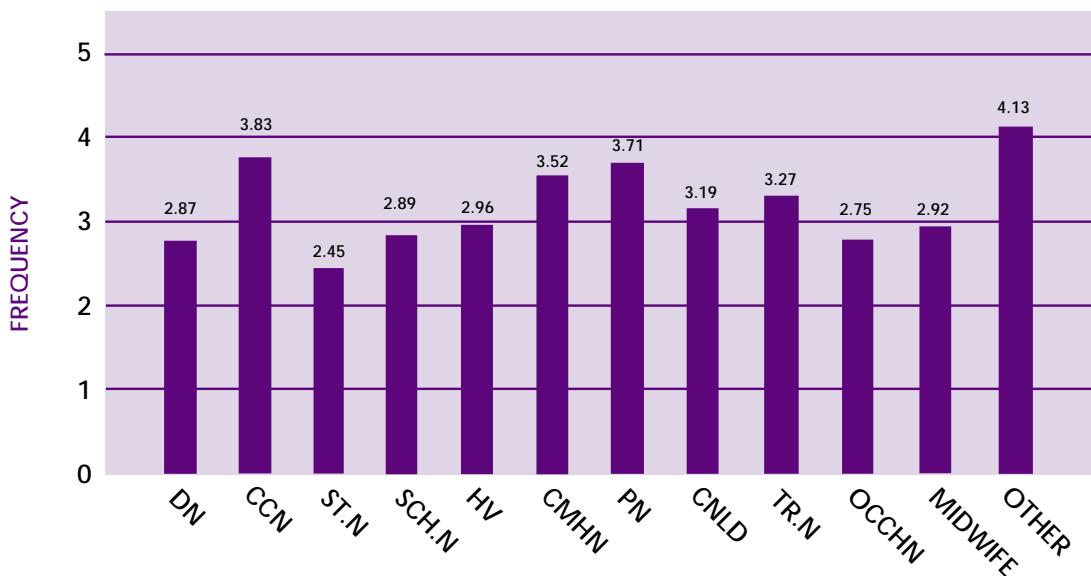
The next statement explored practitioners perceptions of their ability to retrieve evidence (on which to base practice) from computers in their workplace. The results highlighted that 40% of staff could not access such data within the work setting. Of those that could access evidence treatment room nurses were the most likely group to be able to do this.

Training and development needs in relation to ICT were explored by asking if community nurses required further training in computer skills. Twelve per cent of respondents stated that they did not require further training, whilst 80% agreed that they would require more training, the remainder were unsure or failed to tick a preference. Figure 15 gives a breakdown of training needs by job title, demonstrating a reasonably even spread across groups.

Figure 15 Required training in computer skills by job title
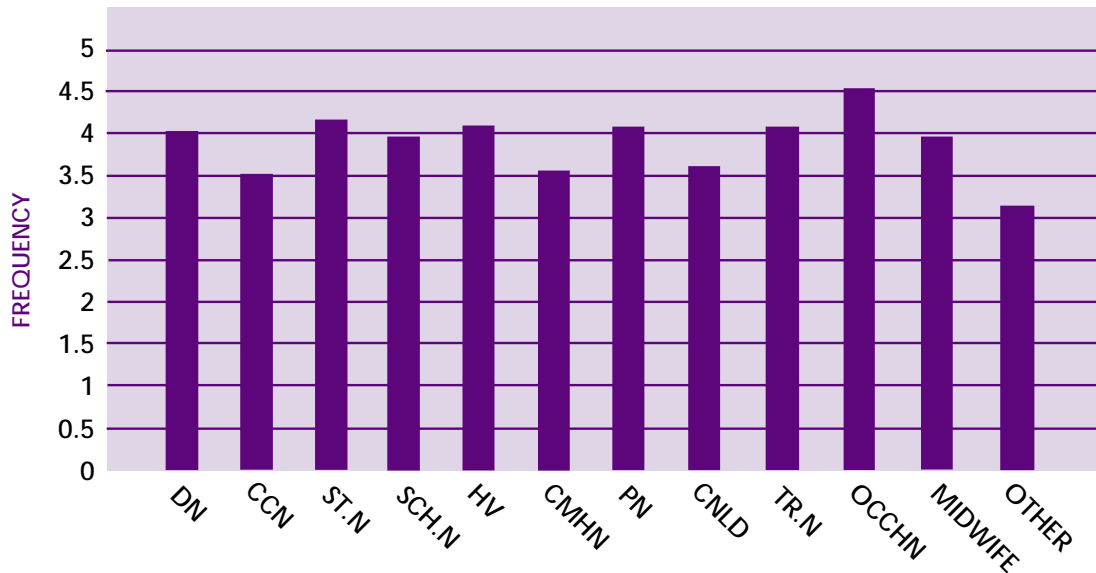
Discussion

There was an inadequate level of PCs although there was some evidence of initiatives to improve the situation, albeit in fairly ad hoc ways. This situation needs to be urgently addressed in a systematic manner throughout the Trusts.

The lack of access to research sources via the internet frequently led nurses to either work at home in their own time or to similarly travel a considerable distance to a library. This context is not conducive to a research or evidence based practice of public health or broader professional interests.

Training in ICT skills to a reasonable level of competency will be required as evidenced in both the qualitative and quantitative data. For example, 80% of all staff surveyed agreed that they would need more training.

Nurses were acutely aware of the increasing gap between their ICT resources and competencies and that of other professionals and many sections of the public. A climate of raised client expectations coupled with their increased access to knowledge and information was perceived to threaten their professional credibility.

In addition to the perceived need to at least keep abreast, if not in advance of the client group, using the internet and intranet was seen to offer opportunities for an increased rational use of nurses' time and an improved quality of care informed by research. With regard to the often needed reliance on other staff in the Health Service for access to a computer such as locum doctors, GP secretaries and so forth, nurses' professional credibility, is, arguably, not enhanced, nor is it conducive to promoting a confident work force or to high levels of morale. In broader terms, nursing needs to keep in touch with developments outside its immediate concerns, to remain plastic, not static and brittle or it risks breaking down.

The issue of trust and the voiced concern that management may not trust nurses to use ICT facilities responsibly, that is, that they may use them for private use is perhaps noteworthy. Although this appears to remain at the level of circumspection and appears not to be founded on any evidence, it perhaps points to some other underlying concerns regarding important features of nurses' professional status and traditional patterns of paternalism within nursing generally. After all, ICT facilities are commonly used in other institutions and in the commercial world by staff who may have less training and probably less responsibility for human life. Given the other grave responsibilities nursing carries this is a curious state of affairs. It may be that the concerns revolving around trust function to express concerns in other areas, such as low staff morale, feelings of powerlessness and of not having a voice in their practice context as evidenced in other areas of the report. If public health initiatives are to take seriously notions of inclusion and equality and of citizen empowerment, then nursing might reflect upon its own cultural heritage and tendencies to infantilise its workforce.

The qualitative and quantitative results are generally consistent in demonstrating that overall community health nurses do not have access to PCs in their work setting. This is certainly the case for most Trust employed nurses although practice nurses, who are employed by GPs, and treatment room nurses, aligned to GP practices, report greater PC access. These findings reflect the huge investment in computer hardware and software to support the GP fund holding scheme and the lack of investment in ICT for community health nursing, as demonstrated in the Community Practitioners and Health Visitors' Association Omnibus Survey (Gaze 2000).

Alongside the lack of access to PCs there is a huge training need in computer skills for the majority of CHNs. There is no doubt that the information superhighway will change the delivery of healthcare in the future and consumers will become more powerful in determining and demanding the healthcare they require. Respondents in this study acknowledged this trend and were aware that they would need to develop their computer skills to keep pace with change. However, it would appear that except for a minority of GP based CHNs only those who had access to ICT at home were able to develop the computer skills they require. There is a paradox here as in order to promote evidence based practice nurses need access to the evidence. As such evidence is most easily obtained from the web it could be argued that the majority of CHNs are being precluded from basing their practice on valid up to date evidence and thus breaching one of the principles of clinical governance.

SECTION SIX: INTRODUCTION OF NEW IDEAS TO IMPROVE PUBLIC HEALTH PRACTICE

Introduction

As clearly evidenced below, factors influencing the introduction and practice of public health are multi-variant and overlapping. None of the factors operate in isolation, but rather, weave into a more compelling work environment where many factors simultaneously coalesce to inhibit public health innovation to a lesser or greater degree.

The qualitative research revealed several excellent innovations backed up by the quantitative data below. For example, the case of healthy eating in schools which was reported to have begun with a dentist's concern over poor dental health and, via inter-disciplinary collaboration, expanded to encompass the diet more generally. Local suppliers of bread, fruit and vegetables were drawn into the network of innovation. However, it became apparent during the focus group research that knowledge of these innovations did not naturally pass between community nurses even within the same area and discipline. Nurses within the focus groups were eager to hear about their colleagues successful experience and enthused by them.

Quantitative results

Examples of good practice
Respondents were asked whether they had introduced new ways of working to improve practice (over the past three years). Just over half (54.9%) of the respondents answered 'Yes' to this

question. These respondents were then asked to describe briefly the most significant initiative in which they had been involved. The majority of the examples of good practice given were activities which would normally be considered part of the routine practice of the individual disciplines concerned. For example, several district nurses mentioned nurse led leg ulcer clinics; practice nurses cited smoking cessation clinics and health visitors alluded to breastfeeding support groups. However, there were more novel initiatives and these were categorised under the following headings: multidisciplinary work; excluded groups; caseload initiatives; increasing service user choice; and, management resource allocation tool. These results are presented in table 3.

Table 3 Developing and adapting new ideas to improve public health practice

Multidisciplinary work	Sure Start. Health Action Zones. Community Development projects. Fit & Well. Teenage Health Project Life skills training including sexual health projects. Healthy eating school based projects.
Excluded groups	Health Check 2000 (Learning disability). Special school health needs assessment. SAM's project (School age mother's).
Caseload initiatives	"Ask me" pilot project by health visitors to routinely discuss domestic violence with all clients on their caseload. Easycare "Elderly assessment tool" is a multi agency assessment and shared record which is sensitive to the service users perception of their need. Home births. Domino births. CBT (Cognitive behaviour therapy). Early family interventions in response to people with psychosis.
Increasing service user choice	Leg ulcer clinics. Cardiac support. Smoking cessation. Behaviour management clinics. Post natal depression groups. Breast feeding support groups. Parenting programmes. Rapid response services.

Additionally respondents were asked to rate their chosen initiative, on a scale of 1(not at all) to 7 (entirely), as to the extent to which it met a range of criteria. These criteria are presented in Appendix III.

Figure 16 Rating of initiatives against quality criteria
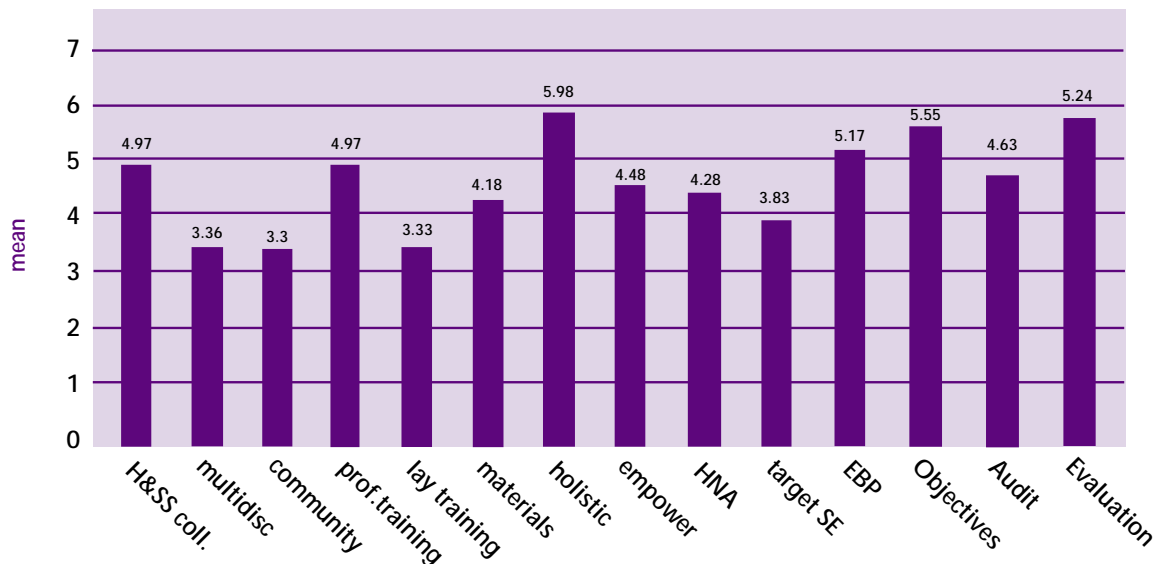
The most highly rated criteria was *holistic in approach*, closely followed by: *objectives were used; evaluated in terms of benefits to patients/clients and, research evidence used to inform design (EBP).* In terms of collaborative activity *collaborative working with health and social care personnel* was relatively high but low for *working with other agencies that impinge on health (e.g. housing)* and even lower for *partnership with local communities.* Furthermore, training criteria showed a similar trend in that *specialised further training for professionals,* was rated quite highly but *lay training* was rated quite low. Despite these low ratings on community involvement respondents rated moderately highly the criteria relating to the use of *an empowerment framework that encouraged individuals and communities to take control of health issues.* Similarly, *a health needs analysis of the target group* was moderately rated but *targeting socially excluded groups* was rated lower. What these results seem to suggest is that there are quite an array

of new initiatives to improve public health practice. Furthermore, practitioners felt they had adopted an holistic approach and carefully designed their initiatives using research evidence and setting and evaluating objectives. However, it appears that initiatives are primarily professionally led by health and social care personnel with a limited level of community/lay involvement and poor interagency collaboration.

Facilitators and barriers to introduction of new ideas for public health practice

Respondents were asked to rate a series of six statements which could have an impact on the development of new ways of working. These results are presented in Figure 17.

Figure 17 Facilitators and barriers to practice improvement
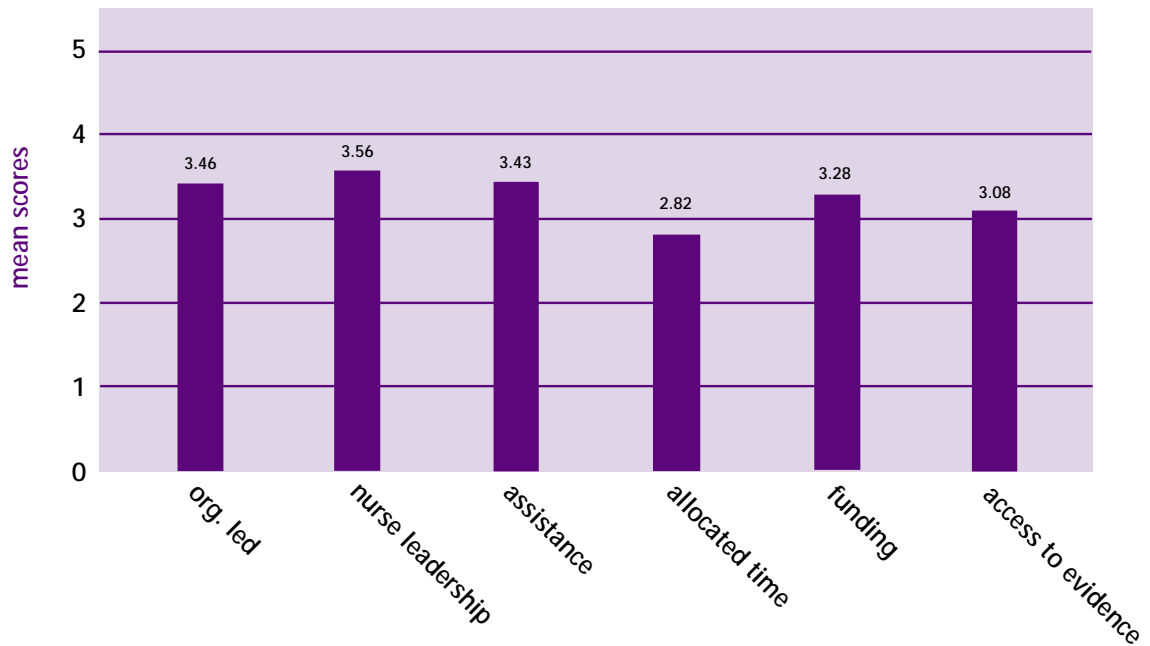
All these ratings hover around the midpoint of 3 (neither agree nor disagree) but the highest rated statement was *strong nursing leadership to support development of new ideas*, with 60% of respondents ticking either agree or strongly agree for this statement. Similarly, initiatives were seen as being *organisationally led* with 55% of respondents agreeing or strongly agreeing with this statement. Furthermore, 56% agreed or strongly agreed that *assistance is given when developing new patterns of working*. However, less than a third (32.8%) of respondents agreed or strongly agreed that *time is allocated to develop new ideas'*. Over half (52.7%) of respondents agreed or strongly agreed that they were *unaware of how to bid for funding for initiatives* and only 41.3% agreed or strongly agreed that *access to public health frameworks are readily available*. These responses seem to imply that whilst there is, in principle, local support for new initiatives this is not carried through by allowing CHNs time to implement new ideas to improve public health practice.

Discussion

It is noteworthy that 60% of nurses rated as important the need for strong nursing leadership to support development. The lack of time to devote to public health, discussed throughout the report, is endorsed in this section of data. Poor inter-agency and community collaboration is noted as is the fact that many of the initiatives are health and social care led. This perhaps points to a need for improved communication between the public, user groups and other professional organisations and institutions.

Many of the reported innovations related to their 'normal' practice, for example, leg ulcer clinics and breast feeding clinics aimed at individuals. Patient's continuing needs and ingrained institutional practices, coupled with a legacy of traditional education and training largely shape such responses and practices.

The quote from the qualitative section perhaps typifies the traditional (if largely discredited) approach to health education which largely ignores the socio-economic – cultural reasons for smoking and drinking and relies solely upon behavioural models for change. Education and training are key to implementing robust changes in public health practice.

Many nurses already have some existing skills and are ready to learn more given the appropriate infrastructural changes. Improved forums for the sharing of skills and experience and innovative practices could be sought.

SUMMARY OF MAIN FINDINGS

Introduction

The main findings of the report suggest that Community Health Nurses (CHNs) in Northern Ireland perceive public health as an integral part of their role and are being recognized as having key and increasingly important roles to play in society's efforts to tackle current public health challenges. They are contributing to the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people's rights and changing needs and have a vital role in the creation of organizations and systems that work with communities to identify and address their problems (WHOb, 2000). However, the report has highlighted a number of areas which demonstrate some of the barriers and difficulties encountered by CHNs and which offer lessons which might usefully be learnt before embarking on new ways of working. Most of the lessons relate to a poor understanding of the nature and goals of public health; working in isolation; role definition within working relationships; education and information technology needs; and, the environment in which community practitioners are working. Nevertheless, there were examples of public health initiatives. Examples of these initiatives, their characteristics and factors which support or inhibit such developments are summarised below.

Public health initiatives

Several public health focused initiatives were reported. These included multidisciplinary/multiagency projects such as Sure Start; initiatives targeting excluded groups, for example Health Check 2000 for clients with learning disabilities; caseload planning tools, such as the Easycare elderly assessment tool; and, group initiatives to meet specific client needs, for example post natal depression support groups.

Characteristics of public health initiatives

Initiatives were rated as holistic, in approach; involving Health and Social Services collaboration; based on valid research evidence; working to pre set objectives and generally audited and evaluated.

Factors supporting public health initiatives

- Strong nursing leadership
- Organisational support
- Local assistance in implementing new ways of working.

Factors inhibiting public health initiatives

- Competing demands e.g. excessive administration; unrealistic expectations of clients, managers and other professional groups.
- Perceived lack of leadership for public health practice.
- Lack of appropriate multidisciplinary education addressing the public health agenda.
- Collection of excessive amounts of activity data which does not appear to reflect the nature of the work undertaken and is generally not accessible to help in the planning, delivery and evaluation of public health practice.

- Lack of access to ICT and the perceived lack of training in the use of this technology.

Key Recommendations

The recommendations from the report form a plan or design for Public Health Nursing that includes the following:

Vision: to create an environment which enables and empowers nurses, especially community public health nurses, to provide comprehensive health and social care to individuals and populations within the remit of their individual roles and particular cultural contexts in collaboration with relevant others to achieve improved, effective public health for all.

The recommendations to DHSSPS are:

- Support, develop, fund, pilot and evaluate innovative models of public health practice and disseminate examples of 'best practice' within the wider sector.

- Work towards establishing a clearly identified public health care nursing infrastructure to provide professional leadership of the public health workforce at strategic and operational levels. This includes supporting the role of nurses in resource management, decision-making and policy development.

- Create appropriate education and training pathways at different levels of public health practice and support experienced community health nurses who wish to specialise in public health. This is likely to include knowledge of political skills, economic principles, budgeting, resource use and cost-effective practice.

- Support the development and evaluation of the joint QUB/UU multidisciplinary/multiagency MSc in Public Health with a commitment to DHSSPS funded places with the establishment of new and improved existing processes for community health nurses to access funding for relevant postgraduate education and scholarships.

- To address the barriers highlighted by CHNs in the report such as the need for greater access to information technology, the over extension of role and inadequate staff resources.

- Work with community and public health nurses to develop information systems and coding mechanisms that enable the collection of data and other information for monitoring and evaluation that is actually (and perceived to be) relevant to effective practice.

- Establish evaluation processes to ensure that the governance, management and leadership of innovations are being met and to seek to improve ways of incorporating public and user groups' perception and understanding of public health needs.

- To ensure a set of reflective processes and practices are integral to cohesive future public policy decision making at strategic and operational levels.

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APPENDIX 1

Community nursing services: current practices and possible futures

The aim of this questionnaire is to explore current practice in community nursing and how this might shape the delivery of community health care in the future. **Confidentiality & anonymity are guaranteed.** Answers will only be seen by the researchers and results reported in aggregated form as part of the final report . If you have any concerns about this questionnaire please contact Linda Patton, School of Nursing, University of Ulster at Jordanstown. (90368356).

Thank you for your participation in this project
_____

PART 1: BIOGRAPHICAL DETAILS

The first part of the questionnaire asks for details about you and your work.
Please tick appropriate box.

1.   **What is your job title...**

District nursing sister	☐	Community children's nurse	☐
Community staff nurse	☐	School Nurse	☐
Health visitor	☐	Community mental health nurse	☐
Practice nurse	☐	Community learning disabilities nurse	☐
Treatment room nurse	☐	Occupational health nurse	☐
Midwife	☐	Other (please specify below)	☐

………………………………

2.   **What professional qualifications do you hold?**

RGN ☐   RHV ☐   RSCN ☐   RM ☐   NDN ☐   CPN ☐   CMHN ☐

OHNC ☐ School nurse cert. ☐ CCN ☐ GPN ☐ Other (please specify) ☐

………………………………………… ☐

3.   **Please list other post registration courses that you hold including academic degrees and diplomas.**

……………………………………………………………………………………………..

……………………………………………………………………………………………..

4.   **Who is your employer?**

NHS Trust   ☐ Name…………………………

General Practitioner   ☐

Other (please specify) ☐ ……………………………

Part 1 Current ways of working

This section asks you about your current working practices and the extent to which you work at community (e.g school, workplace), family and/or individual level.

1. In an average month what proportion of your time would be spent on the following:

Activity	Percentage									
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99
Home visiting to families										
Home visiting to individuals										
Individual consultation / treatment in a clinic										
Individual consultation / treatment in a surgery										
Individual consultation / treatment in a school										
Individual consultation / treatment elsewhere; please specify										
Meeting with community groups to discuss issues										
Undertaking community based education										
Undertaking community surveys										
Other activities please specify:										

2. I have completed a comprehensive   Yes   ☐   No   ☐
    population based needs analysis.   If yes go to **Q3**   If no go to **Part 2**
                                         Please tick

3. In completing the needs analysis   Yes   ☐   No   ☐
    did you use a needs analysis tool to   If no go to **Q 4**
    facilitate identification of health need.

                                         Please tick

If yes please give more detail:

_____

_____

Please indicate the extent to which the following were involved in your needs analysis.
Circle the number that most accurately reflects their involvement

	Completely	To a large extent	Somewhat	To a limited extent	Not at all
4. To what extent was the local community involved in compiling the needs analysis.	5	4	3	2	1
5. To what extent were other members of your immediate multidisciplinary team involved in compiling needs analysis	5	4	3	2	1
6. To what extent were other agencies (e.g. housing), involved in compiling the needs analysis.	5	4	3	2	1
7. To what extent has the needs analysis been used to set local priorities for practice.	5	4	3	2	1
8. To what extent has the needs analysis been used to influence the skill mix of the health and social care workforce.	5	4	3	2	1
9. To what extent has the needs analysis been used to influence commissioning decisions.	5	4	3	2	1
10. To what extent has the needs analysis been used to influence policies affecting health.	5	4	3	2	1
11. To what extent do you feel the needs analysis has improved practice outcomes for individuals and communities.	5	4	3	2	1

Part 2 Factors influencing work practices

This section looks at ways that your practice is shaped according to policies and practices within your work setting.

1. To what extent is your practice influenced by the following: please indicate by circling the appropriate number.

	Completely	To a large extent	Somewhat	To a limited extent	Not at all
National policy	5	4	3	2	1
Board policy	5	4	3	2	1
Trust policy	5	4	3	2	1
Local organisational policy (eg occupational environment)	5	4	3	2	1
Education and training undertaken to date	5	4	3	2	1
Valid research evidence	5	4	3	2	1
Feedback from audit and evaluation	5	4	3	2	1
Feedback from service users.	5	4	3	2	1

The following questions explore the influence of teamwork on your current practice.

Do you consider you work as a member of a team   YES   ☐   NO   ☐
Go to part 3

If YES please tick which **ONE** of the following best describes the team with which you have the most involvement:

Primary care team ☐ multidisciplinary nursing team ☐ community mental health team   ☐

Unidisciplinary nursing team (e.g. district nursing) ☐ community learning disability team ☐
school health team ☐

Other (please specify) ……………☐

In relation to the team indicated above please consider the following and circle the most appropriate answer for each question:

		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
3.	We share information generally in the team rather than keeping it to ourselves	1	2	3	4	5
4.	People feel understood and accepted by others	1	2	3	4	5
5.	Everyone's view is listened to including those in a minority	1	2	3	4	5
6.	Members of the team meet frequently to talk both formally and informally	1	2	3	4	5
7.	Objectives are set as a team	1	2	3	4	5
8.	Team objectives are clearly understood by other members of the team	1	2	3	4	5
9.	Members of your team are committed to these objectives	1	2	3	4	5
10.	Team objectives can actually be achieved	1	2	3	4	5

Part 3: Developing/Adapting new ideas to improve public health practice

This section deals with ways you have introduced new ideas to improve your public health practice.

1. Over the past three years have you introduced new ways of working that you feel have improved your practice and have benefited your patients/clients. *Please tick*

YES   ☐   NO   ☐
If **NO** please proceed to **Q3**

If **YES** please describe briefly the **most significant** initiative in which you have been involved.

_____
_____
_____
_____
_____

2.   Please rate the initiative described above in terms of the extent to which it meets the following criteria.

Criteria	Not at all 1	2	3	4	5	6	Entirely 7
Involved collaborative working with health and social care personnel.							
Involved collaborative working with other agencies that impact on health, e.g. housing.							
Involved partnership with local communities							
Required further specialist training for professionals							
Required further training for others eg. lay workers							
Required support materials e.g. videos							
Holistic in approach							
An empowerment framework that encouraged individuals and communities, to take control of health issues was used							
The initiative involved a health needs analysis of the target group							
Research evidence was used to inform the initiative design.							
Objectives were used							
These objectives were audited.							
The initiative was evaluated in terms of benefits to patients/clients							

The following questions relate to organisational factors which influence the introduction of new ways of working to improve your practice. *Please circle the response that most closely reflects your opinion.*

		strongly disagree		neither agree nor disagree		strongly agree
3.	Working initiatives are led by my organisation	1	2	3	4	5
4..	There is strong nursing leadership to support the development of new ideas	1	2	3	4	5
5.	Assistance is given when developing new patterns of working	1	2	3	4	5
6.	Time is allocated to develop new initiatives.	1	2	3	4	5
7.	I am unaware of how to bid for funding for initiatives	1	2	3	4	5
8.	Access to evidenced based public health frameworks are readily available	1	2	3	4	5

Part 4 Technology

		strongly disagree	disagree	neither agree nor disagree	agree	strongly agree
1.	I have access to a computer in my workplace	1	2	3	4	5
2.	I have the necessary skills and knowledge to retrieve internet/intranet information	1	2	3	4	5
3.	I am unable to access internet/intranet evidence based practice data at work	1	2	3	4	5

Part 5 Administration

This section examines current methods used to collate and use statistical information, in relation to community nursing practice. *Please circle the most appropriate number.*

	Strongly disagree	disagree	Neither agree nor disagree	agree	Strongly agree
1. I understand the relevance all of the statistics collected	1	2	3	4	5
2. I am fully aware of what happens to assimilated data	1	2	3	4	5
3. The information supplied is not a true reflection of my work	1	2	3	4	5
4. The information I supply is on occasions inaccurate	1	2	3	4	5
5. I have no idea why these statistics are collected	1	2	3	4	5
6. I am able to retrieve information to inform my practice	1	2	3	4	5
7. I am able to access these statistics for research purposes	1	2	3	4	5
8. Data is most often used to plan interventions/services in relation to individuals	1	2	3	4	5
9. Data is most often used to plan interventions/services in relation to families	1	2	3	4	5
10. Data is most often used to plan interventions/services in relation to communities	1	2	3	4	5
11. During the last year I have retrieved such data regularly.	1	2	3	4	5
12. I feel that collection of statistics is a poor use of my time	1	2	3	4	5
13. It is my opinion that such data collection is necessary to protect the public	1	2	3	4	5

Can you suggest more relevant methods of collecting and assimilating statistical information?

_____

_____

_____

Could you briefly suggest how community nursing and public health practice might develop in the future, within existing health resources.

_____

_____

_____

_____

_____

_____

Please return the questionnaire in the prepaid envelope to:

Linda Patton,
School of Nursing,
University of Ulster,
Shore Road,
Newtownabbey,
BT37 0QB

Thank you

Qualitative study

The qualitative study consisted of two methods of data collection, namely, focus groups and face-to-face interviews.

Focus group: Pilot
The focus groups began with a pilot study of three groups in one Belfast Trust. District Nurses, Health Visitors and Community Mental Health Nurses each formed discrete uni-disciplinary groups of up to ten people in each group.

Focus group: Main Study
For the subsequent study, nine discrete uni-disciplinary groups were held in each of the two different research sites. One site was in Belfast, the other a peripheral, border area of Northern Ireland. Twenty-one focus groups were held in total, including the pilot study. The community nurses who contributed to the focus groups comprised of the following: District Nurses, Health Visitors, Midwives, Community Health Nurses (some of whom were Cognitive Behavioural Therapists), School Nurses, Occupational Health Nurses, Learning Disability Nurses, Paediatric Nurses, Practice Nurses and Treatment Room Nurses. The focus groups were mainly videotaped and/or audio taped and later fully transcribed for thematic analysis.

Face-to-face interviews
Ten face-to-face in depth interviews were conducted after an initial analysis of the focus group data. The respondents were largely but not exclusively, drawn from the two main research sites and included four nurse managers, a representative of a non-governmental organisation for substance abuse, an Environmental Health Officer, two Directors of Public health and a related, relevant member of staff and one GP. The research remit and funding resources did not permit a more systematic consideration of a wider or larger number of respondents for this stage of the research process. The interviews formed supplementary data to the main data collection methods and do not claim to be representative of the institutions the individuals represented.

Quantitative study

Pilot study
In order to refine the questionnaire and pick up any errors a small pilot study was carried out. The questionnaire was administered to 57 post-registration nursing students studying on a variety of community nursing programmes at the University of Ulster. The questionnaires were distributed and collected on the same university day. As a result of the pilot study minor changes were made to the questionnaire, which resulted in the correction of two typing errors and the design of one question was simplified.

Main study
An initial letter was sent by Miss Judith Hill Chief Nursing Officer for Northern Ireland to the Executive Nurse Directors in Northern Ireland. The letter outlined the purpose of the study and requested organisational support for the research project. A link person was identified in each Trust and Board and asked to supply numbers of community nurses employed in each discipline. Based on the figures supplied a 15% sample size was

calculated for each Trust and Board. The link person was then sent the designated number of questionnaires with precise instructions as to the numbers to be distributed to each discipline. This constituted a quota sample as although it was hoped to achieve a15% sample of each discipline from all areas of Northern Ireland, individual practitioners were selected by the link person, thus introducing a degree of selector bias into the process.

A self-addressed envelope was included for each questionnaire and reminders were sent to each link person three weeks after the first mailing. Confidentiality and anonymity were maintained by asking respondents not to include their name on the questionnaire and assuring them that data collected would only be presented in aggregate form so that no individuals could be identified.

Statistical analysis
The Statistical Package for Social Sciences 9.0 (SPSS) was used to analyse the quantitative data. First of all the numbers and percentages in each category were explored. Factor analysis was used to reduce the number of variables in some of the longer scales (e.g. teamwork) and One-way Analysis of Variance was used to explore responses by job title.

APPENDIX III

Potential Indicators or Characteristics of a Successful Public Health Intervention - Table 1

1. APPROACHES / PARTNERSHIPS

An intensive approach - vigorous or intensive approaches have been shown to improve the identification and subsequent effective treatment of individuals, particularly those from deprived communities. These intensive programmes involve CHNs and health professionals and inter-agency alliances tackling a wide range of health and social problems together with the aid of community health workers to screen, counsel, follow-up and monitor people with, for example, high blood pressure, alongside smoking and obesity issues all within a primary care setting. Similar work is on-going in schools with health professionals and teachers working with asthmatic children by illustrating the effects of smoking and pollution and by training teachers about these young people's health needs. The report identifies marginalization of some of the workforce and there is potential to create more intensive approaches by improving formalized pathways of multi-professional working and settings.

Multifaceted approaches - successful programmes appear to employ a combination of interventions to improve the health of deprived individuals/ communities e.g. intensive 'stepped care' for those with hypertension. This involves specialist treatment combined with attempts to improve access to the service. Research suggests that combining education and legislation is more effective than education alone in modifying children's behaviour in relation to bicycle helmet use. The data suggests poor communication flows between agencies and that there is a need to improve the communication between individuals and agencies to allow for a more multifaceted approach.

Partnerships/health alliances/inter-agency working - successful public health interventions allow individuals, community groups, inter-agencies and voluntary groups to work together with the statutory services to promote health and raise the issues concerned on macro, meso, and micro levels. All stakeholders need to share the responsibility of promoting health. Working together has a central part to play in allowing community or lay/user participation into practice. All of these social networks may be an important resource in the process of enabling and empowering people to increase control over or improve their health and social well being. Partnerships can also include the use of peer education, support and self-help groups where help comes from individuals working together. The report highlights that CHNs have identified a lack of time to develop long-term partnerships when public health is seen as only a small part of their workload. However, they are keen to create and maintain 'healthy alliances' for the benefit of the client.

Multidisciplinary team working - working in teams is necessary as no single profession has a monopoly on health or indeed is equipped to address all needs.. There is now a need for new ways of working that involve the creation of supportive health environments to promote collaborative working and provide input from many specialist areas. Multidisciplinary teams or agencies allow the facilitation of adopting different strategies, the development of improved information systems and the harnessing of resources. Analysis of the data suggests that team working can sometimes be difficult for CHNs as other professionals are unaware of their contribution and role. In multidisciplinary team working CHNs report that their contribution is often undervalued. There is a need to see collaborations as a new way of working so that exchange of expertise can take place.

Table 2

2. EVALUATION TOOLS

Evidence-based approach - this is the generation of new knowledge and new approaches that have a general application to the health and well being of both individuals and communities. Evidence is required not only from research but also information about patterns of care, population needs, and the availability of resources to increase the knowledge base about effectiveness, health and environmental impacts and cost effectiveness. It is essential to know what works and what is ineffective and also there is a need to generate theoretical principles that can be applied to situations and individuals. Analysis of the data shows that access to computers and evidence-based knowledge is limited in the workplace. CHNs require access to formal systematic review literature of research evidence through databases such as the Cochrane Library and Effective Health Care Bulletins to enable them to draw together evidence in a structured and critical manner to support 'effective practice'.

Use of previous audit - this is using systematic methods for improving and/or ensuring that the intervention or project meets the needs of local people. Audit is concerned with judging whether an intervention is working effectively in practice and in further assessing whether or not resources are being used to the best advantage. Findings of an audit relate to the work of the team, organization, alliance, partnership or programme. Clinical audit provides a framework within which clinical guidelines, needs assessment, evidence of effectiveness and information on cost effectiveness can be brought together to improve the quality of patient/client/user care.

Use of previous evaluation - evaluation and health impact assessment can combine the use of qualitative (interviews, observation, case studies etc.) and quantitative (surveys, questionnaires, RCTs, experimental work etc.) methods. The report highlights that CHNs require more allocated time within heavy caseloads to access material from audits and evaluation of practice.

Prior needs assessment - this is working to find out target group or community health needs profiling to inform a population view of health and social need and to identify gaps in service and barriers to service delivery. Profiling and monitoring the impact of poverty, social exclusion, and deprivation is essential in any evaluation as it produces a Baseline Measure. Without such information on local public health and deprivation levels and the health and social costs of poverty for individuals and families, evaluators are unlikely to be able to evaluate the effectiveness of current strategies or make judgments about how they should be responding to poverty and health issues. The report acknowledges that as the determinants of health inequalities lie largely outside the health sector the greatest scope for CHNs to improve the public's health requires the knowledge of new policies which are beyond this sector. Health impact assessment (HIA) has emerged to identify those activities and policies likely to have major impacts on the health of a population. HIA is based on a broad holistic model of health, which proposes that economic, political, social, psychological, and environmental factors determine population health.

Table 3

3. RESOURCES

Settings – public health interventions are more effective when embedded in a variety of settings such as schools and workplaces. Many successful interventions have involved home visiting with groups such as pregnant teenagers, breastfeeding mothers and lone parent families who are visited by CHNs, trained peers or lay health workers. Studies show that disadvantaged women with young children particularly valued the social contact provided by small group training sessions held at home. The report shows that CHNs understand the importance of face-to-face interactions with individuals or small groups in an informal setting to increase success.

Importance of delivery agent - the people who are delivering the intervention are as important as the programme and it's setting. Characteristics of the delivery agent should include competency skills such as leadership, knowledge of working with people, empowerment skills, motivation, organizational and communication skills, as well as vision, determination and stamina. The report suggests that CHNs could develop roles beyond those traditionally associated with nursing. but that this will have to be formally encouraged via enabling policies and education starting at pre-registration level and via continual reinforcement throughout post –registration courses and post graduate academic study.

Training of delivery agents - several public health interventions are carried out by non-professional volunteers, often recruited from the target population and trained to perform a task such as delivering a particular health message, or trained to offer

support and guidance, or trained as peer education/support workers. Users and carers need training to promote access to reliable and accessible information to exercise their choice, independent training in advocacy and training to ensure confidence to put forward formal arguments, build effective leadership and competency skills and involvement in decision-making. Professionals can also be trained to provide smoking cessation techniques or emphasize the importance of training carers when they are running classes and programmes for older people or the disabled. The report highlights the need for CHNs to be skilled in community development and the empowerment of others in public health principles.

Use of support materials - many innovative programmes require the use of educational materials such as booklets, CDs and videos. CHNs in public health practice require easy access to inter-agency and multi-faceted material to enable them to provide evidence-based material to patients and communities.

Table 4

## 4. INDIVIDUALS/COMMUNITIES/ORGANISATIONS

A holistic approach to health - this means viewing health and social need by looking at the 'whole' person or the community they live in. This contains many parts such as the physical, the spiritual, the emotional, the mental, the social and the environmental. The report acknowledges that CHNs are aware of the impact of unemployment, poverty and deprivation, poor housing, lack of education, inadequate nutrition, lack of social support and adequate ways of coping with life can have upon and individual's/community's health and well-being. It is also necessary to look at the impact of rural health compared to urban health and the social network in which the individual lives such as those in the homeless community, those acting as carers, those living lonely isolated lives and the effects that these may be having upon their psychological and behavioural well-being.

Empowerment – this means providing effective health promotion that allows the individual or community to take control of their lives, their health and needs and to determine their own destinies and allowing them to take direct action in the process of change. Encouraging patients, clients and users to become involved in health development and decision-making means changing their attitude and that of professionals to allow active participationCommunity development/commitment - commitment to a holistic approach to public health recognizes the central importance of social support and social networks. Individuals and communities need to be fully involved in partnerships and networks to set priorities, make decisions, plan strategies and implement them in order to achieve better health. Analysis of the data highlights CHN's concepts of community development could be usefully developed. The relative lack of development has implications and challenges for public health practice.

Culturally appropriate – this is making sure that the intervention or programme is sensitive to the cultural needs of the target group as this is vitally important with respect to communication and support.. Empowerment of individuals is visible in self-help groups by helping people produce coping skills to reduce depression, allowing increased skills and personal contact and strengthening them to provide a better quality of life for themselves and their families. Empowerment can therefore be personal (increased self-esteem, increased coping ability) or collective as in campaigning for better access to care and services on behalf of all. Analysis of the data shows that empowerment can also be a two-way process in that CHNs can feel more empowered by measuring the effects of good patient/client interaction and positive decision-making, thus creating more effective public health practice.

NOTES

NOTES