Using Practice Development Methodology to develop Children`s Centre Teams:

Ideas for the Future

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Abstract

The Childrens Centre Program is a recent development in the UK and brings together multi agency teams to work together with disadvantaged families. Practice Development Methods enable teams to work together in new ways. Although the term practice development remains relatively poorly defined the key properties of it suggest that it embraces engagement, empowerment, evaluation and evolution. This paper introduces the Children`s Centre Program and Practice Development Methods and aims to discuss the relevance of using this method to develop teams in Children`s Centres through considering the findings from an evaluation of a two year project to develop inter agency public health teams.

Key findings from the evaluation showed that Practice Development Methods can enable successful team development and showed that through effective facilitation teams can change their practice to focus on areas of local need. The team came up with their own process to develop a strategy for their locality. The following emerged as an effective series of steps for the team to follow.

- The team undertook an assessment of the opportunities for gaining information and support relating to sexual health in this area which involved local teenagers and provided a good starting point for further development of future services.
- Effective networking and regular event organising enabled different agencies working in an area to be up-to-date about what was happening, therefore preventing overlap and repetition.
- Influencing strategic decision-making regarding resources, job structure and role development avoided overlap and repetition.
- Joint bidding for resources and joint service development.

- Changing the way individuals practice, and who they work with, particularly when working on a key local priority.

Multi-agency public health team development needs to focus on a specific local need to enable the team to develop effectively. In addition, team members need time to reflect on what inhibits their working together as well as how to do it better, and project or team steering groups from across agencies are the key to enabling organisational learning from this process.

Key Words: Children`s Centres, Practice Development, Inequities

INTRODUCTION AND BACKGROUND

The aim of this paper is to introduce practice development as a potential way of bringing different partners together to develop teams with the aim of reducing inequities in health. The paper will introduce the Children`s Centre Program and Practice Development and will discuss the relevance of using this method through considering the findings from an evaluation of a two year project to develop inter agency public health teams.

Children`s Centres are service hubs where children under five years old and their families can receive integrated services and information by 2010 every community will be served by a Centre. Local authorities have been given strategic responsibility for the delivery of care in these centres in consultation with parents, together with the private, voluntary and independent sectors, Primary Care Trust`s (PCTs), Jobcentre Plus and other key partners. The Children`s Centre program is based on the concept that providing integrated education, care, family support and health services are key factors in determining good outcomes for children and their parents. The concept is not a new one and the centre`s are about building on practice (Sure Start) rather than starting again. Children`s Centres are a key part of governmental policy designed to support families through enabling multi agency working through the centres where services may vary but should include:

- Integrated early education and childcare.
- Support for parents – including advice on parenting, local childcare options and access to specialist services for families.
- Child and family health services – ranging from health screening, health visitor services to breast feeding support.
- Helping parents into work – with links to the local Jobcentre Plus and training.

Currently as this is a new policy initiative it is unclear how successful the Children`s Centres will be in reducing inequities in health. Early evaluations of Sure Start Centres showed mixed results of effectiveness[1,2] in relation to provision of support to families and parents, support for good quality play, learning, childcare, primary and community health care and support for children and parents with special needs. However as the Sure Start Centres evolved and changed their model of service delivery to become Sure Start Children`s Centres (2004-6) more positive measurable outcomes were recorded.[3] The changes that occurred in this period included clear specification of services that should be offered with a strong emphasis on child well being and the need to reach the most vulnerable and adjustment of service provision to the degree of family disadvantage. In the early years of Sure Start there was little specification of how services were to be delivered and to whom which was in sharp contrast to earlier interventions shown to be effective.[4,5,6,7] Effective interventions were characterised by a specific focus on the most vulnerable and disadvantaged families in a local area.

The term Practice Development (PD) evolved from the work of a small number of nursing development units (NDU's) in England during the 1980's.[8] NDU's were centres of innovative practice[9] funded by the National Health Service (NHS) as part of a commitment to develop nursing practice.[10] The aims of NDU's included: reducing the theory-practice gap,[11] increasing utilisation of evidence based practice,[12] development of a better educated workforce[13] and movement away from the medical model towards more patient focused care.[14]

Recognition that the modernisation agenda could only be achieved through multidisciplinary working precipitated a shift from nursing development to PD.[15] Although PD is a frequently used term it can be argued that the exact nature of the concept remains somewhat poorly articulated.[16,17] A regularly cited definition is

provided by McCormack.[18] "PD is a continuous process of improvement towards increased effectiveness in person-centred care, through enabling teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change".

PD has a varied reputation. McCormack et al[18] argue that this may be because the outcomes of such work are often less amenable to measurement than other areas. This idea is echoed by Page[19] who argues that the reputation of PD suffers as it is less easy to categorise than other activities such as audit. A brief review of practice development confirms that the term remains relatively poorly defined. In summarising practice development McSherry and Warr[20] suggest that it embraces engagement, empowerment, enlightenment, evaluation and evolution. The published literature broadly concurs with these ideas and provides a range of key elements that are central to practice development:

- Practice development is intended to improve person/family focused care.[21,22,23]
- Links between practice development and education are strong but education does not automatically produce improvements in practice.[23]
- Practice development should be practitioner-owned and should empower practitioners to instigate change.[21]
- To be effective practice development needs to bring about cultural change.[24,18]

A lack of definition brings about problems when trying to assess the impact of PD activity. In some areas this challenge has been addressed through the implementation of practice development accreditation schemes. These university

based schemes are used to formally recognise PD work. Accreditation has gained increasing attention over the last twenty years[25,26] as a method of emphasising the importance of continually improving practice. The small number of PD accreditation schemes in the UK invite teams to demonstrate how they are meeting improvement criteria. These schemes have over time moved beyond health as their primary focus to teams working across organisations in new ways.

This paper will now go on to consider the PD method in relation to multi agency team development specifically in relation to the learning from a two year project commenced in 2003.

THE PROJECT AIM:

To engage a local public health team in the establishment of an action learning set to develop practice.

OBJECTIVES:

- To focus the activities of the learning set on a relevant public health improvement issue.

- To agree aims, objectives and responsibilities for the practitioners/agencies involved.

- To enable the development of knowledge and skills and to introduce evidence based practice.

- To evaluate both the process and outcomes of the team development.

The approach taken to team PD in this project was action learning a method for individual and organisational learning. Members of the group learn from their experiences and from each other as they attempt to introduce change. The value of action learning in role development is well documented[27,28,29] and is an approach

which links learning with action through small groups called learning sets. These meet regularly to work on practice issues with the aim of learning from and with each other within a specific context or in this case public health locality area.

This project resulted from a proposal through the South West Regional Public Health Academic forum. Members of the team include a health visitor, a health promotion officer, a school nurse, a social worker and a primary mental health worker. Representatives from education, i.e. a local head and deputy head teacher, also attended meetings regularly. Other practitioners included staff from the Youth Advisory Centre and representatives from the local authority who support the development of the local strategic partnership. The area in which the team practice has a large population of young people and a relatively high rate of teenage pregnancy. It was in the 20% most deprived wards in the country in the DETR Indices of Deprivation in 2000.

EVALUATION

The research methods used for this evaluation were predominantly qualitative in nature, however the skills audit undertaken included simple numerical analysis and the final impacts of the project have been recorded using both population statistics and qualitative methods. All emerging themes were discussed with the team under study and the data collection for the evaluation took place from February 2003 to March 2005 and further evaluation of the impacts of the teenage drop in centre established by this team has been undertaken in 2008/9.

- Participant observation in team meetings and steering group meetings.

Participant observation in meetings was undertaken by the researcher (employed by the local university undertaking the evaluation) and all parties were asked for permission at the commencement of meetings to enable this process to occur.

- The Health Development Agency Skills Audit.[30]

Practitioners assessed their ability in the skill clusters below this was completed at the start and the end of the project to focus on whether team members felt they had gained skills through involvement. These skill clusters are:

1. Personal skills and leadership;

2. Workplace management;

3. Policy and strategy implementation;

4. Underpinning public health practice principles;

5. Professional and technical issues.

The Skills Audit results were used to inform training sessions and to monitor individual progress. Key areas of skill development needed were, research and evaluation, managing conflict and change, chairing meetings and lack of IT access and training.

- Semi-structured interviews with participants.

Semi structured interviews with all participants were undertaken and all participants were given written information prior to this process regarding the confidential nature of their replies and that they did not have to undertake an interview and could withdraw from the process at any time.

- Analysis of relevant meeting notes

Documentary analysis of meeting notes was undertaken by the researcher in order to capture the ground rules, team decisions and team planning and learning processes.

- Practitioners' reflective sessions.

The reflective sessions with practitioners enabled them to explore barriers and enablers to team development. The researcher took notes of these sessions with the permission of team members and fed back key themes which emerged to check for relevance.

A steering group for the project was established to feed learning back into organisations and senior management which resulted in increased organisational support and responsiveness to developmental needs relevant to improving the service.

TEAM DEVELOPMENT PROCESS

The project was designed to act as a space for developing practice and it was the role of team members to choose a local focus. The team chose teenage sexual health and a proposal came from this to develop a young people's drop-in. The drop in is now funded and established after having shown a positive impact on local health outcomes.

The following areas were agreed as ground rules for the team. Constant attendance e.g. the same person should come to every meeting, any issues regarding commitment and interest and the effectiveness of the team should be shared. Being non-judgmental and honest and not personalising criticisms of the service that an individual was representing.

DEVELOPING LOCAL ANSWERS – FINDINGS FROM THE PROCESS EVALUATION

The following emerged as an effective series of questions for the team to ask to inform the development of local strategy which have the potential to be used on a variety of public health topics. The findings emerged from the analysis of the following data sources, participant observation, documentary analysis and practitioner reflective sessions.

- What are the health needs of the community or clients you work with? Are there any inequities in access or inequities in health in this area? Do you need to find this out or has this work been done?

- What is 'best practice' for tackling this area? What have other people done?

- Do you need to refocus what you do; drop some things and pick up others?

- How can you work with local residents or different agencies to tackle these needs?

- Do you need to provide services in a different place, at a different time or in a different way?

- In what way is your practice, as a team or as an individual, meeting the needs of your local community?

The following emerged as an effective series of steps for the team to follow to develop local strategy.

- An assessment of the opportunities for gaining information and support about risks to sexual health in the area which involved local teenagers and provided a good starting point for further development of future services.

- Effective networking to prevent overlap and repetition.

- Influencing strategic decision-making regarding resources, job structure and role development.

- Joint bidding for resources and joint service development.

- Changing the way individuals practice and who they routinely work with on key local priorities.

Multi-agency public health team development appears to require an early focus on a specific local need to enable effective development. In addition, team members need time to reflect on what inhibits their working together as well as how to do it better and project or team steering groups from across agencies are the key to enabling organisational learning. It is vital that team members are given protected time to

attend team meetings and that their institutions support their involvement. As findings from the evaluation were be fed back to team and steering group members a culture of learning from evaluation and asking questions of themselves and each other emerged which is why some of the evaluation findings are articulated as questions rather than answers. This approach lends itself to planning public health interventions which are contextual by their nature and require local needs based responses from practitioners.[31]

For the team involved in this project there was a crisis of focus at four to five months as members realised that they needed to work differently to work together effectively. Networking meetings were inside their comfort zone, changing the way they worked on a day to day basis in relation to local need was much less comfortable and required organisational support. This may mean relocation of staff and resources or reorganising and refocusing the provision of service in relation to local need.

Another issue is how to make information accessible for everyone involved. This includes the use of language and presenting documents that can be understood by all team members, including those who are not professionally or formally trained for their role such as volunteers or local community members or in this case young people. Further development opportunities/support may need to be made available to enable their full and effective involvement.

CHANGING HOW PEOPLE PRACTICE – FINDINGS FROM THE OUTCOME EVALUATION

Findings showed that effectively changing how people practice requires the following:

- Practitioners need to feel that the working together differently is essential to improving outcomes for residents/clients.

- They need to feel supported in making changes.

- Institutions need to recognise this need and that resources/organisation of work may need to change.

- Local practitioners need access to relevant local health needs data and information across agencies in an accessible format.

These findings emerged from the practitioner reflective sessions and relate specifically to the Skills Audit.[30] Development opportunities were offered alongside team development and the second assessment using the audit tool on completion of the project showed improvement in all skill areas.

The outcomes from the teenage drop in centre the team established have been positive with no pregnant teenagers at the school (and none having become pregnant and left) since September 2007, a drop in Chlamydia rates and an increase in school attendance being recorded thus far. In addition the qualitative evaluations of the service offered by teenagers have been positive particularly relating to ease of access and confidentiality.

FACILITATING THE PROCESS

Providing services in a different way and dealing with areas of conflict between agencies some of which are historical in origin, requires honest dialogue and effective facilitation. Involving a `third party` (in this case a local public health academic) has been shown to be effective where these conflict areas are deeply entrenched.[20] Setting ground rules within teams is part of the process of managing conflict and change as issues arise. The team could also reflect on its achievements in this development context and the project clearly identified that there were no other mechanisms for team members to express concerns or reflect on positive developments together across different agencies.

CONCLUSION

These practitioners have gone on to become members of the local Children`s Centre team and as a result of the positive outcomes from their work have won the local Health and Social Care Award 2008/9 for Partnership Working.

Although the term PD remains relatively poorly defined the key properties of it as summarised by McSherry and Warr[20] suggest that it embraces engagement, empowerment, evaluation and evolution. These terms are also echoed across much of the global evidence relating to reducing inequities in health in local communities.[32] It may be that it is now timely within public health to consider these issues not only with the communities in which we practice but also with the wider public health communities of practice in which we work in order to build effective sustainable teams and strategies to effectively reduce inequities.

Clearly there are considerable limitations in considering the success of one team without comparison with other teams who have not been exposed to PD methods during their development. However the learning from this development process may still be useful for those working in similar areas with similar issues and can provide guidance for future evaluation studies in this area.

Currently PD methods are being used with four Children`s Centre Teams in the South of England. This project will run until early 2010 and the intention is to capture the impact of this method through mapping the outcomes for the Children`s Centre teams being facilitated using practice development methods.

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