

ENGLAND
CENTRE
for
PRACTICE
DEVELOPMENT



IMPLEMENTING & EVALUATING A COMMUNITY OF PRACTICE FOR HEALTH VISITING

FINAL REPORT

March 2016

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The project Steering group was made up of a number of contributors who offered a depth and range of feedback as well as their time (see Table 1). In addition we would like to thank Carrie Jackson Director England Centre for Practice Development

As this report is completed the the video resources have been launched and are now widely available. Our thanks to Neil and Clare Ashford of Lavender Blue Media Ltd. for the telephone tutorials on script writing and the finer elements of editing and filming.

We are grateful to our service user Marie Tazey, her commitment to the project and contribution to the final production.

Table 1 The Project Steering group

Project Steering Group	Title and Base
Professor Kim Manley	Principle Investigator
Jane Greaves	Research Fellow
Mary Brown	Principle Lecturer, School of Nursing Canterbury Christ Church University
Jane Butler	Head of Clinical Education, Health Education Kent Surrey and Sussex
Sharon Clarke	Professional Lead for Health Visiting Kent Community Health NHS Foundation Trust
Linda Denne	Independent Consultant (Health Visitor)
Diane Gibson	Practice Teacher Medway Community CIC
Madeline Harris	East Kent Hospital Foundation Trust
Louise Holden	Kent County Council Public Health
Heather Keen	Initial Project Lead for the Community of Practice & Action on Health Visiting
Dr Sally Kendall	University of Hertfordshire
Kate Saunders	Foundation of Nursing Studies
Sari Sirkia-Weaver	Canterbury and District Home-Start
Rhona Westrip	Programme Manager Children and Young People Health Education Kent, Surrey and Sussex
Jo Mockeridge, Anna Humphreys and Sarah Chapple	Administration

Executive Summary

Introduction

This report presents the context, approach and findings arising from implementing and evaluating a Community of Practice (CoP) for Health Visitors across Kent and Medway funded by Health Education England (Kent, Surrey and Sussex) and built on the launch of the Communities of Practice concept in Kent and Medway (Keen et al 2013).

The intention of the CoP, with its focus on health visiting practice, was to support a Health Visitor from each locality across Kent and Medway to:

- develop their skills in practice development and clinical leadership
- create effective learning cultures within which students and practitioners can flourish
- explore how the effectiveness of health visiting can be demonstrated

Literature review

National and regional context

Health Visiting is primarily focused on early childhood, which is defined as commencing in pregnancy and extending to eight years of age. Early childhood is considered to be a key social determinant of health by the World Health Organisation because neuroscience research has demonstrated that what happens to children in this period is critical to their developmental and life course pathway acting as a 'powerful equalizer' (Irwin et al 2007). This is reflected in UK policy which promotes 'giving children the best start in life' (Marmot 2010).

After more than a decade of continuous professional uncertainty for health visitors, the NHS Operating Plan 2011-12(DH, 2010) identified the need to end the decline in numbers of the Health Visitor workforce, begin to increase posts, workforce numbers and training posts through The Health Visitor Implementation Plan 2011-2015: A Call to Action (DH 2011) which sets out the new vision for health visiting.

Regional context

Localities in Kent and Medway present a challenging demographic, identified as deprived, already burdened by above national averages and creating burden on all

public services. Inequality directly affects workload for health visitors and in Kent and Medway this is marked by statistics which are higher than national figures for: young people not in education, training, or employment; new entrants to the youth justice system; teenage mothers, substance misuse; poor mental health of young people; smoking in pregnancy ; low breast feeding rates and poor uptake of the MMR immunisation. (PHE Kent June 2015, PHE Medway June 2015).

Increased numbers of health visitor students and newly qualified health visitor practitioners required a cohesive plan as well as an approach which reflects the contemporary requirements of the health visitor workforce. The objectives of the Call to Action Plan will not be achieved by increasing numbers alone (Whittaker et al 2013) but with a level of creativity and commitment to address the demographic health and social care challenges on which the health visitor service will be judged.

Communities of practice

The Community of Practice (CoP) was launched in February 2013 at venues (2) across Kent and Medway with over 150 attendees from the health visiting workforce with the aim of introducing the concept of 'Communities of Practice' to health visiting staff, to involve practitioners in shaping their development locally.

Communities of Practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.” (Wenger et al, 2002, p.4 cited by Le May 2009).

Health visitors: purpose, role, effectiveness

Health visitors are registered with the Nursing and Midwifery Council (NMC) as a sub-section of Specialist Community Public Health Nursing. They work in the community undertaking planned activities with individuals, families and groups basing their practice on the NMC Domains of their profession: Search for health needs; Stimulation of awareness of health needs; Influence on policies affecting health; Facilitation of health-enhancing activities (NMC 2004).

However, these descriptors do not easily explain what it is health visitors do and how they do it as well as how they articulate this and this impacts on demonstrating effectiveness. Exploring the practice of health visiting: *what it is health visitors do?* is important if health visitors are to share and grow their expertise in their practice. Donetto et al (2013) have identified key areas of practice which service users have considered to be central to the purpose of and role of the health visitor; relationships, support, information, co-ordination and service *user involvement* (Donetto et al 2013)

but moreover the impetus for professional regeneration is based on high profile reports stating.

Health Visitors play a key role in child protection, particularly for very young children who are unable to raise the alarm when suffering from abuse or neglect.... In this context, the role of Health Visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives.

(Lord Laming, 2009, s 5.21, 57–58).

Project Aim, Methodology and Methods

The aim of the project was to implement and evaluate a Community of Practice by supporting a health visitor from each locality across Kent and Medway to:

- develop their skills in practice development and clinical leadership
- create effective learning cultures within which students and practitioners can flourish
- explore how the effectiveness of health visiting can be demonstrated

Two interrelated methodologies, action research and practice development were selected because they both focus on practical action in the workplace that is systematically implemented and evaluated through collaborative, inclusive and participative approaches.

Three overarching processes (methods) were used to support the health visitor clinical leaders included:

- active learning (Dewing 2008)
- action learning (McGill & Beaty 2001)
- critical companionship - a helping relationship that focuses on helping a practitioner to learn (Titchen 2000)

Within the lifetime of the project 18 co-researchers across two cohorts were recruited to the action learning sets which were less than the 20 proposed in the initial plan. Recruitment of co-researchers was undertaken in partnership with service managers

The notes generated from each session documented on-going claims, concerns and issues (Guba & Lincoln, 1989), daily evaluations and reflections as well as other

outputs arising from the active learning workshops e.g. tools for using emotional touchpoints with health visiting clients.

The health visitors, as co researchers were involved in co-creating the focus and direction of the project through using the methods and tools, negotiation and ongoing process evaluation around the focus of the sessions; and the analysis of data at various stages.

A Steering group of key stakeholders was established to support the action related practice development project and provide a range of perspectives to challenge and support the project team with achievement of the project's aims.

Findings

The focus of the sessions – co-creating the journey an overview

Twelve (12) sessions were provided for cohort 1 and eleven (11) sessions to cohort 2. Active learning encompassed interactive activities that involved:

- identifying hopes, fears and expectations for the CoP
- developing a shared understanding and purpose of health visiting
- assessing where they were in terms of their confidence and skills and identifying critical companions to support them on a 1:1 basis
- developing an understanding about how others perceive them using qualitative 360 degree feedback
- using, practising and applying tools for developing and improving practice, e.g. emotional touchpoints (Bate & Robert, 2007); values clarification (Warfield & Manley 1990); claims, concerns and issues (Guba & Lincoln 1989).
- exploring collective points of interest that were generated from using the Claims, Concerns and Issues Exercise (Guba & Lincoln 1989) about their own practice and the Community of Practice (CoP).

Action learning (Mc Gill and Beaty 2001) was the focus of the second half of each session and included exploring key questions important to co-researchers as well as developing the skills required to support other staff to be effective in their health visiting practice.

Key outputs included a shared vision, purpose and unique selling point; a framework for identifying enablers, attributes and consequences of effective health visiting. This framework in turn was used to support the:

- pilot of an adapted Cassandra Matrix for capturing workforce patterns and profiles for different types of Health Visitor development of stories that illustrate the actions and impact of health visiting – these are being integrated into an interactive webpage
- development of evaluation frameworks for different aspects of health visiting, but also the adaption of emotional touchpoints to service users, Health Visitor students and staff
- integration of learning within the 4-5,6 model (Bennett 2015) which honed co-researchers political skills
- dissemination of learning through celebratory masterclasses, the development of two videos and an interactive webpage

Implementing and evaluating the community of practice: seven different journeys

Seven different parallel journeys were experienced by co-researchers as they worked collaboratively with the facilitators in taking forward the concept of the Community of Practice, these are summarised as:

- Learning to support and rejuvenate each other in a shared passion for health visiting
- Developing health visiting practice together towards collaborative action and sustaining the CoP
- Becoming more confident and empowered through learning about self
- Developing clarity of role and evaluating its contribution to future health care and becoming more political
- Learning to use tools that can be used with others to develop and lead practice
- Becoming more reflective enablers of others
- Developing theory from practice

Contextual challenges impacting on the community of practice

Four powerful influences emerged that impacted on the co-researchers participation in the project and also the potential for sustainability of the CoP project

Individual Factors: Time, travel, overwhelming workload made attendance and implementation of learning challenging

Workplace Factors: Massive changes - top down driven, changing managers and leaders, toxic cultures, silo working influenced what Health Visitors both needed to do and what they could do

Concept Potential of COP Unrecognised: untapped/undervalued by stakeholders as a resource linked with other initiatives and the Institute of health visiting

Workforce & Clinical Leadership: Overwhelming need to grow, retain and value the newly qualified and established workforce

Discussion, implications, limitations

Understanding the factors and strategies that influence the successful implementation of Communities Of Practice is important to others who may be involved in similar initiatives. Whilst the internal and external factors have been identified, this provides insights about how to enable CoPs to be successful. It is important that CoPs are successful because they have the potential to achieve three important outcomes towards transforming health care. Each has been demonstrated in this project. The CoP has impact on:

1. How health visitors develop their full individual potential as practitioners, their sense of confidence and wellbeing, sustaining their passion for practice, helping them to flourish through the peer support, networking and acquiring the critical and facilitation skills required to be effective and demonstrate impact. Practitioners that fulfil these criteria have a positive impact on the quality of care experienced by service users.
2. Team effectiveness, through team leaders possessing the facilitation, practice development and clinical leadership skills that the CoP focuses on developing and using these with their teams. This skillset has been identified as the catalyst through which individuals develop their own effectiveness and enable the effectiveness of others, subsequently impacting on whether care is experienced as person centred, safe and effective by service users.
3. Transforming future healthcare, bringing their passion, values and expertise to shape and influence health care provision collectively through influencing local and national strategic direction from collaboratively developing their own practice, their clinical leadership role, as well as their ability to evaluate and demonstrate their effectiveness and impact. Practitioners with this expertise will be able to optimise their impact across whole systems through future clinical systems leadership roles.

There were limitations to the programme from the commencement of the sets, the under recruitment of co-researchers and consequent attrition, the difficulties co-researchers experienced in trying to use what they were learning in the workplace, the lack of critical companions within a system which was experiencing much change and the challenges of working within one half day rather than one day for developing essential skills. However through flexibility of all involved many of these challenges were overcome and a small cohort of people now exist who can foster communities of practice both within their own localities and across Kent and Medway. In addition a number of tangible outputs result that can be used with others.

Conclusion

The CoP project was commenced during a period of unprecedented local and national change in health and local authority organisations, with this felt and experienced in the workplace by a range of health visitor practitioners and service managers.

Whilst the work context itself was out of the control of the project facilitators, it is vital that employers recognise that Communities Of Practice and the development of health visiting practice is an invaluable resource that will contribute to both workforce and service transformation.

This implementation and evaluation of a Community of Practice for health visiting has demonstrated impact on how health visitors develop their full individual potential as practitioners; the relationship between practitioner effectiveness and team effectiveness through clinical leadership; and, the contribution that practitioners can make to transforming future healthcare. The models used and the insights resulting from this project will be useful to inform the establishment of communities of practice in other specialisms as well as sustaining more formal practitioner development and networking opportunities that complement e- communities.

Recommendations

Health Education, Kent, Surrey and Sussex

- *The outputs (videos and interactive web page) from the Community of Practice are shared and promoted widely with all sectors to help others develop effective workplace cultures that use the workplace as the main resource for learning*
- *Promote the and use emotional touchpoints as a resource that helps to focus on what matters to people be that service users, staff or students*

- *Attend to the need to develop clinical leaders and also clinical systems leaders across the health economy that draws on the expertise that health visiting has to offer, especially as health visiting is supporting children, their parents and families as the citizens of the future*

Commissioners

- *Commission services that promote whole systems approaches for children and their families across the health economy that draws on the expertise that Health Visitors have in understanding both the needs of children, their parents and families but also public health*
- *Explore how clinical systems leaders can be established with the pre-requisite, clinical credibility, leadership; learning and consultancy expertise (Consultant Health Visitors) needed to lead the development of integrated pathways across all sectors via joint appointment across health and social care.*
- *Ensure that service providers commissioned are committed to growing and developing a strong staff foundation of clinical leaders, who can*
 - *create effective workplace cultures that are person centred, safe and effective*
 - *have the skills to evaluate effectiveness and use the workplace as the main resource for an integrated approach to learning, development, improvement, inquiry and innovation as well as knowledge translation*
 - *Use the 3-8 model of health visiting to attend to the enablers, performance indicators and outcomes of health visiting*

Health service providers

- *To invest in the quality of Health Visitor clinical leadership across all localities as a priority to enable the service to deliver on the outcomes it aspires to achieve and the transformation needed*
- *Future programme initiatives secure strong management support, are dovetailed with other initiatives being introduced and commit to the value addedness of investing a full day rather than half a day in particularly where travelling is involved for co-researchers*
- *To grow further, the quality of workplace preceptors, critical companions and practice educators to ensure they have the full skills required to facilitate and integrate approaches to learning, development, improvement, inquiry, innovation and knowledge translation in the workplace – using the workplace as the main resource*

- *To draw on the expertise of health visitors who have participated in the CoP to facilitate and develop effective teams and workplace cultures in localities across the region as well as enabling them to lead the development of health visiting practice and innovation to inform service transformation*
- *To embed the use of emotional touchpoints that provide rich qualitative data about what matters to people be that service users, staff or students that complement more quantitative data and drive continuous improvement*
- *To integrate the videos produced from the CoP into learning and development programmes*

Educationalists involved with continuing professional development of Health Visitors as well as programmes leading to registration with the Nursing and Midwifery Council

- *To embed the use of emotional touchpoints with students and practice teachers as a learning tool providing rich qualitative data about what matters to people be that service users, staff or students that complement more quantitative data and drive continuous improvement*
- *To integrate opportunities to explore systems leadership within the teaching and learning programme at registrant level as well as for those practitioners progressing in their career to practice teacher*
- *Embed action and active learning (Dewing 2008) in continuing professional development as well as programme modules such as leadership and research but also in 'practice hub learning'*

Health visitors in Kent and Medway

- *Value, use and build on the resource and investment made to health visitors participating in the CoP as critical companions and clinical supervisors as well as skilled facilitators of effective teams*
- *Sustain the CoP across Kent and Medway so as to create a vibrant testbed and network for health visiting practice through organising 6 monthly face to face meetings to complement the Health Visitor e-CoP focussing on regional practice*

Introduction and Context

This report presents the context, approach and findings of a Community of Practice (CoP) initiative introduced across Kent and Medway for health visiting funded by Health Education England (Kent, Surrey and Sussex). The initiative followed a formal launch of the CoP in Canterbury and Medway in February 2013 attended by more than 150 local Health Visitor practitioners, many of whom expressed their interest in taking the concept forward. Practitioners and stakeholders were involved in co-constructing a vision for the support Health Visitors required to develop their practice. This event also introduced co-researchers to the Virtual Community of Practice being developed for the Institute of Health Visiting by Dr Sally Kendall and Dr Faith Ikioda.

The implementation and evaluation of the Community of Practice concept began at a time when the Coalition government priority was to increase investment in the health visiting services and mandated in the NHS Operating plan 2011-12 (DH 2010); the details laid out in the Health Visitor Implementation Plan 2011-2015: A Call to Action (DH 2011). This strategic direction was in response to public inquiries into the safeguarding and protection of children in circumstances which were largely preventable but highlighted the impact of the decline in the health visiting workforce. Subsequently a significant number of cross governmental publications have highlighted the need for improved preventive services for families with young children but also an approach which validates early intervention in early childhood. It was also acknowledged that the health visiting workforce which plays a large part in both early intervention and prevention in maternal and child health and thereby safeguarding children had diminished in numbers as well as direction.

1.1 Project purpose

The purpose of the project was to implement and evaluate a CoP by supporting a Health Visitor from each locality across Kent and Medway to:

- develop their skills in practice development and clinical leadership
- create effective learning cultures within which students and practitioners can flourish; and
- explore how the effectiveness of health visiting can be demonstrated
- sustain the CoP across Kent and Medway so as to create a vibrant testbed and network for health visiting practice through organising 6 monthly face to face meetings to complement the health visitor e-CoP focussing on regional practice

1.2 Project governance

A project steering group was established and comprised representatives from a range of stakeholders and representatives from local provider organisations in which Health Visitors worked as well as organisations that interfaced with the health visiting service and national experts to support the project team, by providing critique and review of the project's focus, direction and progress. The project steering group met four times over the course of the project working to terms of reference (Appendix 1).

1.3 Overview of the report

This report provides:

- a literature review focusing on the practice and effectiveness of health visiting
- explanation of the research approach used to implement and evaluate the communities of practice concept
- an overview of the main research findings illustrating the key outcomes
- a summary of the main contextual challenges impacting on the co-researchers and co-researchers to implementing the Community of Practice concept
- a discussion of implications and limitations
- identification of recommendations that will enable others to learn from this project

2. Literature Review

2.1 Aims and structure

The aim of the literature review is to highlight current understanding of the of the national policy imperatives for health visiting, and to explore the landscape of health visiting practice, leadership and workforce development. It will identify the gaps and priorities for further research in order to develop health visitor practice. Specifically the literature review is structured into the following sections"

- Search strategy
- National and Regional Context
 - National Policy
 - Regional context

- Communities of practice
- Health Visitors – Purpose, role and relationships
- The Role of Health Visitors their knowledge and Workforce development
- Leadership: purpose and role
- Health Visitors and integration
- Health Visitors autonomy, innovation and culture
- Relationships
- What do Health Visitors do?
- What are the outcomes and effectiveness for health visiting practice?

2.2 Search strategy

The literature review is based on three key documents commissioned by the Department of Health to support the strategy within the *Health Visitor Implementation Plan 2011-2015: A Call to Action* (DH 2011). These documents, published by the National Nursing Research Unit (NNRU) in 2013 provide a thorough foundation for Health Visiting practice.

- Why Health Visiting? A review of the literature about key Health Visitor interventions, processes and outcomes for children and families (Cowley, S., Whittaker, K., Grigulis, A., Malone, M., Donetto, S., Wood, H., Morrow, E., & Maben, J. February 2013)
- Health visiting : the voice of service users Learning from service users' experiences to inform the development of UK health visiting practice and services (Donetto, S., Malone, M., Hughes, J., Morrow, E., Cowley, S. & Maben, J. July 2013)
- Start and Stay: The recruitment and Retention of Health Visitors (Whittaker, K., Grigulis, A., Hughes, J., Cowley, S., Morrow, E., Nicholson, C., Malone, M. and Maben, J. July 2013)

To complement this review, a search of relevant professional journals was undertaken to identify subsequent publications relevant to the project (Appendix 2). On circulation of the first draft of the literature review to the project steering group, comments were invited and received in spring 2014. These comments highlighted areas of practice within the original literature review reported as underrepresented but of significant importance to health visiting practice as they have become increasingly topical and political in this period. In particular feedback was received about the impact of:

- Demographic changes within practice by the progressively diverse cultures within Kent and Medway
- The role and purpose of Non-medical Nurse prescribing in health visiting practice

In March 2014 the terms used for the search included, 'health visitor' or 'health visiting' and 'leadership'; 'health visitor' or 'health visiting' and 'practice development'; 'health visitor' or 'health visiting' and 'communities of practice' as well as 'health visitor' or 'health visiting' and 'effectiveness' This search returned no articles but did reveal some publications on leadership (See Appendix 2).

Professional journals, in particular the recently launched Journal of Health Visiting and the more established Community Practitioner were searched manually to identify more recent articles both at the beginning and end of the project. This review has included the plentiful literature from the Department of Health, Public Health England and Health Education England from that period and since May 2015.

Subsequently in July 2015, an updated search of the literature was undertaken based on feedback from steering group members using these former terms but also 'health visitor' or 'health visiting' combined with

- 'non-medical prescribing';
- 'asylum seekers'; 'refugees'; 'immigration'; 'migration'; 'gypsy'; & 'travellers';
- 'vulnerable'; 'safeguarding'; & 'supervision';
- 'commissioning' & 'public health role';

The search returned a small number of recent relevant publications (see Appendix 2). In addition to this search of recent publications the CHIMAT website hosting current health profiles for Kent (PHE 2015) and Medway (PHE 2015) were also reviewed.

2.3 National & regional context

2.3.1. National policy context

Health visiting is primarily focused on early childhood, which is defined as commencing in pregnancy and extending to eight years of age. Early childhood is considered to be a key social determinant of health by the World Health Organisation because neuroscience research has demonstrated that what happens to children in this period is critical to their developmental and life course pathway acting as a 'powerful equalizer' (Irwin et al 2007). The evidence of societal rewards which can be

achieved by 'giving children the best start in life' (Marmot 2010) have now been recognised in strategy (All Parliamentary Group (APPG, 2015) and translated into UK Government policy (DH 2011).

In England, Sir Michael Marmot's defining paper, *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010* called for increased expenditure in early years with an allocation arranged proportionately across the social gradient. This strategy based on extensive national and international research seeks to address the perennial and elusive concern about health inequalities commencing in childhood. By acknowledging parents' need to be supported adequately but also appropriately in these early childhood years, there are benefits which impact on a range of health, educational and social outcomes in the lives of children and young people (Audit Commission 2010, Marmot 2010, & Tickell 2011, Wave Trust 2013, Leadsom 2013, APPG 2015). What benefits children and their families also benefits society and with a financial motivation to take forward this strategy the outcomes when measured are predicted to outweigh the original investment.

Health visitors in the UK have traditionally been the lead health professionals for families and children in the community, but for a myriad of reasons their numbers have been in decline since the turn of the 21st century. The Healthy Child Programme (HCP) (DH 2009) acknowledges the health visitor as the lead professional in the community for child and family health delivering preventative and early intervention activities with families. For example, by emphasising the emotional and social health needs of infants under the age of 3 years, their preparation for formal learning and subsequent transition to school, the HCP programme offers a template for universal outreach to families with children at key child developmental periods. Hitherto, the shortfall in health visitor numbers have significantly contributed to the inadequate universal provision to families sometimes with severe consequences, as highlighted in national inquiries (Laming 2009).

The Coalition Government stated at this time the importance of marriage as the 'bedrock of family life' and the role of the 'big society' to individual and community cohesion, an ideological vision which cannot be separated from their proposals, despite this concept becoming 'lost' in current political rhetoric. The opportunity to influence this early childhood agenda through a universal 'early intervention' and 'proportional' approach has underpinned the revitalised professional role of the health visitor and their contribution to family health and well-being (DH 2011). The publication of cross party reports have highlighted the disparity of early childhood

experiences from varied perspectives; in the importance of early intervention for improved life chances (Allen 2011), early childhood and poverty, (Field 2010) parenting, family and aspiration (Allen and Duncan Smith 2009) all of which reflects the cross political party direction. Taking into account the emerging neuroscience research in the past 15 years, and the impact on our understanding of child development (Harvard Centre for the Developing Child 2012), the importance of early infant relationships (Shonkoff 2000, Sutherland 2010, Pereira Grey 2013), these reports make a persuasive case for improved investment in all children's services. In particular, the acceptance of what happens to infants and children from conception to two (2) years old has lifelong consequences across the developmental spectrum, with economic consequences of delayed and reactive intervention in education, social services, health and employment as well as crime, policing and the corrective services but overall to society. Understandably, this level of impact across public sector organisations has signalled the impetus for political attention and importantly intervention (Audit Commission 2010, NICE 2012, and Leadsom 2013, APPG 2015).

Addressing health issues early in childhood has been shown to improve health outcomes in later life and can reduce demand and cost pressures on the NHS

(Audit Commission 2010:8)

After more than a decade of continuous professional uncertainty for health visitors, the NHS Operating Plan 2011-12 (DH, 2010) laid out the political imperative of the new Coalition government committed to:

'...developing an expanded and stronger health visiting service as a key element in improving support to children and families at the start of life. This will entail ending the decline in workforce numbers, beginning to increase posts, workforce numbers and training capacity...'

(DH 2010 page 33)

The *Health Visitor Implementation Plan 2011-2015: A Call to Action* (DH 2011) sets out the new vision for health visiting revealed in three planned areas

Growing the workforce recruitment and retention activities to increase and retain health visitors in the workforce

Professional mobilisation: to promote, restore and strengthen (professional) development and career opportunities and enable a transformative approaches; restoring professional autonomy & decision making

Aligning delivery systems: to enable commissioning of the new service delivery model and integration with Sure Start Children's Centre to ensure delivery of the Health Child Programme

The new health visitor workforce will be, by 2015 made up of 50% practitioners who have qualified in the past three years and expected to achieve a range of outcomes detailed in the Early Years Profiles (PHE 2014, NHS England 2015) (Appendix 3).

At this time of revised interest in child health and inequalities, the DH has also invested in piloting an intensive home visiting programme delivered by a range of nurses and midwives as well as health visitors in a preventative and early intervention model of care for children and their families who have specific and additional needs. The Family Nurse Partnership, an evidence based programme from the USA has been proven to demonstrate specific outcomes in children born to first timeteenage parents and operates a highly structured regular intervention (Olds et al 2004). Similarly, the Maternal Early Child Sustained Home Visiting programme (MECSH) from Australia (Kemp et al 2011) operates on a similar basis with its emphasis on health equity in sections of marginalised groups in society. The evaluation of these programmes will contribute to further professional and service development as part of the Health Visitor Implementation Plan (DH 2011).

The Coalition Government (2010-May-2015), together with countless professional, voluntary and NHS organisations have pledged (DH2013 e) to improve a range of health and social outcomes (APPG 2015, DH 2013b); as a result of this shared concern health visitors have been charged with a renewed role at the forefront of this child health policy.

2.3.2 Regional context

South East Coast NHS previously made up partly of Kent, Surrey and Sussex Strategic Health Authority estimated the need for 984 more Health Visitors across these counties. During the period 2011-2015 the Action on Health Visiting strategy (Kent and Medway) has been challenged with increasing the workforce from the then current 198 to 421 WTE health visitors to fulfil the DH trajectories. This analysis, which is based on one full-time employed health visitors for every 400 children aged 0-4 years includes a statistical allowance for areas of high disadvantage (Cowley 2011¹) and identifies the area as having the largest deficit of health visitor numbers in

¹ Reported to KSS SHA in presentation

England and correspondingly the largest increase required in headcount of health visitors.

The health visitor services in Kent and Medway have been described as an 'ageing workforce' with many practitioners reaching retirement age and a minimal number of practitioners who have left undertaking a 'return to practice'. As a consequence and early in this agenda the priority was to increase student numbers to meet the workforce trajectory but moreover replace it. The pressure on student placements has required a creative approach with shared planning between HEIs, stakeholders and commissioners to ensure the adequacy and provision of practice learning develops a workforce fit for purpose (NMC 2004).

Within Kent and Medway proximity to major ports and the Channel Tunnel has led to an increased population through migration, often from Eastern European countries and has substantially contributed to demographic and population change in recent years. While there are parts of Kent and Medway which have experienced the historic impact of social decline associated with British coastal communities, and subsequently blighted by the attraction of plentiful cheap housing; it is the combination of migration, asylum seekers and refugees on these areas combined with existing levels of poverty and deprivation which have increased need in the population. The workload of Health Visitors is known to be affected by high rates of complexity and poverty and the demographic changes across Kent and Medway are indicative of this workload. In the Medway towns, in particular, the demography has evolved rapidly due to resettlement from London especially for example those asylum seekers 'who do not have recourse to public funds'.

In the last year, migration was the key component of the total population change in Kent accounting for 78.1%, or +13,200 residents (KCC 2015)

Localities in Kent and Medway have been identified as deprived, already burdened by above national averages and creating burden on all public services, but in health visiting practice, health and social inequality directly affects workload and in Kent and Medway this is marked by statistics which are higher than those national figures specifically:

- young people not in education, training, or employment
- new entrants to the youth justice system
- teenage mothers,

- substance misuse
- poor mental health of young people
- smoking in pregnancy
- low breast feeding rates and poor uptake of the MMR immunisation.

(PHE Kent June 2015, PHE Medway June 2015).

While specific variations prevail between communities it is in the Medway towns where these factors are underpinned by higher numbers of children living in poverty as well as higher rates of infant and child mortality and family homelessness (PHE Medway June 2015). Moreover, the impact of increased numbers of asylum seeking unaccompanied minors who require accommodation by Social Services (BBC Kent News September 2015) have been an additional strain on child protection resources.

Health Visitors have a specific role in assessment and identifying need with asylum seeking families and young people (Lawrence 2014) but have previously been described as ill prepared to work with refugees and asylum seekers (Drennan and Joseph 2005 cited in Cowley 2013). While there is little evidence to suggest this has changed it is the complex nature of their needs which places a responsibility on Health Visitors as they are often the sole health professional involved in supporting access to care and services.

Migrants on the other hand and although legally entitled to live and work in the UK, bring multiple challenges to health visitor practice in their ability to access health care (Richards et al 2014) as well as public and community services (Teshome Tesfaye and Day 2015, Hogg et al 2014). However, for the health visiting service the availability of translation services can really make a difference and has been demonstrated in several fields (Halonen 2015) but at times of austerity may not be considered a priority (Burchill and Pevalin 2015) a trend which can only be reversed through political action.

The boundaries and organisation of local government are separated in Kent with Medway designated a Unitary Authority. Medway community health services are managed by Medway Community Healthcare, arranged as a 'not for profit' social enterprise. Both Kent and Medway have main hospitals rated unsatisfactory by the Care Quality Commission following recent inspections, with Medway Maritime Hospital taking significantly longer to reverse this situation. Prison statistics reveal an aspect of Kent and Medway demographics not widely recognised; but with 10

Prisons including a detention centre for asylum seekers (Dover), Kent and Medway is recognised as having one of the largest prison populations in the UK.

Set within this local context of a challenging demographic picture in the local population, the increased number of health visitor students and newly qualified health visitor practitioners, launching a Communities of Practice in Kent and Medway (Keen et al 2013) required a cohesive plan as well which reflects the contemporary requirements of the health visiting workforce. After all, the objectives of the Call to Action Plan will not be achieved by increasing numbers alone (Whittaker et al 2013) but with a level of creativity and commitment to address the demographic health social care challenges on which the health visiting service will be judged. This is particularly relevant as the service commissioning transferred to local authority in October 2015 with future tendering a reality (Local Government Association 2015).

2. 3.3. Communities of practice

The Community of Practice (CoP) was launched in February 2013 at venues (2) across Kent and Medway with over 150 attendees from the health visiting workforce with the aim of introducing the concept of 'Communities of Practice' to health visiting staff, to involve practitioners in shaping their development locally. Keynote Speakers, Dr Sally Kendall and Dr Faith Ikioda, who were working with the Institute of Health Visiting to establish an on-line CoP delivered an enthusiastic presentation about their research.

From this success and acknowledging the considerable interest shown by health visitor practitioners and the positive evaluation at both launches a CoP Implementation Plan was developed to enable a project steering group of interested practitioners and service managers to take forward the COP concept in Kent and Medway. This project represented the next stage in the implementation through supporting health visitors as clinical leaders to develop their practice and embed person-centred and evidence based approaches in everyday practice. All of which are designed to benefit children and their families through using practice development approaches and evaluating their contribution and impact through an action related practice development project.

Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.” (Wenger et al., 2002, p. 4 cited by Le May 2009)

2.4 Health visitors – purpose, role and relationships

Regulated by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) from 1983 until the Nursing and Midwifery Order in 2001 established the Nursing and Midwifery Council the following year but removed the name ‘health visitor’ from statute. Nevertheless, since this regulatory change the purpose of health visiting has been firmly based on public health principles notable by the terms such as health assessment, communities, populations and individuals; social deprivation, promotion of health and key partnerships with other health and social care professionals (NMC 2004). By offering a series of ‘outreach’ contacts to parents prescribed within the HCP (DH 2009), linked to the revised service delivery (Box 1) there is a focus on planned activities geared towards prevention and early intervention. Evidence of health visitors’ effectiveness remains limited but evident in areas of their work including support for breastfeeding, support for parents and parenting, work with families experiencing domestic violence, and multiagency working. (Cowley et al 2013). However, there is limited evidence of effectiveness in a range of wider areas of practice due to insufficient research (Cowley et al 2013) but evidence of effectiveness is anticipated to be demonstrated through collected data in six (6) areas of high impact in public health outcomes (PHE 2014-15) (Appendix 4).

Box 1 Definition of a health visitor

A health visitor is a qualified and registered nurse or midwife specially trained to assess the health needs of individuals, families and the wider community. They aim to promote good health and prevent illness in the community by offering practical help and advice. The role involves visiting people in their homes, particularly new parents and children under five, and work with other sections of the community.

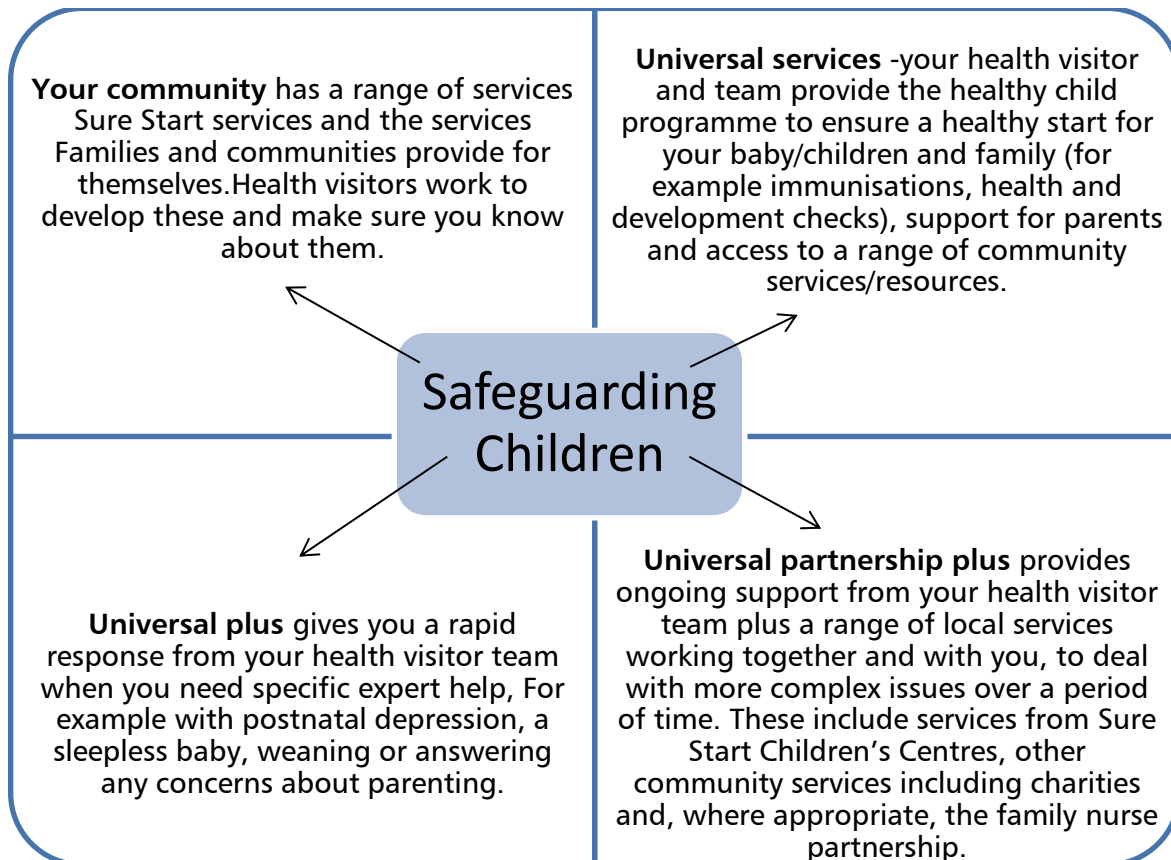
Working as a health visitor can include tackling the impact of social inequality on health, and working closely with at-risk or deprived groups within a defined community with individuals, families, communities and populations. This will include the ante-natal period in partnership with General Practitioners and Midwives (NMC 2004).

In leading the delivery of the Healthy Child Programme (DH 2009), the principal purpose of the health visiting profession is to enable optimal parenting in an environment where children can flourish and reach their full potential and parents feel effective in their role. This programme, with extensive evidence of what works in the field of early years identifies areas for future research which will be imperative to the maintenance of the revised health visiting profession to support families in the early years (PHE 2015).

The service delivery model (Box 2) proposes a template for the organisation of health visiting to facilitate services proportionate to the families identified needs and circumstances. Likewise, this enables parents and families to understand what they can expect from the service but does require health visitors to inform parents of the service offer (Brook and Salmon 2015) as partnership and collaboration is at the heart of health visiting practice.

This health visitor service model demonstrates levels of interventions with families and the complexity involved, but is initially an offer made universally and designed without stigma. This type of preventative healthcare is anticipatory and offered proportionate to the needs of individual families and communities which are assessed holistically before an autonomous decision making process supports the practitioner to offer intervention or care to the family. Ultimately the purpose is to support parents with the developmental needs of their children, to address those health and social inequalities which commence in childhood and are known to have profound implications for adult health and social outcomes in society (Marmot 2010). Increasingly, the term ‘early intervention’ has entered the debate within the structure and importance attached to the service offer.

Box 2 The Health Visitor Service delivery model (Adapted from DH 2011)



Health visitors have undertaken home visits to every family with a new baby as part of promotion of health and preventative health care for over one hundred years; continuing support at strategic times from the antenatal period until the child reaches school age. However, since the turn of the century health visiting has become increasingly reactive in its presentation and away from this intended role of prevention and health promotion. Meanwhile, this professional decline, in health visitor numbers and poor service strategy has led to other financially driven solutions by using a 'skill mixed' team, comprising nursery nurses, registered nurses and midwives who are often delegated to the less intense child and family cases and interventions relevant to their specific knowledge skills and competencies. Subsequently, health visiting practice has evolved towards the complex end of child and family scenarios as a mainly protective function and away from the intended universal preventative role; described as a service without the quality families could expect or indeed wanted (Gimson 2007). During this period nationally, family health statistics have altered demand and increased need, for example; the birth rate has increased, survival rates for children with complex medical conditions has increased and the number of mothers with post-natal depression has also increased (DH 2013c) with corresponding demographic changes to the population specifically in areas of Kent and Medway. In the absence of a Public Health policy for children and young people (Audit Commission 2010) the preventative health care of children and their families has been compromised by fewer health visitor practitioners responsible for an increasingly vulnerable population.

2.5 The role of health visitor, their knowledge and workforce development

As part of the Call to Action a service delivery model framework laid out what parents can expect from the health visiting service (DH 2011), which was timely because this had become increasingly misunderstood by families and poorly explained to them by health visitor practitioners (Brook and Salmon 2015). Parents may not be alone in this confusion as during the period of Health Visitor professional decline the knowledge and skills required by health visitors in their role have been poorly maintained and at times undermined (Whittaker et al 2013). The role of the health visitor was in need of clarification for service users as well as for practitioners and their managers without negating the complexity involved and the underpinning aspect of safeguarding children.

Health visitors need to build relationships with the families they visit, to be able to undertake a social version of health assessment in partnership with them; through a

strengths based approach support the family in developing appropriate but also individually acceptable solutions. It is recognised the birth of a baby transforms families and is a time when parents are receptive to health promotion advice. As a universally offered service, health visitors take into account the different needs and dynamics of individuals and groups in society to support and advise on maternal and child health and wellbeing. Evidence based practice which is supportive through health promotion and behaviour change interventions can support fluctuating family needs in a range of public health identified areas.

Neuroscience research validates the importance of consistent and responsive care to all infants and children by their parents and /or carers recognising for optimum parenting this level of responsiveness is required by the infant and child at least 50% of the time (Howe 2011). The complex circumstances in which some parents raise their children, caused by the competing demands of poverty and disadvantage have been recognised in need of specific intervention which health visitors can provide through public health strategies to individuals and groups by addressing health inequalities and improving social inclusion (Marmot 2015). Strengths based support is known to build resilience in families and although poverty does not cause poor parenting (Field 2010) it is the stress involved which affects the ability to cope with the complex social circumstances. All of which leads children of poor parents having poor childhoods and failing in a range of social and health outcomes (Marmot 2010). It is perhaps this section of society where health visitors have historically been involved and can have positive impact but effectiveness has been limited due to poor organisation of the service (Cowley, Dowling and Caan 2009), inadequate leadership (Drea et al 2014) and inadequate professional coping mechanisms on which to draw such as compassionate resilience especially in challenging situations (De Zuleta 2014 quoted by iHV 2014). Brook and Salmon (2015) consider this to be due to poor levels of communication in relationship building with families and a product of professional decline.

As well as building relationships with families the role of the health visitor requires them to build effective working relationships with other professionals, for example, midwives, general practitioners, school nurses and social workers to achieve Public Health outcomes. This has been identified as effective because services are more efficient when they co-operate and collaborate and ultimately integrate for the benefit of the service users (Machin and Pearson 2013).

The Cumberlege Report (DHSS 1986) first recommended community nurses and health visitors role should include prescribing with the project steering group set up by the DH in 1989 concluding;

Suitably qualified Nurses working in the community should be able, in clearly defined circumstances to prescribe from a limited list of items and to adjust the timing and dosage of medicines within a set protocol

(Crown Report 1989 cited by DHSS)

Prescribing by health visitors can contribute to tackling health inequalities by utilising a range of nursing skills alongside a tool to support health promotion and access to healthcare and therefore distinguishing it from medical prescribing (Greaves 2014); not solely about prescription writing but making an holistic assessment followed by the prescribing of clinical advice and health promotion. Non-medical prescribing by health visitors has now been declared as an important practice resource across the six high impact areas, breastfeeding: (initiation and duration) transition to parenthood and the early weeks, managing minor illness and reducing accidents (reducing hospital attendance/admissions) and healthy weight, healthy nutrition (to include physical activity and maternal mental health (perinatal depression) (Greaves 2014, cited by Bishop and Gilroy 2015). However, for some time now health visitors in Kent Community Health Foundation Trust have ceased prescribing activity because an audit confirmed low activity due to the shortfall in prescriptions issued. While this picture is different in Medway access to prescribing training and modules has been restricted across Kent and Medway in reflecting a national picture for health visitors (Smith, Latter and Blenkisopp 2014).The subsequent role conflict has led to practitioners to seemingly be unable to fulfil their professional capacity and serve the community due to this poor organisational leadership (Bishop and Gilroy 2015).

Managing risk is a principle of health visiting practice which has in recent years been focussed towards the aforementioned reactivity and defensive practice involved in child protection and for which considerable resourcing will remain. However, in order to renew the purpose and moreover focus, as one of prevention, an analysis of skills and training of the workforce will be required by managers to enable delivery of the service model which has been developed in order that outcomes are met from the expanded workforce (Swift 2014). The health visitor practice teacher (PT) who leads practice learning for students has a role to play in the wider context of work based learning and professional leadership emphasising attributes of a positive culture or community for effective workplace learning as illustrated consistently in national policy and national and international work (Devlin et al 2014).Nevertheless, in Kent

and Medway despite the increased workforce, geographic distances combined with the demography present a challenging working environment to pursue workforce development. Possible approaches can be found in action research and action learning sets (Haydock and Evers 2014) and clinical academic hubs to standardise practice training & career development, audit & retention as well as improve service delivery (Hollingshead et al 2015). While the emergence of e-communities of practice can support workforce development without structured facilitation which is recommended to embed change the culture workforce will remain unchallenged limiting their effect (Manley et al 2011).

Individuals take part in e-COPs to secure knowledge, resolve problems, improve individual capability, absorb specialised knowledge and create innovations

(Sherry et al 2015)

2.6 Health visitor leadership: purpose and role

Health visitors are primarily registered nurses or midwives with additional training and registration with the NMC and while it is not within the remit of the review to debate the ideology of widening entry to the profession through non nursing paths as it has been suggested elsewhere, the public may not perceive health visitor as nurses. Chambers (2013) considers this omission to be endorsed by health visitors as well as managers. Nevertheless, the Chief Nursing Officers (CNO) 6 C's (Cummings & Bennett 2012) remain relevant to health visiting and underpin its purpose (Chambers 2013). Although increased health visitor numbers has raised expectations of the role, increasing numbers alone does not ensure there will be quality and improvement (Whittaker et al 2013). Central to leading in times of change is shared team attributes in challenging organisational influences of which this disconnection is an example (Drea et al 2014). As the literature for health visiting and leadership is slim and usually refers to leadership within 'community nursing' or 'nursing' it does not always translate as the landscape for leadership within health visiting as it has a different context because of the public health remit health visiting (Baldwin 2013).

At times of enormous change, commitment as the foundation for practice is a characteristic which defines purpose (Oshikanlu 2015), role and relationships which if absent (PHE, 2014a) will undermine the realisation of the implementation policy aims (DH 2011).

2.7 Health visitors and integration

Although for many observers the Call to Action (DH 2011) was a welcome development for the profession there are critics from within the profession and those in associated roles who are seemingly concerned about the level of investment at a time of national austerity and competing demands in the NHS. It is also possible that prioritising concern for children is not universally welcomed (Marmot 2015) nor is there sufficient concern about the specific needs of diverse populations in which complex health and social care issues exist and corresponding rights of access to care.

However, the public health outcomes will not be achieved by isolated health visitors but with greater integration within a multi-disciplinary framework. Cowley et al (2013) identified an improved collaborative culture can lead to greater partnership in the community. By realigning health visitors away from Primary Care and 'back to their roots' in the Local Authority confirms the end of the health visitor 'resource' attached to a general practice with opportunities for wider partnership working. At times, and

revealed anecdotally, this change has affected collaboration needed for effective family centred care as the limited numbers of health visitors have struggled to maintain and even straddle the demands of liaison with GPs leading to an apparent invisibility. This reorganisation away from GP 'attached' caseloads and towards a public health function aligned with Children's Centres seems to be widely misunderstood by GPs (RCGP 2010, cited by Canterbury and Coastal Clinical Commissioning Group Health Needs Assessment September 2012) and even health visitor practitioners further fragmenting family services. Nevertheless, it does seem the decline in health visiting numbers and the consequent decline in service offered has led to an increased workload for General Practitioners and their staff, as well as other after-hours services as patients

Other health professionals with whom health visitors work with through referral a system, Speech and Language Therapists for example, may also be concerned about the consequences of higher referral rates with the expanded workforce uncovering more child development anomalies (Communication Trust 2012). Social Workers and their management on the other hand have been heard to be concerned with freeing up their services by raising referral 'thresholds' to influence health visitors to 'hold' more intense cases of child protection as there will be more practitioners but a corresponding national crises in social work (LGA 2014).

However, criticism from within the profession maybe detrimental as memories linger on the strengths of the past 'golden age' of health visiting against a clouded veil of unknown effectiveness (Cowley et al 2013). By challenging relationships between existing practitioners and the new health visiting workforce the strengths of both parties needs to be realised as the experience and expertise of current practitioners will be essential to the support and professional development of those more recently qualified practitioners. Health visitors, after all have remained loyal to their profession but not always to the employing organisation (Whittaker et al 2013). The increased health visitor numbers, if realised, will make up the new but inexperienced workforce potentially compromising interprofessional working as there continues to be misunderstandings of role and responsibilities which after all is the core requirement for effective integrative working practices (Machin and Pearson 2013).

2.8 Health visitors autonomy, innovation and culture

Autonomy has been considered as an attribute of health visiting and associated with flexibility in a range of situations including the implementation of care and professional relationships (Whittaker et al 2013, DH 2013). Service providers have

been encouraged to enable autonomous practice by health visitors (DH 2013) as part of the transformational aspect of the Call to Action. The nature of autonomous practice, has been suggested as a cultural entity (Francis 2013) and to this end it requires a review of personal and professional values including clarification of the term 'autonomy' for a transformed service. However, a whole systems approach to autonomous practice through integration and interdependence requires a shared philosophy within and between teams, as well as professional groups for autonomy and innovation to flourish, and has been referred to as 'active human management' (Cowley et al, 2013).

'The culture of provider organisations will need to support professional autonomy, innovations and change to enable transformation to take place' (DH, 2013:17)

By building relationships health visitors are enabled to connect with parents and ultimately enable decisions by the family as to the level of take up of the service. For the health visitor this will mean active interaction to motivate and enable parental behaviour (Barlow and Coe 2013). However, for health visitors to be purposeful in their role the organisation needs to reflect similar qualities as those expected of their practitioners with this impact of the management culture far reaching, in its affect on how the service is delivered. Examples given refer to health visitors mirroring the controlling management practices they experience in their interactions with clients (Cowley et al 2013) Moreover, Bidmead (2013) identifies the importance of interpersonal communication skills and attitudes required to build relationships by health visitors with their clients but equally important to be shown by managers towards practitioners. When all this is explored provider and employing organisations will require greater synchrony to enable a culture within the future workforce to develop and deliver innovation (Swift 2014).

2.9. What do health visitors do?

Health visitors work in the community undertaking planned activities with individuals, families and groups basing their practice on the NMC Domains of their profession

Search for health needs

Stimulation of awareness of health needs

Influence on policies affecting health

Facilitation of health-enhancing activities (NMC 2004)

However, these descriptors do not easily explain what it is health visitors do and how they do it. Having considered the purpose and role of health visitors it is intended in

this part of the review to explore the practice of health visiting: *what it is health visitors do* as this is important if health visitors are to share and grow their expertise in their practice. Donetto et al (2013) have identified key areas of practice which service users have considered to be central to the purpose of and role of the health visitor; *relationships, support, information, co-ordination and service user involvement* (Donetto et al 2013). Based on effective support to families this section will adapt the order of the themes to explore health visiting activity as it effects the client's journey as laid out in Figure 1 (Cowley et al 2013) but also indicates how this can be a complex activity and integrated with the CNO's 4,5,6 model (Bennett 2015) (Appendix 5).

2.9.1 Health visitor relationships with clients

The relationship between health visitor and client is central to accessing the service and hence should be considered the primary objective of health visiting practice (Bidmead 2013, Seal 2013). Health visiting practice has been described recently in the context of valuing individuality, the uniqueness of personal situations, and health as a personal strength while not specifically referred to as a *person centred approach* it is indicative health visitors apply this to their practice. Cowley et al (2013) refer to this as *the orientation to practice* and based on three distinct concepts:

1. 'The practice of **human ecology** or understanding of the person in their situation which stems from the health visitor assessment of need as a continuous process which places importance on the individual and personal situational circumstance
2. Through the positive regard for others or **human valuing**, by keeping the 'person in mind' the health visitor practice focus is one of alignment with client need enabling health visitor practitioners to recognise the potential for unmet need.
3. All of which when combined with a **health creating** or **salutogenic** approach which is proactive and health creating, by building personal strengths and resources in the pursuit of solutions

(Cowley et al 2013:12)

This orientation to practice is used by the health visitor with 'executive' communication skills in a '**triad of activities**'; the health visitor develops, **the health visitor client relationship; undertakes health visitor home visiting** and pursues **health visitor needs assessment** (Cowley et al 2013). It is within this context health visitor orientation to practice is activated but without specifically acknowledging the dynamic and cultural health and social circumstances which practitioners would infer is the reality of practice with consequences for limited resources.

As the lead community practitioner involved in the delivery of Child Health Services, health visitors have long understood the effect of the home environment, relationships and early experiences on the development of children (Cowley 2013) and moreover that they are experts in child development as part of this process (Bryars et al 2015). But what is often difficult to explain is what it is health visitors do; and most importantly how it impacts on service users inviting a range of challenging questions about their effectiveness and their contribution compared with others in the skill-mix team for example. It has been suggested this difficulty in explaining health visitors contribution and impact is due to the lack of visibility and scrutiny by undertaking practice in, home, community or neighbourhood setting (Robinson in Luker and Orr 2012). However, in this private domain health visitors are undertaking a very public activity on behalf of stakeholders, commissioners and the government so it is essential to be able to fully understand and explain what it is health visitors do and demonstrate their impact. The recent change of commissioning services (Local Government Association (LGA) 2015) has described this succinctly as part of the health visitor role in leading delivery of the HCP. To:

- identify and treat problems early
- help parents to care well for their children
- change behaviours which contribute to ill health
- protect against preventable diseases.

A starting point for analysis is the recent declaration of the *orientation to practice*, as a way of understanding how health visitors interact in communities to achieve this followed by the triad of (health visitor) activities (Cowley et al 2013) which clarifies how they initiate contact and more importantly maintain it with individuals and families based on the identification of need.

Home visiting however, has a specific remit in the context of health visiting because it heralds an introduction of health visitor to a family, undertaken at the home, proactively by appointment and mainly without the (prospective) parent's request. by way of active listening, facilitation, empathy and the notion of valuing other humans, the health visitor is able to assess the needs of the family and for the family to feel this is a reciprocated experience (Seal 2013). This introduction is the foundation of the uptake of advice and support during the child's early years. It is based on the acceptability of the health visitor to the family as a person and not just the advice dispensed. Communication sustains relationships in their practice (Bidmead 2013),

".. every utterance is an action produced for a purpose..." (Robinson in Ed Luker et al 2012:13)

2.9.2 Health visitors supporting individuals and communities

Health visitors are trained to develop expertise about the neighbourhood or community in which they work, facilitating a universally offered service to families with preschool children. To enable adequate and appropriate support health visitors undertake a systematic assessment of need, which is a core public health skill. From this activity a level of care provision is anticipated and then facilitated by the health visitor in partnership with the and tailored to their identified need and available community resources. Terms such as *building the community capacity* and 'strength' based (salutogenesis) have entered into the language of health visiting more recently, as ultimately health visitors aim to understand the level of resilience in families and communities. The resilience of parents and carers enables secure attachment of children and is understood to sustain families in the pursuit of optimal child rearing and are the basis of health visiting support (Moullin, Waldfogel and Washbrook 2014). Despite this it has been recognised for example, that health visitors are not proficient in the identification of secure attachment (Appleton et al 2012)

The identification of need enables the health visitor to prioritise support proportionately (Marmot 2010) and then identify families with complex or additional needs requiring greater support and input from a range of services. At times this support may not be at the request of the parents or carers and which, here in, lies unease as to the underlying purpose of the health visitor. In essence the health visitor is pursuing a role of early intervention, (early in the infant's life and early in the identification of problems) and prevention by addressing health inequalities which can impact on the outcomes for children and require specific support to parents (DH 2013d).

Against a backdrop of a traditional approach to family life the orientation to practice has long focussed on 'mothers' (Cowley et al 2013), with only recently a greater emphasis being placed on engaging fathers. Fathers are now acknowledged as having specific qualities which impact on children's well-being and development and attending to fathers has become an area for health visitor professional improvement in their contact with families (Donetto et al 2013).

Health visitors identify need but also manage risk and vulnerability balancing this alongside 'threshold guidance' of referrals to Social Services when parents are unable to provide children with optimal care (LGA 2015). Aspects of the Call to Action programme and service delivery model make explicit what health visitors do that clearly links to a safeguarding and protective role (DH 2015). However, because of their universal role, health visitors will be at the forefront of identifying and assessing

need when the care a child is receiving suggests 'significant harm' (HM Gov 2015). The health visitor 'support' will include statutory requirements to address those needs to improve the child's outcomes to make them safe, (HM Gov 2015) and thereby in effect, protect them.

Health Visitors play a key role in child protection, particularly for very young children who are unable to raise the alarm when suffering from abuse or neglect... In this context, the role of Health Visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives.

(Lord Laming, 2009, s 5.21, 57–58).

At times it has been suggested parents are loathed to reveal some of their personal circumstances because of fear about the health visitors' role in child protection for example, in the identification of Post-natal depression (PND) (Centre for Maternal and Child Enquiries (CEMACE) 2011) or where a child is disabled. Despite this concern addressing PND is part of the support health visitors can offer and moreover the evidence demonstrates how health visitors can be effective (Cowley et al 2013) while children with disabilities are known to experience a range of disadvantages by way of health and social inequalities.

Non the less both these areas require support and supervision of the highest quality to clients and for the health visitor (Drea et al 2014); to regulate and reflect on practice and restore the practitioners and enabling greater understanding of the challenges the clients faced (Jarrett and Barlow 2014). In the absence of routine preventative health visiting practice the burden of child protection has become disproportionate especially in areas of poverty and deprivation compromised by an increasing diverse population, of which Kent and Medway is an example. Most recently health visitors and student health visitors have been scrutinised in two Serious Case Reviews undertaken after the unexpected death of two children (Fox 2014, Tudor 2014) indicating the need for a revised approach to student preparation (Haydock and Evers 2014) and even a national curriculum to meet the needs of students and the service (Hollingshead and Stirling 2015). Health visitors in their assessment of need must be alert to the toxic combination of substances, interpersonal violence as well as adult mental health issues (DH no date). Along with a range of social issues this toxicity can impact not only on optimal parenting but also safe parenting. The complexity of these situations means health visitor must actively participate in clinical supervision as well as case management.

2.9.3 Health visitors and information

Underpinning advice offered to parents by the health visitor is the assessment of parenting (human ecology) and fine tuning advice which is appropriate to the situation, individualised and moreover evidence based. Health visitors use observation skills to understand the attuned relationship between the parent (usually the mother) and infant enabling the formation of a secure attachment (Bowlby 1960 cited Moullin, Waldfogel and Washbrook 2014) and which will ultimately define the Public Health outcomes (NHSE & PHE 2014). Health, across the lifespan combined with the impact neuroscience research lies behind the restoration of universal family support by health visitors, and supporting parents with information to ‘... give(ing) children the best start in life’ (Marmot 2010), however, the maintenance of and skills development in this area is known to be poor (Appleton et al 2012) despite their supposed expertise (Bryars et al 2015).

As a universal service and as a minimum requirement all families with children under 1 year old should know and moreover be familiar with the health visitor who is responsible for the family (NHSE 2014). Parental concerns expressed in caring for their infant or child include feeding and nutrition, growth and development, behaviour including crying, sleep and toilet training, childcare issues such as skin rashes, teething, and ultimately minor ailments all information of which is available from a variety of sources. However, in advising parents, health visitor information needs to be understood within the contemporary and prevailing culture of the family and community (human ecology). The health and well-being of parents is vital to the care and survival of the infant with the outcomes for infant well-being being dependent on physical and mental health of the mother in particular. Within this context information and advice may be offered through non-medical prescribing and in areas of population diversity this tool can be effective in a range of PH outcomes and moreover present a ‘tool’ or framework for offering information (Greaves 2014).

2.9.4 Service user involvement in health visiting

Health visiting practice relies on effective partnership with parents to enable support and information to be tailored to the needs of the family (human ecology). Families have highlighted health visitors can be sensitive to difficult situations (human valuing), they feel listened to as well as the building of trust and reciprocity to enable a relationship and the involvement in their care (Bidmead 2013, Seal 2013). However, organisation changes seem to affect service users more than expected or even realised, highlighted in the way health visitors are able to maintain contact with families despite poor autonomy in their caseload management and inadequate resources to access clients especially when English is not the first language. The

reduction in health visiting contact through home visiting has been highlighted by service users to interfere with their access to the service (Donetto et al 2013).

2.9.5 Co-ordination in health visiting

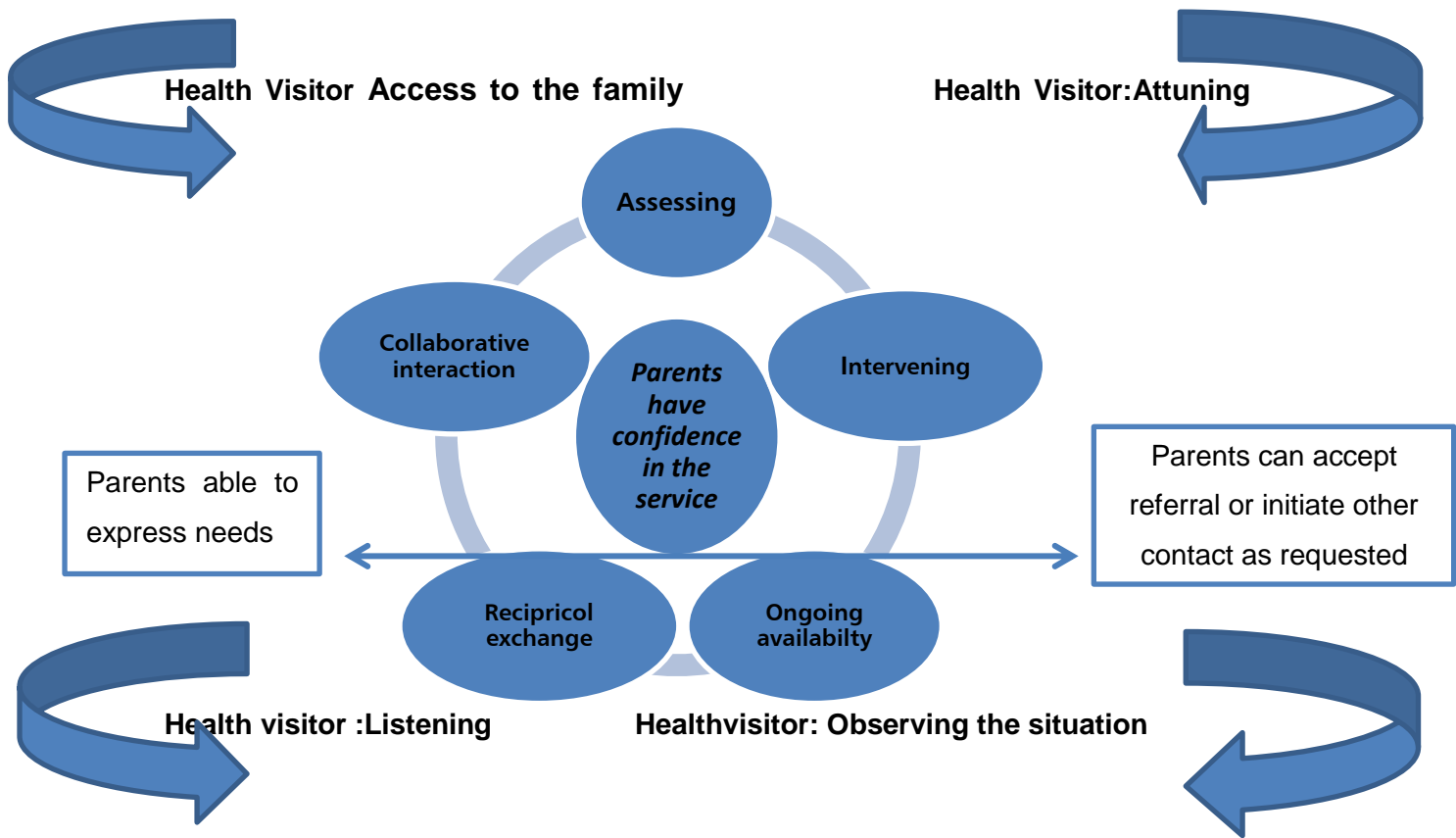
The expertise of the health visitor in this time of decline has been increasingly prioritised towards those families with complex levels of high need (Whitaker et al 2013) necessitating not only co-ordination of and between a range of health and social care services but also within the 'skill mix team'.

Recommended (Donetto et al 2013), and supported by the DH (2013) is greater integration between health visitors and midwives. This co-ordination has clear benefits to professional working as well as enabling a more seamless approach to care for parents and families. Now specified in the service specification (NHSE 2014) the introduction of health visitor in the ante-natal period signally the level of service transformation expected (Donetto et al 2013) but will require adequate communication and active co-ordination between professional groups.

Health visitor activity has been identified to positively impact specifically with breast feeding and the identification and treatment of post-natal depression (Cowley et al 2013). While routinely stimulating awareness of other relevant public health topics routinely such as immunisation, sudden infant death and a range of contemporary topics which when adequately co-ordinated this can directly relate to public health indicators (Appendix 4) (NHSE& PHE 2014).

By enquiring into the activity of health visiting three important models have been uncovered that drive practice but also explain a service often hidden in domestic privacy but now becoming open to scrutiny because of the emphasis placed on the profession to demonstrate a range of outcomes and effectiveness which has hitherto been elusive. The client service journey (Figure 1) lays out the interaction between service user and health visitor and utilises the aforementioned models to explain this journey. Ultimately health visitors will be required to develop and maintain strong interprofessional connections & integrated service delivery ensure optimum achievement of the PH objectives (DH 2013).

Figure 1 The Health Visitor - Client service journey (Adapted from Cowley et al 2013)



2.10 What are the outcomes and effectiveness for health visiting practice?

While it is possible to describe the activities of health visiting using the framework of the '*orientation to practice*' and '*the triad of activities*' without a body of evidence on what sets health visiting practice apart and moreover how it impacts on effectiveness remains elusive despite the recent investment and professional regeneration. Without clear outcome measurements the service remains vulnerable to financial accountability as it becomes part of local authority commissioning.

There is currently enormous investment in the health visiting service, with increased numbers of practitioners being trained and employed in Kent and Medway to enable the profession to lead on the delivery of the Healthy Child Programme (DH 2009). Seemingly, this represents a 'leap of faith' by the previous government; as a political imperative it is expected to improve a range of health and social outcomes, in the knowledge of the negligible effectiveness and outcomes for health visiting (Cowley et al 2013). Further to this there are only modest results from studies which directly evaluate delivery of interventions by health visitors in comparison to delivery by other professionals. Health visitors are effective in several important family health areas, namely, breastfeeding, domestic abuse, child behaviour and postnatal depression. Nevertheless, the evidence suggests this is mainly in programmes as well as specific extra training which provides practitioners with renewed capacity as well as support and supervision (Cowley et al 2013). While the 'generic' work of the health visitor which has yet to have its effectiveness evaluated and points to a re-evaluation by practitioners as to their contribution and response to the transformation agenda (DH 2013). It also denotes the opportunity to question; *who within the health visiting team should deliver this area of care?*

Against the publication of recent documents from Health Education England the contribution of health visitors to meet specific Public Health outcomes has been laid out (PHE 2014). This effectively heralds the way in which information and data on specific interventions will be collected by organisations employing health visitors and judged against a range of health outcomes by commissioners (Appendix 4). However, the effectiveness of these outcomes maybe better judged by examining the quality of integration with other services as they are shared objectives health visiting will not achieve alone (Machin and Pearson 2014).

Unlike the Family Nurse Partnership (Olds et al 2004) and the MECOSH project (Kemp et al 2012), health visiting has only been shown to be effective in supplementary

areas of practice. Invariably the literature and policy documents refer to health visitors as being 'well' 'suitably' or even 'ideally' placed to contribute, but because there is no clear evidence that what health visitors do makes a difference in terms of effectiveness this appeal lacks objectivity. The plethora of publications on the importance of early intervention in childhood highlighted in this report have driven the DH agenda with a determination that health visitors will deliver the bulk of the Public Health Outcomes Framework and in so doing demonstrate the impact of the service and moreover their practice by ensuring cost savings later in a child's life (DH 2013).

Organisation and management of health visiting services have been charged with steering unprecedented professional change and transformation of practitioners and the service they offer. The impact of this to service delivery cannot be underestimated and has been clearly stated as requiring emotionally competent and resilient practitioners and managers (PHE&NHSE 2014) but moreover leaders. However, when the management culture reflects those values which health visitor need to work in the front line the outcomes are improved (Cowley et al 2013). Similarly, health visitors can be shown to be effective when the organisation of the service took account of parental needs by adapting and enabling ease of access (Donetto et al 2013). In this way families can have better experiences of the health visitor services through improved quality of relationships which have a cascading effect through the organisation to the front line of delivery of care.

The literature demonstrates the purpose and role of the health visitor and how this operates to enhance services by their involvement in the delivery of specialised programmes related to key areas of the Healthy Child Programme (DH2009). However, Cowley et al (2013) highlight the variations in their mode of delivery and type of support associated with these programmes as not easily transferable across the generic health visiting workforce. This aspect of reviewing the effectiveness and outcomes of Health Visitor is disappointing and indicates the importance of research which is specific in its intentions and methods to allow examination of *health visitor* factors and effectiveness. This seems poignant at a time of unprecedented professional regeneration and on which there has been placed so much hope.

Experienced and senior health visitor practitioners who are developed to become Practice Teachers can demonstrate effectiveness in the extension of their education role. By developing team and 'hub' learning in the workplace the Practice Teachers can enable a wider reach of evidence based practice beyond the apprenticeship model of 1:1 student learning (Hollingshead and Stirling 2014).

In conclusion, this literature review has sought to appraise a range of contemporary literature on health visiting and answer specific questions linked to the project funded by Health Education England Kent, Surrey and Sussex, *Implementation and Evaluation of the Communities of Practice Kent and Medway (Health Visiting)*. While it may seem of concern to practitioners about the slim evidence of the effectiveness and outcomes for health visiting it is timely to now consider this within the frameworks published and the opportunities invested in this project.

3. Project Aim and Objectives

3.1 Aim

The aim of the project was to implement and evaluate a Community of Practice by supporting a health visitor from each locality across Kent and Medway to:

- develop their skills in practice development and clinical leadership;
- create effective learning cultures within which students and practitioners can flourish; and
- explore how the effectiveness of health visiting can be demonstrated.

3.2 Objectives

1. To develop 20 Senior health visitor practitioners (based on the 15 localities for Kent and Medway health visiting services but allowing for parity) via two active and action learning sets to take forward the Communities of Practice concept and embed this in their localities.
2. To enable these senior health visitor practitioners to grow the expertise necessary to facilitate innovation in practice and practice enquiry for the benefit of improving patient care, public health outcomes for children and families and learning placements.
3. To create effective learning cultures within which students and practitioners can flourish.
4. To mobilise the health visitor workforce through practice development and clinical leadership approaches for the purpose of reducing health visitor student and newly qualified health visitor attrition creating a sustainable workplace culture.

5. To simultaneously develop and evaluate individual and collective health visitor practice through an action related practice development project, therefore making a contribution to the body of knowledge in relation to health visiting practice and community settings nationally.
6. To implement and evaluate a series of Master classes for the wider health visitor practitioner workforce in response to identified health visitor workforce learning and development needs.

3.3. Methodology and methods

The Community of Practice in Kent and Medway aimed to develop health visitors as clinical leaders to embed person-centred and evidence based approaches in everyday practice for the benefit of children and their families. Two interrelated methodologies, action research and practice development were selected because they both focus on practical action in the workplace that is systematically implemented and evaluated through collaborative, inclusive and participative approaches.

Practice development is an internationally recognised and sustainable approach to improving service user experiences of care by:

- Transforming care and services to be person-centred, safe and effective
- Creating good places to work and learn
- Ensuring that the best evidence and research informs everyday practice
- Embedding new, more effective and person-centred ways of working within teams and workplaces (Manley et al, 2011).

Action research is change orientated but focussed on those practical problems experienced by practitioners (Lewin 1947). It aims to simultaneously develop practitioners; develop practice and also develop or refine existing theory and fulfils three criteria; 1) it focuses on deliberate strategic intent – in this case to implement, embed and evaluate the delivery of person centred and effective care through establishing communities of practice; 2) spirals of planning, implementation, reflection and action which will take place within the active and action learning sets; and 3) widening participation as others are touched by the research – this guides how co-researchers will work with stakeholders in their localities (Titchen & Manley 2006).

Three overarching processes (methods) were used to support the Health Visitor clinical leaders included:

- active learning (Dewing 2008),
- action learning (McGill & Beaty 2001), and
- critical companionship- a helping relationship that focuses on helping a practitioner to learn (Titchen 2000).

Two facilitators (one leading the research and facilitation and the other providing health visiting expertise and research support) worked collaboratively with two cohorts of participating health visitors who undertook the role of co-researchers. Active learning (Dewing 2008) and action learning sets with 14 co-researchers over 12 months have focused on developing their expertise in clinical leadership and practice development. In turn, it was envisaged that the co-researchers would work with their respective teams and stakeholders across their localities to develop and sustain communities of practice.

A critical companion was also to be identified for each participant to help co-researchers with their work on an individual basis. Critical companions in turn were to be supported through regular telephone conferences.

The notes generated from each session documented on-going claims, concerns and issues (Guba & Lincoln, 1989), daily evaluations and reflections as well as other outputs arising from the active learning workshops e.g. tools for using emotional touchpoints with Health visiting clients. In the spirit of being co researchers, Health Visitors were involved in the co-creation of the focus and direction of the project through using these methods and tools, negotiation and ongoing process evaluation around the focus of the sessions; and the analysis of data at various stages .e.g. verifying the analysis of evaluation data presented in the session notes; synthesising insights from the action cycles focusing on learning through use of tools in the workplace.

The final analysis was completed by the research facilitators, but the credibility and trust worthiness of the findings were verified at each stage through agreeing the content of the notes and ongoing analysis, involving the co-researchers in generating the research themes and by enabling co-researchers to comment on the draft report.

A Steering group of key stakeholders (see acknowledgements) was established to support the action related practice development project and provide a range of perspectives to challenge and support the project team with achievement of the project's aims.

3.3.1. Project ethical approval

Permission to undertake the study was agreed through the university Ethics Committee. (Appendix 6)

3.4. The project co-researchers and co-researchers

Within the lifetime of the project 18 co-researchers were recruited to the action learning sets, less than the 20 proposed in the initial plan. Recruitment of co-researchers was undertaken in partnership with service managers. It was important the co-researchers were willing to attend and moreover that they chose to attend. A flyer was circulated electronically to both provider organisations for cascading and general distribution to health visiting practitioners in July/August 2013 (Appendix 7) with the intention of recruiting the maximum numbers of 20 Health Visitors in 2 action learning sets. Initially it was planned to run 2 sets concurrently each month for 12 months but the challenge of identifying sufficient numbers for the first group meant only one set started in October 2013. Representation from all localities was planned but this was not possible given the challenge of recruitment.

Flyers were recirculated after October 2013 to recruit the second group, delaying the start date until January 2014 to allow time to establish the first action learning group. However, recruitment to the second set remained slow and despite reminders and re circulation to managers on a number of occasions this did not change the level of interest or applications received. Eventually the start date was delayed further to March 2014 when it was decided to go ahead with a smaller number of co-researchers (7) (see Table 2).

All applications were discussed with a health visitor manager to ensure the criteria were met using the form in Appendix 8. Four expressions of interest were received that did not proceed to submitting of a full application.

Nevertheless, attrition from both action learning sets was significant and although reasons were given it was in the second set where this was more marked not only attrition but also attendance was erratic ending with only 2 consistent attenders. Co – researchers informed us by email when they were not attending and mostly when they would no longer be attending the action learning groups, although this was by

no means consistent and reasons were not always offered. This was a limitation to the project linked to the context in which the project took place (See section 5)

Table 2: Attendance and attrition from Action Learning Set 1 and 2 with employing organisation

Action learning set 1	Action learning set 2
9 Health Visitor Co-Researchers	9 Health Visitor Co-Researchers
<i>Comprising:</i>	
3: Medway Community Healthcare	All from Kent Community Health Foundation Trusts
6: Kent Community Health Foundation Trust	
Attrition: 2 Kent Community Health Foundation Trust	Attrition: 5 Kent Community Health Foundation Trust +2 erratic attendance

During the project a number of co-researchers applied for promotion in a variety of roles in the health visitor service and Table 3 shows the range of professional development outcomes for the groups. Of the six (6) co-researchers working at Grade 6 health visitors who completed the CoP project all but 1 applied for a Band 7 role and was successful. The one participant who was not successful believed this was the correct decision for her and talked about the strengths of her work at the 'front line'.

'That I have become a bit static in terms of development professionally but love being a Health Visitor'
Co researcher Action learning set 1 Evaluation July 2014

The promotion of the co-researchers was restricted to action learning set 1 and although there were changes to jobs in the second action learning set there were no promotions in banding.

Table 3: Indicates the professional development outcomes of the groups

Action Learning set 1	Band at the beginning of the project	Current banding/Situation(shaded = increase in banding during project)
Health Visitor 1	6	7 (secondment opportunity for 8 months outside health visiting)
Health Visitor 2	7 PH Specialist Health Visitor	7 unchanged
Health Visitor 3	7	7(Acting up in absence of lead HEALTH VISITOR)
Health Visitor 4	6	6 interested in doing Practice Teacher course
Health Visitor 5	6	7 Newly appointed to Infant Feeding co-ordinator
Health Visitor 6	6	6 unchanged
Health Visitor7	7	7 achieved Fellow of Institute of Health Visiting
Health visitor 8	6	7 Newly appointed Infant feeding co-ordinator
Action Learning set 2	Band at the beginning of the project	Current banding/situation
Health Visitor 1	7 previous Clinical Development lead	7 Team co-ordinator (withdrew)
Health Visitor 2	7 previous Clinical Development lead	7 Team co-ordinator(withdrew)
Health Visitor 3	7 previous Clinical Development lead	7 Team co-ordinator
Health Visitor 4	7 Practice Teacher	7 PT
Health Visitor 5	8 Locality Clinical Co-ordinator	8 Locality Clinical Co-ordinator
Health Visitor 6	6	6 (withdrew)

Health Visitor 7	7 PT	7 (withdrew)
Health Visitor 8	7 Team co-ordinator	7 Team co-ordinator
Health Visitor 9	6	6 (withdrew)

4. Findings

The findings are presented by:

- providing an overview of the focus of the sessions and the activities which co-researchers chose to address in the Community of Practice influenced by what was important to them in relation to their practice as health visitors;
- the seven journeys, their starting points and end points, experienced by co-researchers. These capture the main research findings and CoP outcomes
- the contextual challenges impacting on the development of the Community of Practice

4.1 The focus of the sessions – co-creating the journey an overview

Twelve (12) Sessions were provided for cohort 1 from 9.30-12.30, which were then extended to 9-13.30 at their request. Eleven (11) sessions were provided for cohort 2 from 9-1, following a request for a shorter time span changed to 9-12.30. Both groups were brought together for three (3) sessions after the first cohort had completed their sets (Appendix 9).

Using Participatory action research it was important that co-researchers were collaborators in implementing the CoP across action spirals. As co-researchers they influenced the content of sessions through the tools used with a focus on what was important to them. Verifying notes and participating in analysis was therefore an important part of the CoP contributing to the data emerging. This experience also enabled a focus on foundation research and evaluation skills to develop.

Following the identification of hopes, fears and expectations for the project – (See Table 4), early sessions focused on active learning during the first half of the session and action learning in the second part.

Table 4: Hopes fears and expectations – key themes arising from cohort 1 and cohort 2 Session 1

HOPES	FEARS	EXPECTATIONS
<ul style="list-style-type: none"> • Learn, support & challenge through vision and leadership • Share passion, clarity or role and develop practice for clients • Achieve local, regional & national influence and impact • Encouragement for a way forward • Improve student learning • Sustainability of project 	<ul style="list-style-type: none"> • Time, commitment & workload, work-life balance/stress will negatively impact on potential of programme • Fails to make a difference • Different expectations, people don't turn up • Combining work & study 	<ul style="list-style-type: none"> • Develop skills, knowledge & improve practice • Learn to challenge & support, share, develop & network • Professional regeneration & job satisfaction • Measure service outcomes • Good leadership

Active learning (Dewing 2008) encompassed interactive activities that involved:

- developing a shared understanding and purpose of health visiting,
- assessing where they were in terms of their confidence and skills and identifying critical companions to support them on a 1:1 basis
- developing an understanding about how others perceive them using qualitative 360 degree feedback
- using, practising and applying tools for developing and improving practice, e.g. emotional touchpoints (Bate & Robert, 2007); values clarification (Warfield & Manley 1990); Claims, concerns and issues (Guba & Lincoln 1989)
- exploring collective points of interest that were generated from using the Claims, Concerns and Issues Exercise (Guba & Lincoln 1989) about their own practice and the Community of Practice (CoP).

Action learning (McGill and Beaty 2001) was the focus of the second half of each session and included exploring key questions important to co-researchers as well as developing the skills required to support other staff to be effective in their health visiting practice. In addition, these sessions provided an opportunity to use co-researchers' own practice as a test bed for theorising from practice by identifying

strategies that work or don't work when addressing issues identified. Theorising involved using a framework termed 'action hypothesis' (Manley et al 2013) which helped to clarify the triggers, and strategies that work and the outcomes desired.

Key outputs included a shared vision, purpose and unique selling point (USP) (Box 4 in the research journey) and also a shared purpose framework for identifying enablers, attributes and consequences of effective health visiting (Appendix 10). This framework in turn was used to support the:

- pilot of an adapted Cassandra Matrix for capturing workforce patterns and profiles for different types of health visitors (Appendix 11).
- development of stories that illustrate the actions and impact of health visiting – these are being integrated into an interactive webpage
- development of evaluation frameworks for different aspects of health visiting, but also the adaption of emotional touchpoints to service users, health visitor students and staff
- integration of learning within the 4-5,6 model (Bennett 2015) which honed co-researchers' political skills
- dissemination of learning through celebratory masterclasses, the development of two videos and an interactive webpage

At the beginning of the project, self-assessment of confidence in relation to: describing what they do; articulating the impact of their role and working collaboratively identified a spectrum of responses (See Table 5).

Table 5: Confidence at the beginning of the project in relation to describing what health visitors do, articulating the impact of their role and working collaboratively

Describing what they do:

'I find it difficult to put into a statement what we do as health visitors'' (co-researcher 1, response to pre project cognitive mapping)

'I understand both the clinical role of the health visitor and their responsibilities in relation to trust/national standards (co-researcher 2 response to pre project cognitive mapping)

Articulating the impact of their role on public health outcomes:

'No I don't! I feel our public health role has been eroded over time due to staff shortages and currently this only happens on a 1:1 basis with individual families.' (co-researcher 3 response to pre project cognitive mapping)

'Health Visitors contribute to public health outcomes but this is often limited by data collection' (individual 4 response to pre project cognitive mapping)

Working collaboratively with a range of other professionals:

'I feel as a health visitor we have such a depth of knowledge regarding the work other agencies and being able to sign post appropriately.' (co-researcher 3 response to pre project cognitive mapping)

'Where able. Difficulties with communication are a problem. Massive organisational changes prevent this at times for ourselves and our partners.' (co-researcher 1 response to pre project cognitive mapping)

In relation confidence was low except in relation to working collaboratively which was generally positive, and only slightly tainted by the experience and impact of massive organisational change. From this starting position, the improvements in confidence experienced throughout the project are demonstrated in the research journeys illustrated in the next section.


4.2 Implementing and evaluating the community of practice: seven different journeys

Seven different parallel journeys were experienced by co-researchers as they worked collaboratively with the facilitators in taking forward the concept of the Community of Practice, these are summarised as:

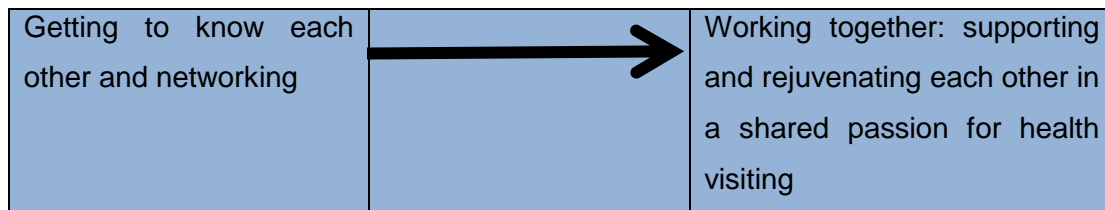
- Learning to support and rejuvenate each other in a shared passion for health visiting
- Developing health visiting practice together towards collaborative action and sustaining the CoP
- Becoming more confident and empowered through learning about self
- Developing clarity of role and evaluating its contribution to future health care and becoming more political
- Learning to use tools that can be used with others to develop and lead practice
- Becoming more reflective enablers of others
- Developing theory from practice

Each journey is characterised by a start point and an end point and these are summarised in Table 6. Each will be described drawing on data from the project. In addition the order of the starting points for each journey is reflected by a vertical arrow.

Table 6: Seven parallel journeys emerged from project data to describe the experiences of the co-researchers

	Starting Point		End Point
	Getting to know each other and networking	→	Working together: supporting and rejuvenating each other in a shared passion for health visiting
	What is a Community of Practice (CoP)?	→	Developing Health Visitor Practice together – sustaining the CoP
	Learning about self	→	Becoming more confident and empowered
	Clarifying, analysing, questioning, valuing role and practice	→	Clarity about role and evaluating its contribution to future health care - more political
	Learning to use tools as a participant	→	Using tools with others/teams
	Developing reflection and enabling skills together	→	Becoming more reflective, enabling others to reflect, challenge and support, recognise the importance of feedback
	Developing theoretical Insights to practice	→	Theorising from own practice

4.2.1. Learning to support and rejuvenate each other in a shared passion for health visiting



Co-researchers were from different localities and didn't originally know each other. However being in the same place and connecting with the group provided sources of support from like-minded people through the recognition that they had similar goals and shared a common purpose.

'Supportive group enabling development of individuals and profession' Cohort 1 session 2

'Group work for a common understanding about health visiting' Cohort 2 session 2

For some this was difficult in the context of work challenges:

'Must learn to enjoy session and not think about outside worlds' Cohort 2 session 2

The focus in early sessions were around developing a shared understanding about health visiting that led to a feeling of cohesiveness in the group through sharing experiences and reconnecting each time.

'The feelings of cohesiveness in the group.'

'Hearing from others and their experiences'

Cohort 1 session 4

Co-researchers enjoyed working together and catching up with each other as well as reigniting their passion for health visiting rejuvenating a shared vision as well as knowing they were not alone - particularly evidenced in cohort one. This was also expressed by cohort 2 in early sessions, although less regular attendance was remarked on in later sessions and a sense of loss experienced by those attending about those who did not:

'Working in a small group all on one table, sharing and feeling safe and supported with mutual understanding' Cohort 2 Session 3

'Thinking and sharing together as a cohesive group'

Cohort 2 Session 5

'I enjoyed working as part of the large group and missed other members'

Cohort 2 session 6

Team support and reconnecting with each other acted as an inspiration to focus on sharing ideas and motivating individuals, in the context of the demands of the workplace as well as the recognition that maintaining enthusiasm and motivation in others was also a responsibility.

'Like-minded people sharing ideas, inspiring each other' Cohort 1 session 10

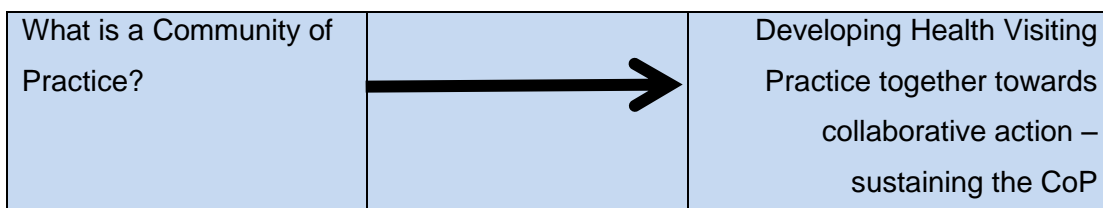
'I attend this group and feel clear and motivated to put into practice, but often struggle (again) to find time to do the work. I have now put the time aside in my diary to give it the work it needs.'

'How do we keep the enthusiasm and energy to keep people interested in what we do and keeping them on the journey with us' Cohort 1 session 10

Creating a supportive and enabling environment for development was an intentional purpose, one that was achieved from the beginning by facilitators and co-researchers, with the specific endpoint achieved of working together: supporting and rejuvenating each other in a shared passion for health visiting.

In parallel to creating a safe and supportive environment for development a second journey focused on the question, what actually is a Community of Practice?

4.2.2. Developing health visiting practice together towards collaborative action and sustaining the cop



At the beginning there was confusion and uncertainty about what a CoP was and also the role of the action research in developing and evaluating this. A better understanding of communities of practice and its purpose grew quickly and led to a clear definition developed by Cohort 2 (See Box 3).

Box 3: What is a Community of Practice? It is about:

- Developing a crisp explanation of health visiting and its benefits through empowering a generation of Health Visitors with tools to use in practice
- A journey to examine, develop and enhance leadership through:
 - time to:
 - network and build relationships and develop communication;
 - reflect, encourage critical thinking and plan in protected time away from practice;
 - motivate, challenge and support self-awareness in this exploratory process, demonstrating commitment through attendance.

Cohort 2 Session 2

Co-researchers applied themselves to active learning (Dewing 2008) and action learning (McGill & Beaty 2001) in the first instance beginning to define and understand their work to enable a better understanding of the CoP and the management issues affecting health visitors and how their learning could be used in practice with their own teams. This understanding grew with each session.

I have a better understanding of CoP and really able to put the pieces of the puzzle together each session and beginning to understand what CoP is and how I might be able to use it in practice.’ Cohort 2 Session 3

Clarity also began to arise with a recognition that the focus of the CoP was about health visiting practice. Clarifying health visiting, its primary purpose, how it achieved its purpose, how it could be developed, how the programme would change practice and how practice could be evaluated was revisited many times. Much attention was given to the enablers of health visiting and also the workload of health visiting – where should it be, where was it. What proportion of their time was being spent on different activities?

This exploration led to the development of a clear vision and purpose for health visiting as well as insights into the unique contribution of health visitors. These are outlined in Box 4.

Box 4: Vision, mission, purpose and unique selling point for health visiting practice

Vision for health visiting Practice

'All children in area have the best start'

Slogan (mission)

'Inspiring and supporting families'

Ultimate Purpose:

To lead the provision of the best start for children across the community *through:*

Empowering and supporting families to enhance and improve outcomes;

Improving public health of families, parents, carers;

Evidencing gaps and improving services.

Unique Selling Point (USP) of health visiting

Leading provision of services to achieve the best start with all families through building a relationship to enable a plan to be developed, delivered by team, and evaluated.

Cohort 1 Session 5

Towards the end, the CoP enabled clearer focus for individuals who could see how all the bits of the jigsaw fitted together.

'CoP is an important part of our work now.' Cohort 2 Session 7 claim

'I am seeing links between the CoP and Institute of health visiting and areas that support both' Cohort 1 Session 7

'It's great to see how all the jigsaw pieces are starting to fit together' Cohort 1 Session 8

How to enthuse and influence others in sustaining the CoP became a frequent focus of questions posed in the busy work context

'I have clarity but it is so busy for others they can't see it.' Cohort 1 Session 6

What is the future of CoPs and what strategies are used to sustain CoP in other sectors? Cohort 2 Session 8

Various activities occupied the later cohort meetings concerned with sustaining the CoP. Initially, collaborative plans were made to present a number of masterclasses in both Kent and Medway (Appendix 12). These were planned carefully and an initial masterclass was presented in both areas as a celebratory event that shared some of the CoPs outputs with all health visitors in both Kent and Medway. It became clear that planned masterclasses would not be effective when requests by employers were made for them to be deferred because of the challenges experienced in maintaining the service. Therefore, it was decided to focus on more tangible outputs that would be able to be disseminated widely through the media of videos and websites. This was recognised as having wider and potentially greater influence than what could have been achieved through the masterclasses. Linked to sharing the outputs from the CoP was the establishment of a twitter account to enable Kent and Medway health visitors communicate more easily and freely about their practice. At the end of the project co-researchers reflecting on their confidence expressed the contribution that the CoP had made:

'I feel empowered to share the benefit of communities of practice with my colleagues to share current evidence based practices and support the implementation plan to improve outcomes for families'

Co-researcher 3 post cognitive mapping assessment

'The CoP project has helped me acquire books and a broader knowledge of my role as a Health Visitor'

Co-researcher 5 post cognitive mapping assessment

'The possibilities for the use of the CoP are exciting' Cohort 2 Session 4

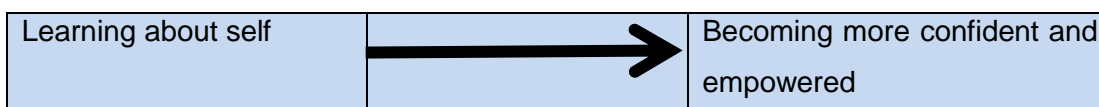
Developing health visiting Practice together towards collaborative action – sustaining the CoP was the end point of the journey.

Whilst sustainability remains uncertain, the links with the Institute of Health Visiting virtual CoP have been strengthened and the potential for 6-12mthly face to face opportunities to share best practice together with using the twitter network remains an option for taking the CoP forward. Co-researchers are keen to use their skills with their teams and this may need to be the next priority before the CoP is able to further flourish.

' I feel empowered as part of CoP, the national CoP of fellows and positive that we will be able to develop and sustain health visiting and take a leading role in early years intervention' Cohort 1 session 10

The development of confident and empowered practitioners is a pre requisite for self-directing communities of practice passionate about the contribution health visiting practice can make to public health and this is reflected next in the co-researchers own journey.

4.2.3. Becoming more confident and empowered through learning about self



Learning about self and the leadership potential each co-researcher possessed marked the beginning of this particular journey.

'I feel this has sparked the beginning of a personal journey.' Cohort Session 2

'I feel I am still very much at the beginning – there's a lot more to teams than I thought.' Cohort 2 session 3

Learning was demonstrated in the early stages through recognition of qualities such as:

- an increased self-awareness, confidence and willingness to act and challenge;
- the importance of persistence and courage
- having a can-do attitude

Having the opportunity to develop and understand new processes was valued and insights progressed to recognising they were leaders, who can be creative and act as catalysts for change as well as having a role to play.

'I am developing my leadership role and taking more learning opportunities. I understand the importance of this learning opportunity for our health visiting service.'
Cohort 1 session 6

These insights and self-awareness led to feelings of empowerment for most – the motivation to want to act - as evidenced in the following quotes:

'I am now beginning to really see the purpose behind this and am eager and enthusiastic to be able to implement what I have learnt into my practice.' Cohort 2 Session 4

Action learning empowered me to increase my confidence and audit the team around electronic notes Cohort 1 Session 6

'Being inspired to take up a more 'leadership' role in my Health Visitor workplace' Cohort 1 Session7

'Empowered to new roles. Focused on what we are trying to achieve' Cohort 1 session 7

For a smaller minority the journey was hard and frustrating:

'It is difficult at times to keep people focused on the task, and at times very frustrating' Cohort 2 session 5

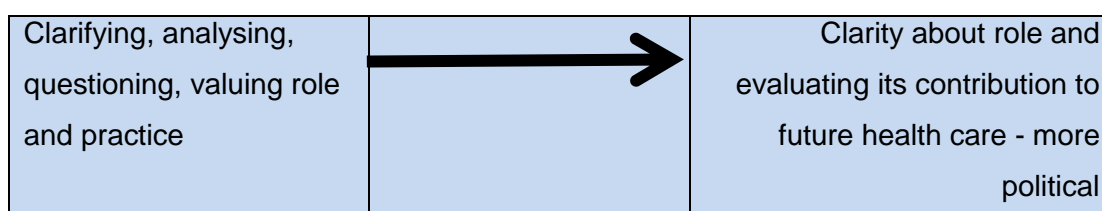
'That I am unable to make changes that affect my colleagues' Cohort 1 session 5

Overall the co-researchers who sustained their participation in the CoP felt confident and empowered at the end through learning about themselves and their potential as leaders and were inspired to action, as reflected in the following quotation;

'I now feel empowered to share practice locally and nationally to support achieving the service framework and have found the combination of narratives and evidence base to highlight Health Visitor Impact is very positive.' Co-researcher' Individual 3 Post cognitive mapping

This quotation alludes to the specific work that was undertaken on the Health Visitor's role, contribution and evaluation of effectiveness which is illustrated in the next journey

4.2.4. Developing clarity of role and evaluating its contribution to future health care and becoming more political



This journey began by enabling co-researchers to clarify, analyse and question their practice whilst valuing their role, knowing that this would help them with their own teams.

'My need to identify my role and my focus so that it will help me move forward and move the team forward.' Cohort 2 Session 2

The CoP aimed to support health visitors to develop person centred and community centred practice individually and collectively. It did this by first developing a common and shared understanding about the role of health visiting, refining the attributes over a period of time to tease out what it was that health visitors specifically did and what this meant, in terms of 'means and ends'. The latest iteration is presented in Box 5 and Appendix 10 locates these attributes in the context of both enablers and consequences.

Box 5: Revised Attributes of health visiting practice (V3) Cohort 1 session 5

Attribute 1: Building Family¹-centred relationships

- Inspiring and supporting families
- Working with families in a person-centred way to improve outcomes²
- Using holistic assessment skills in partnership with families
- Developing a care plan to be implemented (by team) and evaluated

Attribute 2: Improving public health of families, parents, carers and communities

- Engaging groups and communities
- Enabling health and happiness through working with groups and communities using a team approach

Attribute 3: Improving services³ using evidence

- Developing partnerships and integrated ways of working with multi-agency colleagues and partners
- Utilising communication and feedback with colleagues and partners
- Influencing commissioners and CCGs
- Networking with Health visitors, professional bodies and other partners to share best practice

¹ The term family encompasses children, parents, carers and external family members

² Health outcomes encompasses physical, psychological and social health

³ Services encompass the provision of support to achieve the best start for children

The framework and depth of thinking positioned the CoP advantageously to challenge the national agenda around health visiting when the '4, 5, 6 framework (Appendix 5) was released by Public Health England (Bennett 2015). The challenge was to ensure that the enablers, processes and outcomes of health visiting practice were sufficiently recognised and highlighted by repackaging to synthesise the '3-8 model (Appendix 13) which integrated key aspects that were missing. Political action also ensued by ensuring that through setting up a twitter account for Kent and Medway CoP this could be rapidly shared.

In tandem to these activities there was a focus on evaluating the role of the health visitor. A number of initiatives associated with demonstrating effectiveness, included:

- **Estimating the percentage of time spent on each of the attributes** (Box 5) which then led to adapting the Cassandra model (Leary, 2011) previously used with community nurses to capture the complex interventions they provide (Jackson et al 2013; 2015). Health visitor attributes were aligned with the three attributes (Appendix 11) and 3-4 co-researchers tested the approach through collecting ten days of data each about their role piloting its potential as a workforce tool that can evidence the ratio of time that health visitors spend on these activities.
- **Developing evaluation strategies for different foci** that would enable the triangulation of data to demonstrate impact. For example through unpacking a health visitor led initiative – a post-natal support group - the key enablers and attributes were identified, as well as the impact which could potentially be measured (See Box 6)

Box 6: Enabling factors, key programme interventions and impact measures for post-natal programme

Enabling Factors	Key Programme Interventions	IMPACT /Measures
<ol style="list-style-type: none"> 1. Health visitor Led 2. Support from Children-Centres 3. Funded Resources & Venue 4. Parents know/invited 5. Evaluation Strategy 	<ol style="list-style-type: none"> 1. Supports parents with parenthood 2. Establishing a learning & support network 3. Reinforcing key Public Health messages 4. Identifying vulnerable parents 	<ol style="list-style-type: none"> 1. ↓ Post-natal Depression 2. ↓ Social Isolation 3. ↑ Accessibility for mothers 4. Interactive & informed parenting evidenced through: <ol style="list-style-type: none"> a. Importance of play b. Potential 6 high impact areas: <ul style="list-style-type: none"> ↓ Accidents ↓ A & E Admissions ↓ Obesity ↑ Breastfeeding rates ↑ Dental Health 5. Social capital in communities (Big society) 6. Achievement of Healthy Child Programme

For the health visitor co-researcher leading this initiative, the following quote captures the light bulb moment when she recognised the impact of what she was providing;

'I did not realise how the post-natal support group could have such impact. I realise how much influence I have – a light bulb moment' (Cohort 1 session 11)

- **Using emotional touch points** to capture what matters to people whether it is clients, staff or students in the health visiting service (Dewar et al 2009)
- **Developing narratives** that illustrate the key health visiting attributes and their impact (box 7)

Box 7: Developing narratives (Brackets refer to enabler 1, 2 etc; Attribute 1,2 etc. and Consequence 1, 2 etc.from Box 6)

Attribute 3: Improving Services Using Evidence *Under one's Pathway'*

The Health Visitor role is recognised within the wider public health arena and working to the national health agenda (E1), therefore Health Visitors have a legitimate role developing partnerships and integrated ways of working with multiagency colleagues and partners (A1) to improve public health outcomes to give all children the best start regardless of where they are born, family or culture (C3) to improve public perceptions of health visiting services (C8).

Driven by conflicting advice from practitioners to parents, media and websites, and lack of recognition of workforce skills to deliver programmes which were being delivered/commissioned from private practitioners was an issue in practice .

Utilising communication and feedback with colleagues and partners, and clients and engaging groups and communities we worked in a person centred way to improve outcomes of families. The consequence of this was for children in the area to be healthy and ready for school by aged 5 years.

Practitioners have a wealth of knowledge, skills and passion with working with families in a person centred way to improve outcomes. Which in turn creates a happy workforce enjoying their job, and helps nurture a motivated staff and staff retention.

By developing adequate resources using a joined up system we can satisfy targets within the national Health Visitor agenda and influence commissioners and CCGs at a local level to incorporate innovative service delivery into their Operational Framework.

The Postnatal Group pack was developed by Health Visitors with the skills and knowledge of their specialist training to deliver a 5 week programme to new parents and those with a considerable age gap for siblings, to engage groups and communities to improve public health. As Health Visitors with a wealth of evidence based knowledge we were best placed to engage families in these group sessions.

Working collaboratively with SureStart Children's Centres (CC) we set about developing the Toolkit and training Health Visitor and CC teams on how to use the resources within it. Once developed the Toolkit was piloted in 2 CCs and evaluated by parents, CC and Health Visitor staff. Using this feedback the Toolkit was adjusted accordingly and then delivered again (in pilots until it was polished).

This project has also created a working party of multi-agencies to devise roll-out and costing for it to be delivered across the local area in 19 children centres. A launch date was set and the working party went about planning sessions within their CC timetables. Management support in words, actions and expertise with the willingness to engage with change (E3) allowed the Health Visitor team coordinators to allocate staff to each of these sessions. Although the course is 5 sessions there is a 6th session, allocated to the timetable so that CC and Health Visitor staff could review and evaluate the sessions, replenish resources and plan and advertise for the next 5 weeks. Evaluation forms were also completed by parents, staff and session leads following the course of 5 sessions.

Knowing how to influence the wider agenda so as to share insights drove an interest in influencing strategies. Earlier, this was demonstrated when recognising the importance of responding promptly to national initiatives. When using Claims, concerns and issues it was important to help co-researchers identify which themes were within Health Visitors control totally and partially or what was out of their control so that they focused on what they could influence' e.g. the impact of the COP was considered to be *in the participant's control* (Action Learning set 1 November 2014).

In the workplace changes in senior leadership posts meant service direction altered but co-researchers recognised the need to address this through the skills they were developing and becoming more familiar with. At times this seemed as though they were re-connecting with a more 'political' stance. For health visitors this is particularly important in reviewing, regenerating and reinventing their role in the revised landscape. Co- researchers were therefore supported to develop key messages about what health visiting can contribute for each stakeholder group to translate this 'influencing' to the workplace. Table 7 identifies how this was captured.

Table 7: Developing key messages for different stakeholder groups

Cohort 1 Action learning set 1 November 2014

Commissioning	<ul style="list-style-type: none"> • How Health Visitor can lead and influence early intervention • How CoP can clarify role and the impact on building evidence and using tools to measure outcomes • Recognise the Health Visitor role in communities to continue investment in Public health
Local teams	<ul style="list-style-type: none"> • Showing teams shared purpose and way forward • Building evidence relevant and reflective from practitioners and clients (meaning what we value) • Recognising team members contributions
Managers	<ul style="list-style-type: none"> • Selling ourselves- USP • Presentation to CEO and Senior managers

The importance of influencing was therefore beginning to be appreciated:

'Different language – powerful to influence others.' Cohort 1 Session 7

How can I use what I have learnt to influence others? Cohort 1 Session 10

At the end of this journey co-researchers were clear about their role, its contribution and how to evaluate this contribution as well as how to influence future health care more politically:

'Over the year, my own understanding of Health Visitor has increased and I can now pinpoint the attributes health visiting to others. ' Co-researcher 4 Post cognitive mapping

'Public health outcomes are achieved over a period of time but regarding breast feeding support and nutrition for the child and family I feel I am in a good place to influence.' Co-researcher 1 Post cognitive mapping

'Using the attributes and outcomes has allowed me to focus on the impact and I can now articulate these using language and skills developed.' Co-researcher 4 Post cognitive mapping

'I feel confident in articulating the impact of my role on children and families to others to demonstrate the unique health visiting skills that can effectively improve public health outcomes through empowering parents with knowledge and skills' Co-researcher 3 Post cognitive mapping

4.2.5 Learning to use tools that can be used with others to develop and lead practice



Learning to use tools within the safe environment created within the CoP marked the beginning of this journey. The tools included:

- Qualitative 360 degree feedback
- Values clarification
- Emotional touch points (Appendix 14-emotional touchpoints kit and video)
- Claims, concerns and issues
- Concept analysis
- Evaluation frameworks

- Promoting Action on Research Implementation in Health Services (PARIHS)
- Creative approaches to understanding culture

Part of the learning included how to co-create direction, how to work collaboratively with different ideas, and how to bring these ideas together through collaborative theming that reflects what matters to people. Co-researchers were empowered by unpicking the tools, refining their use and looking at them in depth.

Taking time out of practice was valued by co-researchers as time to step back and become clearer about role. The tools and using them were positively evaluated as claims:

'Tool used to enhance practice development and how it is used in practice' Cohort 2 Session 4

'Toolkit/strategies to help to make things more effective and help outcomes.' Cohort 2 Session 4

Facilitators modelled the tools, enabled co-researchers to practice them and discuss how they could be used in the practice setting. Co-researchers liked also using tools that would support them in evidencing the role:

Liked best in session 5: 'Provision of a tool from the Cassandra Matrix – to be able to evidence my role' Cohort 2 session5

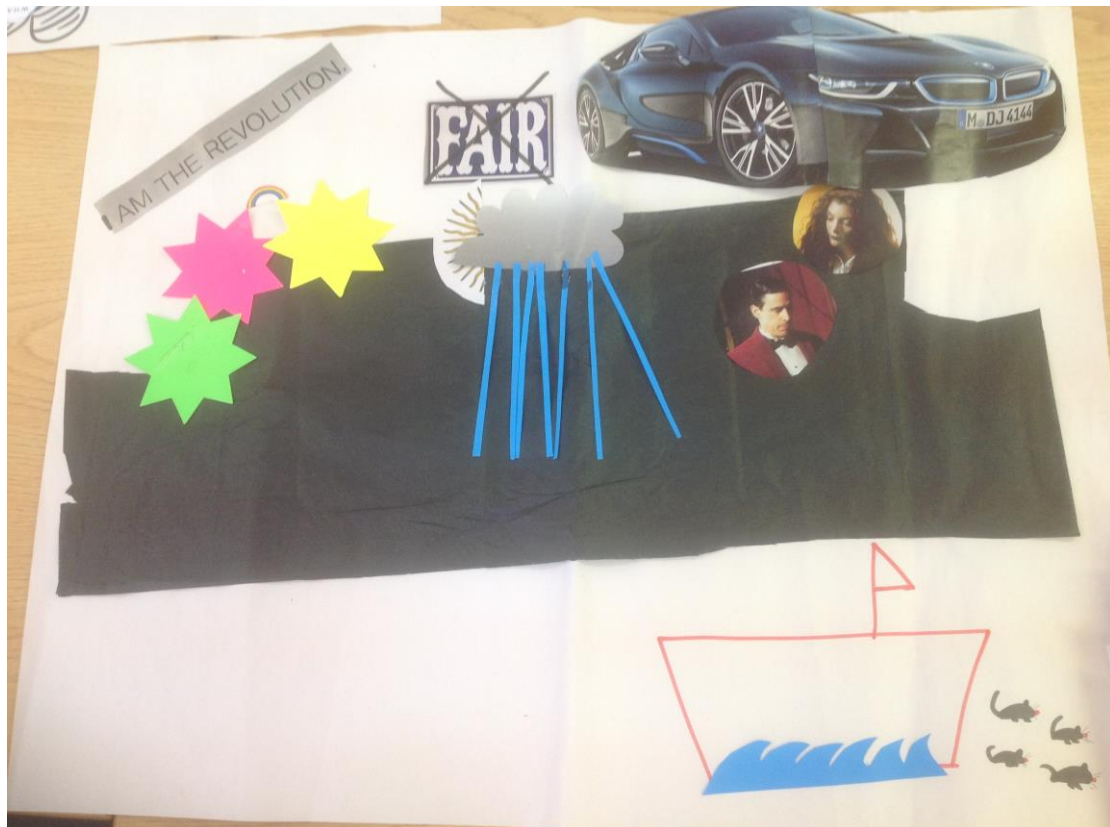
Co-researchers were keen to try the tools in their own practice, but were challenged by concerns and issues evident in Box 8 from cohort 2:

Box 8: Concerns and issues relevant to using tools in practice (Cohort 2 Session 5)

- 'Time to support what is learnt in the session and implements what you have learnt and confidence to use the tools in practice.'
- 'How to engage all members and individuals in the workplace who would try and sabotage the meeting?'
- 'How do I time manage the exercise'
- 'How do we manage people who don't want to engage?'
- 'If CoP cohort believe this is useful why are we losing so many people from the group?'

Finding a way to support the development of effective workplace cultures for co-researchers emerged from an exploration of their own cultures using creative approaches. An example of this can be seen in what was termed 'warzone'.

Figure 2: Collage to reflect workplace culture – warzone (Cohort 1)



Emotional touchpoints (Dewar 2009) were adapted for health visiting. A specific emotional touchpoints pack was developed across both cohorts to reflect the needs of a revitalised service that focussed on person centred approaches that applied equally to staff students and service users and a way of obtaining in-depth feedback about what matters to people.

Co-researchers commenced working in their teams using skilled facilitation of claims, concerns and issues where they felt empowered to do so.

'Need to make sure I share good news with others and to do more claims concerns and issues. I feel inspired'

'Being inspired to take up a more 'leadership' role in my Health Visitor workplace'

Co-researchers ALS 1 November 2015

'Finding my way better along the road but still coming up against potholes and roadblocks from caseload requirements to be able to give this project the time it needs in practice (However I will work at home on my Portfolio)'

'How can strategies be implemented in a dysfunctional team? 'Cohort 2 Session 4

Increased awareness of the role and impact of workplace culture by co-researchers are evidenced in the claims (positive statements) celebrated by cohort 1 in session 4 (Box 9).

Box 9: Claims Identified by Cohort 1 in session 4 about their cultures

- Good communication which has led to good happy working team
- Sharing of information and resources ad hoc and comfortable
- Work is always covered as the team is supporting, 'no drama' and will step up as needed
- Team has embraced change and given themselves time to adjust. Positivity wanted to work there
- Good culture in the workplaces leads to less sickness
- Culture gives immediate emotional support
- Positive change have ammunition and reinforcements

One co-researcher brought the tool 'mindfulness' to share as a resource with others, providing an opportunity for helping each other to manage the multiple challenges in daily work being experienced.

Co researchers began to realise from using different tools and frameworks what needed to be done, their own potential leadership role in this, and how the tools would help them with this. Cohort 1 session 4 evaluation feedback illustrate this

'Time is needed for unpicking issues'

'My client service is not as good as I had hoped'

'My workplace culture is poorer than I thought'

'Seeing the vital need for leadership within the team, encouraging a positive environment'

'That I can act as a catalyst for change I just need to be brave'

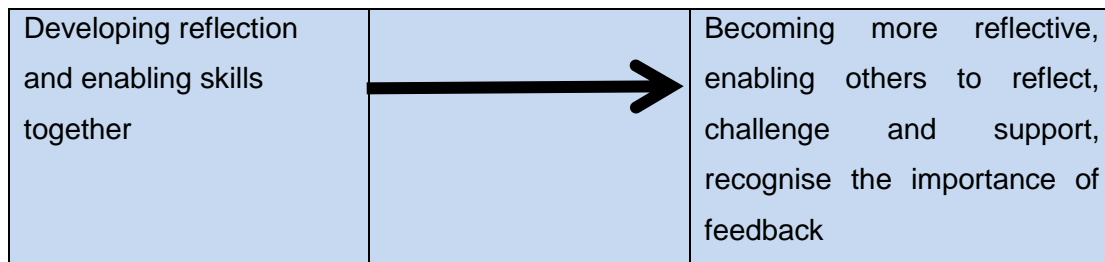
The endpoint of the journey was marked by using tools with their own teams to develop practice and a realisation of the complexity of the job

'I am beginning to appreciate the depth and complexity of the task of developing health visiting practice and training the future workforce.' Cohort 1 Session 5

'Empowerment from tools' Cohort 1 Session 10

The journey began with unfamiliarity with the tools they were introduced to, but through practice enabled co-researchers gained greater confidence and insight into their value so that they felt able to begin to use them with their own teams. This journey was interdependent with being and becoming more reflective enablers of others – the focus of the sixth journey.

4.2.6 Becoming More Reflective Enablers Of Others



The action learning sets focused co-researchers on reflective approaches and enabling skills by establishing a safe environment for learning to explore key challenges co-researchers were experiencing themselves. The action learning had two purposes; to help co-researchers with the challenges of their own work and practice through enabling questions as by other group members and reflection; and helping co-researchers develop the skills they required in the workplace to enable others to be effective.

At the beginning of this journey the range of questions they were asking themselves as individuals are outlined in Box 10.

Box 10: Questions co researchers were asking at the beginning of action learning (Cohort 2 Session 1)

- How can I facilitate fair allocation to staff and consistent messages to clients?
- How can I measure what Health Visitor to in response to PMH?
- How can I move forward a development for a healthy weight in Health Visitor for children in Kent?
- How do I work towards changing attitudes and behaviour in my new team?
- How can I motivate and support staff through change?
- How can I support preceptors in their role?
- How do I change the negativity of the team to enable newly qualified Health Visitor to want to work in this area ?
- How do I make sure newly qualified Health Visitor do not get shot in the clouds or PTSD that I and others do not sink ?
- How can I create an atmosphere of positivity for staff?

Action learning (Mc Gill and Beaty 2001) was positively evaluated and helped co-researchers develop both their thinking, enabling and challenging skills which could then be taken back to practice. They liked the opportunity to reflect on their practice.

It was intended that each co-researcher would have a designated critical companion, a person to help them to reflect and learn to challenge their assumptions about their own practice and help them make sense of their own self assessments. It became clear in early sessions that finding people with the skills required was proving difficult. Also, understanding what critical companions would offer was novel to co-researchers. In previous research, Manley et al 2005; Manley & Titchen 2012 identified the difference that a critical companion can make to helping practitioners think about and develop their practice and evidence this in a portfolio on an individual basis. Only a small number of co-researchers accessed a critical companion and so this took its toll on the achievements of individual co-researchers and the development of portfolios that could have been accredited at Master's level and also used for revalidation. Although individually the full potential of what this had to offer was not experienced, collectively there were considerable outputs and outcomes that can influence health visiting practice more widely e.g. the 3-8 model , the videos and integrated web site with its stories of impact.

The skills developed in action learning sets led to co-researchers identifying the following insights:

'I need to listen more and not rescue' Cohort 1 S2

'I need to spend more time between sessions reflecting and refreshing what I have learnt' Cohort 2 S3

Focus of thoughts and making you think what you do, why you do it and how you can do it more effectively Cohort 2 S4

Helping other people to find answers through the questions that you were asking Cohort 2 S5

High support and high challenge Cohort 2 S5

Reflective space C2 S5

Impact of questioning and increased awareness of responding to issues when time is limited to ensure containment and positivity Cohort 1 S2

'I need to be more challenging and not allow myself to get laughed down by negativity which paralyzes me' Cohort 1 Session 8-9

Across the workforce leadership skills were identified as being required to enable a service to be delivered and teams to be effective in this delivery. The learning sets were construed as a safe environment in which to develop skills in facilitation and clinical leadership. At times co-researchers expressed frustration at the misunderstanding of this supportive environment and the inadequate skills displayed within the group and the frustration experienced between a range of practitioner grades (graded bands 6-8).

Difficulty in getting presenter of the action learning to answer the questions and going off on a tangent

Participant ALS 1 June 2014

However, recognising that it was a safe environment for learning and practising, enabled confidence in the skills developed and recognition of a change in the way co-researchers perceived they were working.

'Becoming more reflective, enabling others to reflect, challenge and support, recognise the importance of feedback' Cohort 1 Session 3

Changed the way I challenge/question staff r: problems C2 S8

'Learning the ability to challenge ways of thinking perceptions and behaviour' C1s3

Co researchers enjoyed 'getting feedback on facilitation skills and learning to recognise new applications for identified skills.

Whilst not developing a formal portfolio, a reflective review was completed by most and this enabled a summary of their personal achievements, enablers and challenges to be captured and be exposed to critique by each other.

'Liked working together on the in depth reflection model' C1 S10

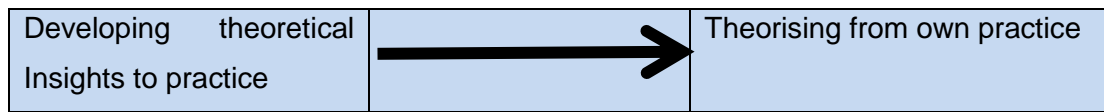
Co-researchers also recognised the links between reflection, and researching and theorizing from their own practice strategies that could be implemented and refined over time.

Liked 'Linking between reflection and action hypothesis as strategies C1 S3

'Like action learning, action hypothesis, use, practise and strategies' C1 S3

Developing theory from practice through reflection therefore provides the final link to the last journey experienced by co-researchers

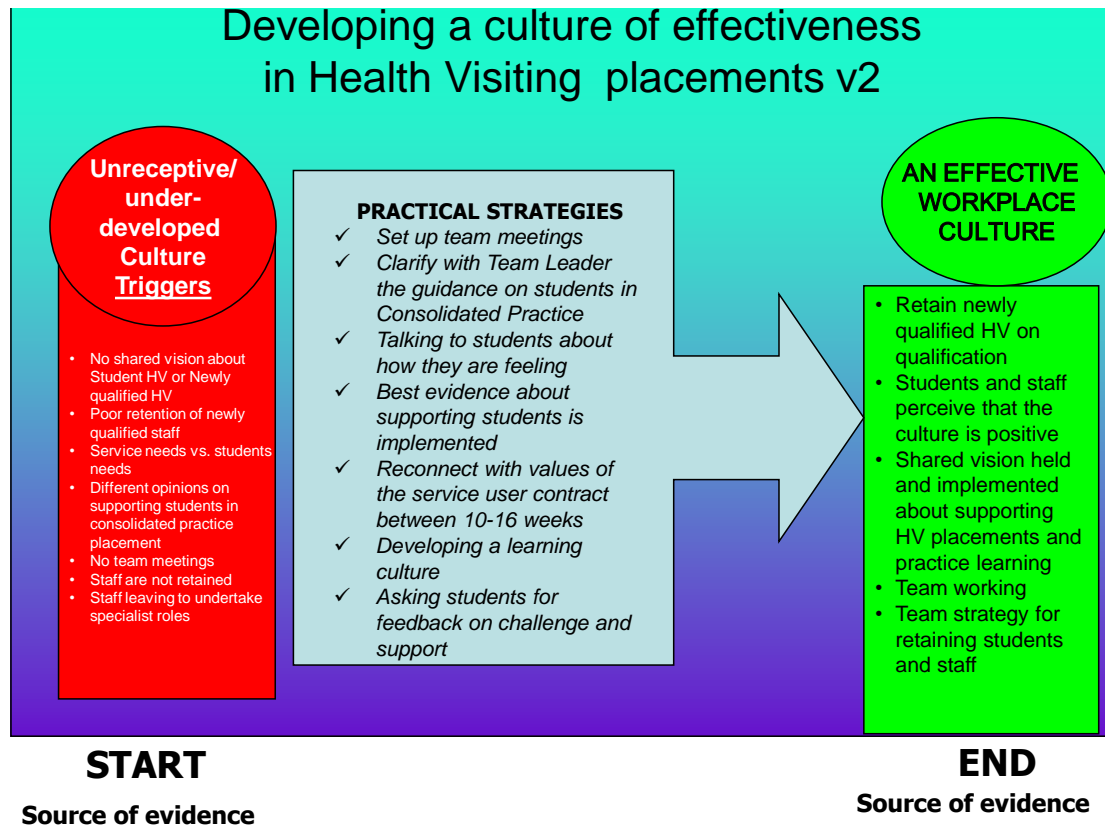
4.2.7 Developing theory from practice



Action hypotheses was a framework (Manley et al 2013) introduced to co-researchers as a tool that would help co-researchers make explicit the strategies they were intentionally using in everyday practice to address the challenges they met. These strategies were made explicit from the action learning presentations which tended to be the origin of the action hypotheses generated across the project. But through collaborating on and enabling expertise from other health visitors a picture could be built up about how to tackle specific issues recognising that experimenting with different strategies would help refine them.

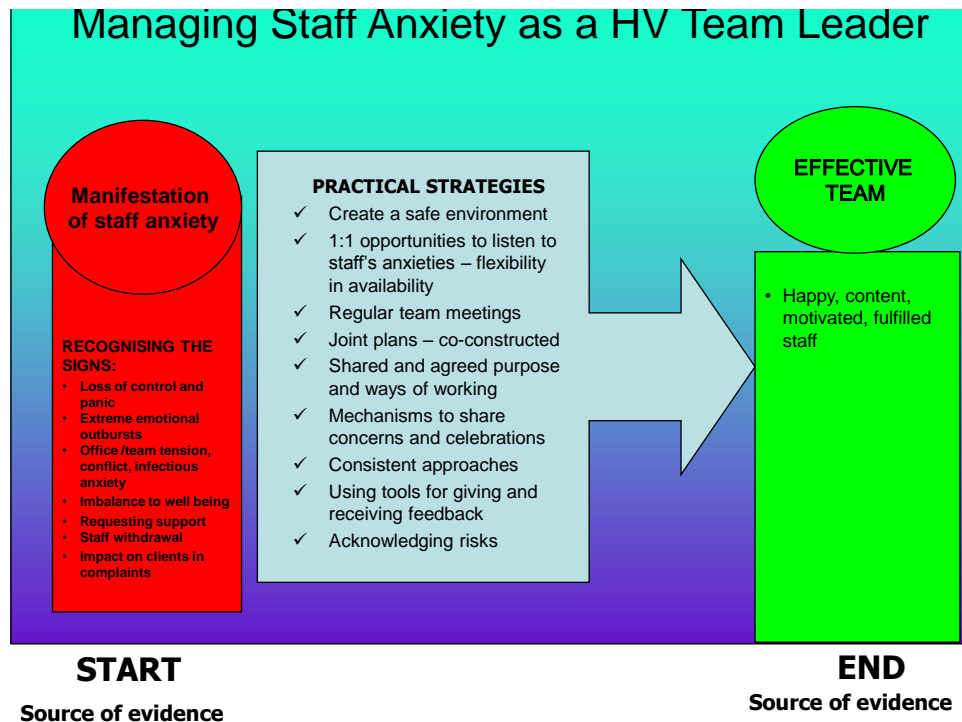
Cohort 1 first worked with the action hypotheses framework in relation to the wide recognition that workplace cultures were not always conducive to retaining Health Visitor students, something that was considered a priority if there was to be sufficient health visiting capacity for the future. The triggers for an unreceptive/under-developed culture were first identified from one action learning set presentation but were then embellished by others' experiences. Strategies were identified and it was quickly realised that an effective culture for health visitor students would also be an effective culture for staff. The understanding generated criteria for an effective culture identified in Figure 3.

Figure 3: Triggers, strategies for addressing unreceptive cultures and criteria's for an effective workplace culture



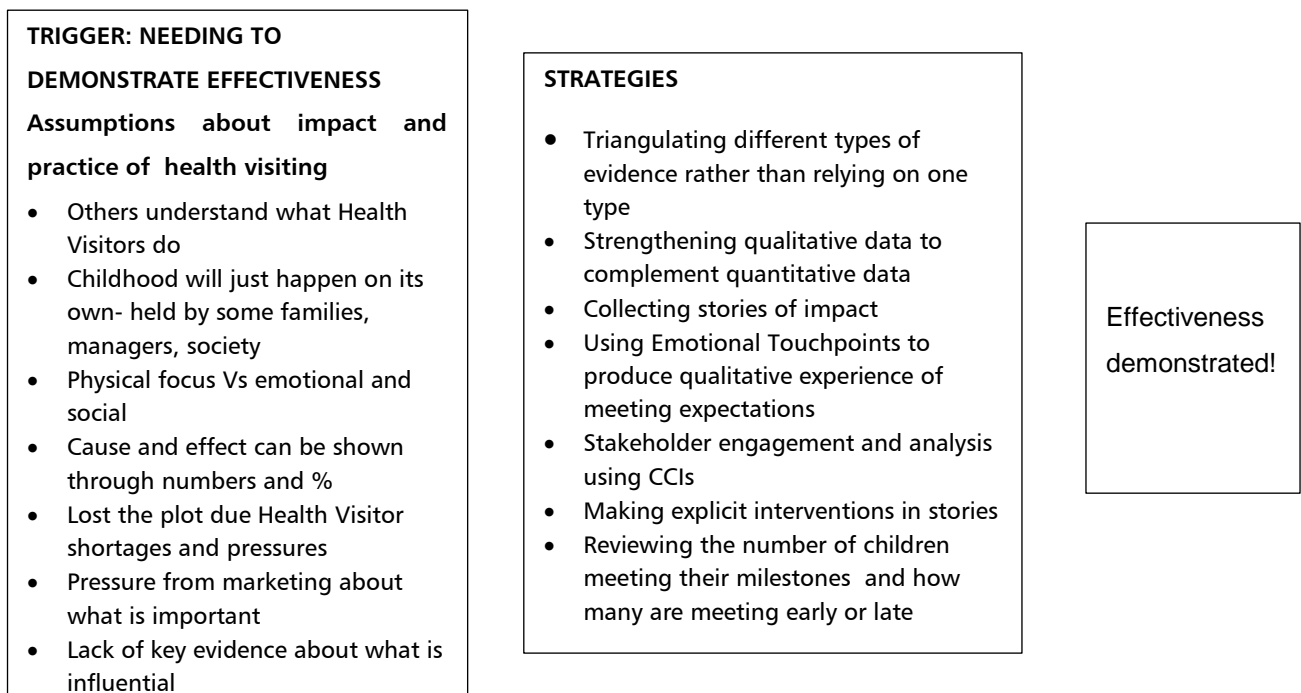
Cohort 2 in response to challenges they were exploring in action learning about how to help anxious and stressed staff also provided an opportunity to develop an action hypotheses that might help others first recognise the triggers/manifestation of staff anxiety and stress, the strategies in practice teams that would address these, as well as the indicators of success.

Figure 4: Recognising staff anxiety, strategies with indicators of success



Lastly in trying to answer the question 'How do I measure that the programme has changed practice? In cohort one, session six, co researchers learned about how to develop an evaluation strategy, the importance of triangulating different data sets and how to capture staff learning. This story was converted into the action hypothesis below. Figure 5.

Figure 5: Action hypotheses around evaluation of programme impact



This last journey involved co-researchers improving their awareness of theories and how these could be developed from their own practice, tested and refined through their practice. This approach of theory from practice complemented their understanding of the factors that influence the implementation of knowledge and evidence into practice, specifically the role of context (culture, leadership, evaluation) and facilitation highlighted when using the PARiHS tool referred to previously.

The endpoint of this final journey integrates all the endpoints from the other six journeys which are reflected in the ability to theorise from practice as a strategy that can make explicit the triggers, strategies and outcomes influential when addressing or exploring different areas of practice. This was experienced as a bottom –up approach that was both liberating and empowering in the context of what felt to many co-researchers a top-down and ‘done to’ era of change.

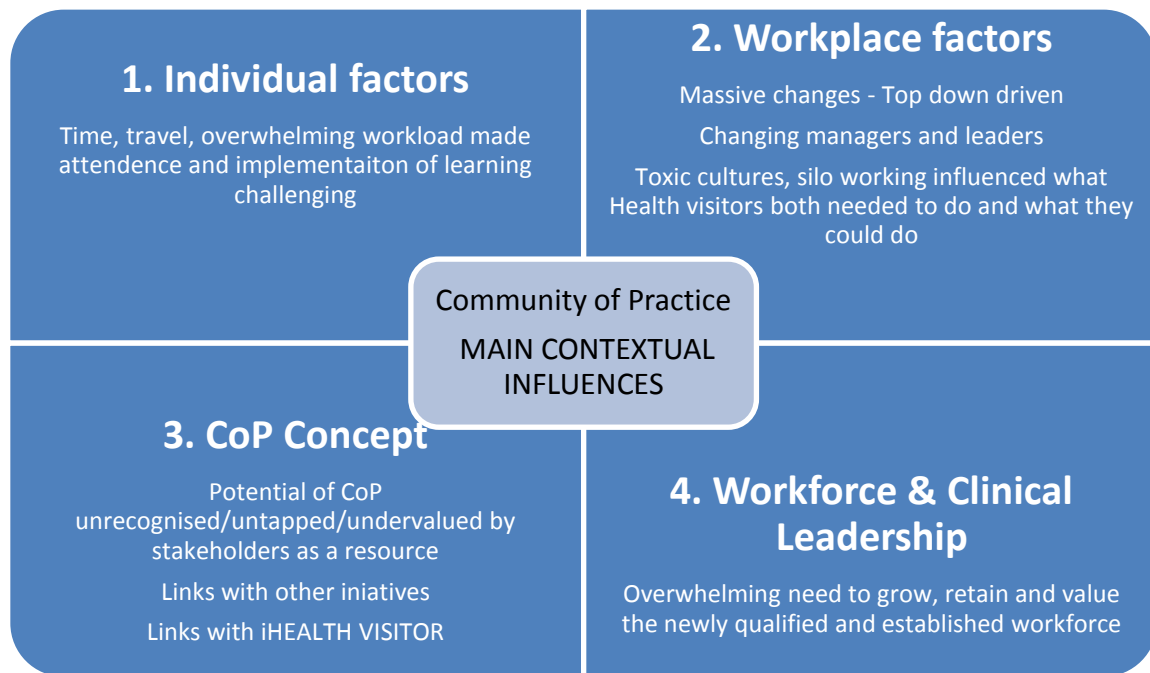
‘I feel confident in articulating the impact of my role on children and families to others to demonstrate the unique health visiting skills that can effectively improve public health outcomes through empowering parents with knowledge and skills’ Co-researcher 3 Post cognitive mapping

These journeys took place within a challenging context that influenced the experiences of the CoP. These challenges are now presented, derived from an analysis of session notes and evaluation data.

4.3 Contextual Challenges impacting on the Community of Practice

Through the use of claims, concerns and issues and analysis of data resulting from the CoP four powerful influences emerged that impacted on the co-researchers participation in the project and also the potential for sustainability of the CoP project. Whilst everything possible was done to enable maximum uptake of this opportunity by health visitors, including the delay of starting dates on several occasions to enable optimal recruitment, and working flexibly with stakeholders, there were a number of challenges that impacted the project. These are summarised in Figure 6 and expanded on below:

Figure 6: Four key Challenges to the Community of Practice and its implementation



4.3.1 Individual factors: Time, travel, overwhelming workload made attendance and implementation of learning challenging

Co-researchers described the individual challenges faced in attending the sessions and which were evident from the beginning of the project during recruitment following the information circulated in the flyers (Appendix 7) with applications agreed between researcher and line managers in a transparent manner (Appendix 8). Overwhelmingly in their feedback the co-researchers identified time, dates & travel practicalities and for this reason a central university location was chosen, accessible to major motorways with good parking. However, co-researchers reflected on their isolation as the sole attendee from a working locality or base as it was initially proposed the attendees would represent each of the localities where health visitors were based across Kent and Medway (15).

'Long way for me to come no other colleagues from my team or even area involved'

Cohort 1 October 2013

At the end of the first session, in both learning sets, the evaluation captured individual responses which reflected time factors as a major barrier. In the first group 'time' applied to the length of time of the sets needed to make it worthwhile travelling long distances. The group felt it needed to be extended by 1.5 hours (9-1.30pm) in

order to process their new learning and which was subsequently agreed by managers.

Tight time- although any longer and my brain would have started hurting a bit'

Cohort 1 October 2013

Nevertheless, time pressures within these half day sessions continued to be raised in the daily evaluations as the facilitators aimed to fit in a range of developmental material;

- *Running out of time with critical question*
- *Time pressure*
- *Would have liked a longer session to continue theme*

Co- researcher feedback on things less helpful week 2 Set 1 November 2013

The second group, which quickly became smaller in numbers, 'time' meant keeping to a three (3) hour time slot for each session starting early and finishing promptly. As identified the impact of the half day sets required specific action and it was agreed to extend some sessions for a whole day. Nevertheless, there was attrition from both sets with the more stable group being the first set and the second set losing members often without notification.

An implication for future projects would be enabling a full day rather than half a day for participating in the CoP.

4.3.2 Workplace factors: Massive changes - Top down driven, Changing managers and leaders, Toxic cultures, silo working influenced what Health Visitors both needed to do and what they could do

The workplace was described by a co-researcher as '*... like working in a war zone'* (Co-researcher Action learning set 1 November 2014) with fears expressed about the service offer and 'that won't be able to deliver the service that is currently being delivered because staff shortages' and further more '*... Reduced caseload is not how I want to practice'* (Co-researcher Action learning set 1 January 2015). Such shortages seemed to contradict the management data, indicating there was an increase in health visitor numbers to deliver the new model (DH 2011) which refocused on core number of family contacts by the health visitor and away from the 'skill mix' team.

'How are we expected to deliver basic services when the formula around our staffing levels are wrong?' Co- researcher ALS 1 June 2014

Transition to this new service model, while balancing the demands of child protection work may not have been widespread; the subsequent publication of the CNO's 4, 5, 6 model (Bennett 2015) suggests clarification was required across the country. As a consequence of the central management of data as well as service performance, pressure was mounting on employing organisations which was projected onto staff who were struggling with multiple changes including the roll-out of a new IT system which the co-researchers did not feel was fit for purpose.

'...Technology not there to back us up' Co-researcher ALS 1 June 2014

In Medway and later Kent this change to the IT systems culminated in the co-researchers considering balancing these changes alongside the complex aspects of Health Visitor work.

'Where do I go with important information? Domestic Abuse and Safeguarding'

Co researcher ALS 1 June 2014

At times the co-researchers felt aggrieved about bringing the toxicity of their workplace to the CoP; however this was mirrored in other settings associated with the CoP. The CoP seemed to be an unknown entity or undermined by some managers in both organisations as 'just a research project' as reported by a co-researcher in preparation for the Masterclasses. But did nevertheless lead the co-researchers to new ways of thinking about their work and role despite the organisations being unready for this type of project.

'That I can't wait for people to change things for me I have to be the change I want to see' Co-researcher Action Learning set 1 January 2015

Co-researchers were recognising the power of the action learning sets in the context of Practice development and as the foundation for a realistic CoP which had the power to facilitate develop and grow individuals to deliver the service required.

Whilst the work context itself was out of the control of the project facilitators, it is vital that employers recognise that CoPs and development of health visiting practice is an invaluable resource that will contribute to both workforce and service transformation. This is achieved through growing effective leaders and practitioners who can contribute creative and innovative approaches and effective workplace cultures to meet the challenges of increasing demand and complexity in service need.

4.3.3. Concept Potential of CoP unrecognised/untapped/undervalued by stakeholders as a resource linked with other initiatives and the Institute of Health Visiting

Building Community Capacity (BCC), a DH endorsed module was offered alongside the Community of Practice action learning sets to all health visitor practitioners but this duality resulted in a level of conflict over which offer took precedence. To this end the CoP project seemed undervalued by some of the health visitor managers and 'something that was being done to the service' rather than a staff developmental opportunity to support them reach organisation objectives. At times co-researchers were frustrated by the low numbers as well as the unreliability of attendees and suggested managers may not have circulated information on the CoP to enable optimum participation.

For future projects it is vital that the skills developed in growing the workforce through communities of practice that focus on using the workplace as the main resource for learning and leadership are understood in terms of how they contribute to workforce and service transformation, not detracting from it.

4.3.4 Workforce & Clinical Leadership: Overwhelming need to grow, retain and value the newly qualified and established workforce

Although co-researchers did not feel there had been a noticeable increase in the staffing numbers to achieve the level of service required they were acutely aware of the disproportionate numbers of experienced health visitor to students in consolidation or newly qualified health visitors. Co-researchers were keen to make the early careers of newly qualified health visitors a positive experience and ensure expectations were aligned with reality as there was a

'Danger of them getting despondent / lost in work force, not able to shine' (Co-researcher ALS 1 June 2014).

The co-researchers believed if this was not addressed it would affect their ability to maintain a workforce and demonstrate the required public health outcomes and ultimately the future service commissioning of the health visiting service.

'Commissioning – mismatch, fear they might go elsewhere' Co-researcher ALS 1 June 2014.

Greater understanding of issues affecting the management of health visitors emerged in co-researchers consciousness but despite these insights co-researchers

described a working environment underpinned by anxiety which was displayed in the workplace through unacceptable behaviours, for example:

(by) emotional outbursts and angry outbursts; (*being*) quiet or speak(ing) a lot; emotional meltdown – tears etc; breakdown – tears; can be angry, upset or disgruntled (Co-researchers Action learning Set 2 January 2015).

This explanation of emotions in the workplace combined with the earlier account of the ‘war zone’ suggested this experience was commonplace and due to multiple changes cascaded from the top of organisations. This acknowledgement led to the use and development of the emotional touchpoint (Appendix 14) tool for staff and students in the workplace as well as the identification of key strategies that can be used in the workplace to minimise stress and anxiety.

Despite, challenging workplace contexts and multiple changes over the course of the project, for one Health Visitor during the CoP project recognition from her employers of the initiative she led (‘Born to Move’) resulted in a fellowship award from the Institute of health visiting, enabling the organisation to raise their profile with the DH.

The challenges experienced by co-researchers were recognised by them as opportunities through the CoP for learning and supporting each other, learning about themselves and the leadership resources they were developing.

‘Making progress- seizing opportunities to raise Health Visitor profile-cpHealth Visitor and audit conference and fellowship opportunity’ Co-researcher Action learning set 1 November 2014

This learning is further described in the seven research journeys identified in the first part of the findings, following a summary of the hopes fears and expectations for the project

5. Discussion, implications and limitations

5.1 Discussion and implications

The CoP project took place at an unprecedented time of professional regeneration with multiple changes experienced within the health visitor profession locally as well as nationally. While some of these changes emerged during the project and ranged from team formation, evolving roles and responsibilities, to the introduction of new IT systems with revised methods of workload allocation, other changes were anticipated such as the commissioning of the health visitor service by the local authority. The DH

led priority was based on 3 strategic strands of work from growing the workforce in ways to increase numbers of qualified health visitor and to promote, restore and strengthen (professional) development and career opportunities enabling transformative approaches; restoring professional autonomy & decision making. Ultimately this health visitor workforce would deliver a commissioned service model in collaboration with Sure Start Children's Centre to ensure alignment in the delivery of the Health Child Programme. All of which was a 'top down' approach to extensive and exceptional change for the current health visitor workforce, managers and leaders of the service. To this extent the implementation of a Community of Practice for health visiting required a new and radical approach across the largest county area in England with corresponding diverse population as well as size. Its focus was on developing practitioners to be influential in their leadership.

To deliver the service in Kent and Medway professional regeneration resulted in further changes at the operational level further impacting on the health visitor workforce. While these were not the subject of the CoP they did impact on not only participation but also recruitment and retention of co-researchers in the project. The profile of co-researchers was a mixture of Band 6 and 7 health visitors, with a number of the Band 6 health visitors successfully achieving promotion to Band 7 during the project (Table 3). However, there is little doubt that combined with these prescribed changes, the landscape of health visitor practice and the complex demands from the population served across Kent and Medway meant contributing to this project and coping with caseload work was insurmountable. At times this affected attendance and lead to not only attrition from the sets but also commitment to the sets. There were challenges for the co-researchers who were tasked to identify a 'critical companion', a senior practitioner or manager who could support them in their leadership journey. Co-researchers struggled with this aspect of support and despite support offered by the facilitators to proposed critical companions (e.g. materials and telephone conferences) the level and tone of replies suggested inadequate leadership resources for the co-researchers on which to draw (Drea et al 2014). These factors highlight the range of organisational enablers that need to be in place for communities of practice to flourish and contribute their full potential to public health vision and direction

The CoP has therefore provided the sort of development, skills and tools and clinical leadership required in practice localities that appeared to not have previously existed. These qualities will be essential to create workplace cultures that can support major transformation in health visiting practice and innovation linked to whole systems

approaches to public health. The co-researchers have developed skills needed to create effective workplace cultures in their own teams, cultures that are open, value staff and students, learning and innovation and keeps service users and communities at its heart. This focus on workplace culture rather than organisational culture has driven the focus of one of two videos produced by co-researchers that illustrate how the tool *Claims concerns and issues* can be used with teams to not just achieve such a culture but one that grows staff too in these approaches. So, although there was a dearth of skilled critical companions and facilitators in the workplace to support the potential for transformation of co-researchers, these co-researchers are now in a position, as a small critical community, to provide this valuable support to others.

Co-researchers identified the shortcomings of the leadership within their organisations within which they worked and the action learning sets enabled them to develop strategies and formulate their own clinical leadership approach when they realised there was really only management in the service. Empowered to deliver presentations to the CEO on the work of health visitors, and contributing to meetings in ways which built on their facilitation skills the co-researchers increasingly practised a range of new skills gained from the sets. These skills encompassed using the workplace as the main resource for learning, improving and developing and developing the high support high challenge strategies essential for clinical supervision.

At times this seemed to meet opposition from a 'top down agenda' but co-researchers recognised that they needed to try and influence this and realised their leadership role and potential in this. At other times their potential for leadership was exercised to address situations they were faced with in the workplace by established colleagues who were perhaps suffering 'change overload' or newly qualified health visitors who the co-researchers were highly worried about retaining. The development of the emotional touchpoints tool (Appendix 14) captures a range of emotions enabling an open conversation with colleagues, health visitor students or clients of the service so that what matters to people can be used to inform the development of the service. This tool was therefore the subject of the second video developed with the service user. Co-researchers therefore developed skills in developing effective workplace cultures linked to growing in confidence and expertise with their clinical leadership roles.

With all these changes the project was timely in identifying with co-researchers new ways of addressing team attributes and their purpose aligned to Public Health outcomes. However, for all these challenges caseload supervision both clinical and

child protection has hitherto been the sole tool used to develop safe and effective practice. The findings of the project identified the range of distress caused to the co-researchers by change but nevertheless, the constructive process involved in the action learning sets enabled the co-researchers to develop their own resilience further within by analysing and hypothesising about their workplace cultures, and also develop strategies for enabling others. These strategies have been identified as catalytic in the link between developing own effectiveness, developing the effectiveness of others and achieving person centred safe and effective care (Manley & Titchen,2006). As building or developing professional resilience has been highlighted by the Institute of health visiting aligning this mechanism within the action learning sets could contribute to team development as well as individual professional capacity.

All of the insights and outcomes from participating in this joint endeavor contributed to the co-researchers pushing the boundaries of the CNO's 4, 5, 6 Model of practice (Bennett 2015)- a timely outcome of the project and one that shows how influential practitioners can be when supported to work together collectively for a shared purpose. In so doing the co-researchers demonstrated how they had embedded their learning and development from the action learning sets as they recognised that this model, a compilation of a number of DH central initiatives was neither going to be realised let alone achieved without making explicit the individual, team and organisational enablers and specific performance indicators expected of health visitors. By the co-researchers identifying purpose and attributes of health visitor this ultimately contributed to their understanding and expression of the enabling factors required to meet public health outcomes; how their performance could really be judged but moreover and most importantly how this could be demonstrated to have made a difference to the lives of children and families. The production of the 3-8 model is a significant output of this project (Appendix 13) and provides effective guidance to programmes developing Health Visitors as well as practitioners in their clinical leadership roles.

Health visiting does not exist alone but relies on partnership and collaboration (NMC 2004) which will be required even further in the new landscape of local authority commissioning as there will be a greater need to show financial returns on the professional investment. The health visitor links to midwifery are an historic pathway and for this reason the inclusion of a consultant midwife on the Project steering group was invaluable, but visibly absent were those from school nursing or the wider health visitor team as well as Children's Centres. The role of skill mix, a

poorly researched area in health visitor practice but on which the service has hitherto relied, to which co-researchers referred to delivering person centred care that was based on a 'team approach' with specific contributions based on individual members strengths. The Cassandra model (Leary, 2011) pilot undertaken within the CoP provides a foundation for further development of workforce tools that could be expanded to embrace a whole systems approach inclusive of others. Whilst co-researchers identified their USP as 'leading provision of services to achieve the best start with all families through building a relationship to enable a plan to be developed, delivered by team, and evaluated' (See Box 4), there is potential also for thinking around clinical systems leadership and the role consultant practitioners can play in the development and evaluation of pathways for children across the whole health economy and its evaluation (Manley et al 2016; Manley & Titchen, 2016).

Systems leadership seeks to affect change for the social good across multiple interacting and intersecting systems. It can be contrasted with leadership styles such as one which uses an organisation based on direct, positional authority (often referred to as a 'command and control' style) or transactional approaches, which are held to be less effective in the circumstances most public service leaders now face, which are better addressed through non-linear, emergent, systems leadership approaches (NHS Academy Leadership 2015)

Such consultant posts could build on the strengths of the health visitor role which requires them to develop and sustain relationships with other professionals to achieve Public Health outcomes for example, with midwives, general practitioners school nurses and social workers, because services are more efficient when co-operate and collaborate and ultimately integrate for the benefit of the service users (Machin and Pearson 2013).

Disseminating and sharing the benefits of the CoP was a focus of several activities, which led to the realisation that more tangible outputs such as videos and interactive webpages as well as social media would all have a part to play over the longer term. The need for occasional face to face meetings for the purposes maintaining commitment was recognised, sustaining a network for clinical supervision, fostering innovation and celebrating achievements was important. Growing this commitment was recognised as essential by co-researchers to sustain the CoP in a direction that complemented other electronic initiatives yet grew and maintained a passion for health visiting locally.

Understanding the factors and strategies that influence the successful implementation of communities of practice is important to others who may be involved in similar initiatives. Whilst the internal and external factors have been identified, this provides insights about how to enable CoPs to be successful. It is important that CoPs are successful because they have the potential to achieve three important outcomes towards transforming health care. Each has been demonstrated in this project. The CoP has impact on:

1. how health visitors develop their full individual potential as practitioners, their sense of confidence and wellbeing, sustaining their passion for practice, helping them to flourish through the peer support, networking and acquiring the critical and facilitation skills required to be effective and demonstrate impact. Practitioners that fulfil these criteria have a positive impact on the quality of care experienced by service users but moreover are more likely to be retained in the workforce (Maben, Latter and Clark 2007).
2. team effectiveness through team leaders possessing the facilitation, practice development and clinical leadership skills that the CoP focuses on developing and using these with their teams. This skillset has been identified as the catalyst through which individuals develop their own effectiveness and enable the effectiveness of others, subsequently impacting on whether care is experienced as person centred, safe and effective by service users (Manley & Titchen 2016).
3. transforming future healthcare, bringing their passion, values and expertise to shape and influence health care provision collectively through influencing local and national strategic direction from collaboratively developing their own practice, their clinical leadership role, as well as their ability to evaluate and demonstrate their effectiveness and impact. Practitioners with this expertise will be able to optimise their impact across whole systems through future clinical systems leadership roles (Manley et al, 2016).

Limitations

There were limitations to the programme from the commencement of the sets, the slow and ultimately under recruitment of co-researchers, the time involved through to outputs. While flexibility by everyone involved was essential in achieving as much as we did, some of the competing demands co-researchers were experiencing and the

response to dissemination of the project required ongoing review to the original plans.

It must be recognised that while an e-CoP has much to offer professional groups for example developing knowledge and information e-CoPs will never be the whole answer to professional and practice development. The leadership skills required to facilitate groups and teams so that information can be used to drive evidence based practice are best developed within safe enabling and empowering environments which action learning(Mc Gill & Beaty 2001) and active learning (Dewing 2008) have demonstrable outcomes on person centred care. However, action learning requires sufficient time and the sessions were limited to half day as agreed to by managers in both organisations – with hindsight a full day would have been beneficial.

Co-researchers experienced limited responses to their call for a critical companion as there was inadequate availability of senior practitioners or those leading the service with these skills. The programme has now developed a number of practitioners with these leadership and facilitation skills who are currently employed at Band 7 suggesting an overwhelming need to develop a stronger foundation in practice development and leadership skills at Band 8 and above, particularly linked with clinical systems leadership.

Co-researchers were supported to develop 360 degree feedback mechanisms and peer review in their workplace. The co-researchers struggled to complete this activity although where they did they felt it was a useful exercise. This response seemed at odds with the organisations' strategy on 360 feedback especially as it has become part of the appraisal process locally but it may be concluded that the project coincided with change that was yet to be embedded.

As with all activities of the sets these were designed and adapted to enable growth in leadership and practice development skills, using the workplace as the main resource for learning, development and improvement. Likewise the piloting of the Cassandra tool on which the co-researchers worked on in the sets and were charged with returning to the workplace and trial by collecting information; back in the workplace only a few co-researchers were able to reflect the reality their practice and collect data. This situation combined with those described earlier was indicative of poor organisational readiness; one that was conducive to learning and change to by partaking in this type of project. Yet the potential for the tool to be useful in understanding the work and workforce implications of health visiting is a developmental opportunity that needs to be built on..

There was only one co-researcher in each action learning set who had the role of PT and as an underutilised resource in the workplace the CoP project would have enabled wider dissemination of the practice development skills if more PTs had been involved. However, it has to be recognised during this period student numbers were at their peak and PTs were primarily required to manage the learning of students in the workplace. Nevertheless, PTs are required to be at the forefront of student learning in practice and are in need of development to ensure their full potential in the workplace is realised for the potential of all.

With these limitations emerging through the project the lead facilitators tried to adapt and modify aspects of the project commensurate to organisational and individual circumstances as well as working with service leads. The Steering Group recruited a number of local and national experts to feedback on the project and act as critical companions and to advise on the progress and limitations in the project offering suggestions from their own experience.

6. Conclusion

The CoP project was commenced during a period of unprecedented local and national change in health and local authority organisations, with this felt and experienced in the workplace by a range of health visitor practitioners, and service managers. Although originally supported as an initiative by health visitor managers there was poor understanding among them of what the project could achieve let alone how it could contribute to their organisation objectives at this time and in the future. The ability of the managers to enable whole day attendance limited the progress of the co-researchers placing unnecessary pressure on their learning and development in the action learning sets, although the reason for this was understood. Despite this the work of the co-researchers which led to the development of a nationally recognised tool the 3-8 Model (Appendix 13) and set the foundation for some key understanding of enablers as well as outcomes the dissemination of this needs to be undertaken with a wider audience through the development of a 'accessible microsite'.

Whilst the work context itself was out of the control of the project facilitators, it is vital that employers recognise that communities of practice and the development of health visiting practice is an invaluable resource that will contribute to both workforce and service transformation. This is achieved through growing effective leaders and practitioners who can contribute creative and innovative approaches and effective workplace cultures to meet the challenges of increasing demand and complexity in

service need. The facilitation skills co-researchers developed in leading effective meetings using the Claims, Concerns and Issues model (Guba and Lincoln 1984) have been captured on a professional short video clip for wider dissemination.

This implementation and evaluation of a CoP for health visiting has demonstrated impact on how Health Visitors develop their full individual potential as practitioners; the relationship between practitioner effectiveness and team effectiveness through clinical leadership; and, the contribution that practitioners can make to transforming future healthcare. The models used and the insights resulting from this project will be useful to inform the establishment of communities of practice in other specialisms as well as sustaining more formal practitioner development and networking opportunities that complement e-communities. Evaluating service delivery through the use of Emotional Touchpoints (Dewar 2007), a tool which can be used with users of the health visiting services as well as with teams and practitioners. In the latter form, this provides opportunities to address with individuals, the emotional culture of teams. From this project, co-researchers have been enabled to develop a short video clip and resources to demonstrate the effective use of the tool.

7. Recommendations

7.1. Health Education, Kent, Surrey and Sussex

- *The outputs (videos and interactive web page) from the Community of Practice are shared and promoted widely with all sectors to help others develop effective workplace cultures that use the workplace as the main resource for learning*
- *Promote the and use emotional touchpoints as a resource that helps to focus on what matters to people be that service users, staff or students*
- *Attend to the need to develop clinical leaders and also clinical systems leaders across the health economy that draws on the expertise that heath visiting has to offer, especially as health visiting is supporting children, their parents and families as the citizens of the future.*

7.2. Commissioners

- *Commission services that promote whole systems approaches for children and their families across the health economy that draws on the expertise that Health Visitors have in understanding both the needs of children, their parents and families but also public health*
- *Explore how clinical systems leaders can be established with the pre-requisite, clinical credibility, leadership; learning and consultancy expertise (Consultant Health Visitors) needed to lead the development of integrated pathways across all sectors via joint appointment across health and social care.*
- *Ensure that service providers commissioned are committed to growing and developing a strong staff foundation of clinical leaders, who can*
 - *create effective workplace cultures that are person centred, safe and effective*
 - *have the skills to evaluate effectiveness and use the workplace as the main resource for an integrated approach to learning, development, improvement, inquiry and innovation as well as knowledge translation*
 - *Use the 3-8 model of health visiting to attend to the enablers, performance indicators and outcomes of health visiting*

7.3 Health Service Providers

- *To invest in the quality of health visitor clinical leadership across all localities as a priority to enable the service to deliver on the outcomes it aspires to achieve and the transformation needed*
- *Future programme initiatives secure strong management support, are dovetailed with other initiatives being introduced and commit to the value addedness of investing a full day rather than half a day in particularly where travelling is involved for co-researchers*
- *To grow further, the quality of workplace preceptors, critical companions and practice educators to ensure they have the full skills required to facilitate and integrated approach to learning, development, improvement, inquiry, innovation and knowledge translation in the workplace – using the workplace as the main resource*

- *To draw on the expertise of health visitors who have participated in the CoP to facilitate and develop effective teams and workplace cultures in localities across the region as well as enabling them to lead the development of health visiting practice and innovation to inform service transformation*
- *To embed the use of emotional touchpoints that provide rich qualitative data about what matters to people be that service users, staff or students that complement more quantitative data and drive continuous improvement*
- *To integrate the videos produced from the CoP into learning and development programmes*

7.4. Educationalists involved with continuing professional development of Health Visitors as well as programmes leading to registration with the Nursing and Midwifery Council

- *To embed the use of emotional touchpoints with students and practice teachers as a learning tool providing rich qualitative data about what matters to people be that service users, staff or students that complement more quantitative data and drive continuous improvement*
- *To integrate opportunities to explore systems leadership within the teaching and learning programme at registrant level as well as for those practitioners progressing in their career to practice teacher*
- *Embed action and active learning (Dewing 2008) in continuing professional development as well as programme modules such as leadership and research but also in 'practice hub learning'*

7.5 Health Visitors in Kent and Medway

- *Value, use and build on the resource and investment made to health visitors participating in the CoP as critical companions and clinical supervisors as well as skilled facilitators of effective teams*

- *Sustain the CoP across Kent and Medway so as to create a vibrant testbed and network for health visiting practice through organising 6 monthly face to face meetings to complement the health visitor e-CoP focussing on regional practice*

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Whittaker, K., Grigulis, A., Hughes, J., Cowley, S., Morrow, E., Nicholson, C., Malone, M. and Maben, J. (2013) *Start and Stay: The Recruitment and Retention of Health Visitors*. National Nursing Research Unit, London Accessed July 2013) Available at <http://www.kcl.ac.uk/nursing/research/nnru/publications/index.aspx>

9. APPENDICES

Appendix 1: Terms of Reference for Steering group



**Implementation and Evaluation of Communities of Practice
(Health Visiting)
Kent and Medway
March 2014- September 2015**

**Steering group
Terms of Reference**

Main Purpose:

To act as a steering group of key stakeholders to support the action related practice development project and provide a range of perspectives that will support the achievement of the project's aims and provide systematic challenge and critique

Frequency of Meetings:

27th February 2014 Steering Group 1 2-4pm Hall Place or teleconference
1st October 2014 Steering Group 2 2-4pm Hall Place or teleconference
26th March 2015 Steering Group 3 2-4pm Hall Place or teleconference

Terms of Reference:

- To review and monitor project progress
- To critique, offer feedback and expertise to the project team and co-researchers at various stages throughout the project
- To monitor and evaluate main key risks to achievement of project aims
- To monitor and evaluate key project outcomes

Invited co-researchers

Jane Butler Head of Clinical Education, Health Education Kent, Surrey and Sussex SMT KCHT & MCH(invited)

Cheryl Adams- Institute of Health Visiting (invited)

Dr. Sally Kendall University Of Hertfordshire(invited)

Judith Ward & MCH EQUIV Safeguarding Children (invited)

Kate Sanders FON (invited)

Midwifery and Childrens' Consultant nurses East Kent Hospitals Foundation Trust (invited) Stephanie Mansell, Vivenne Milbank & Madeline Harris

Linda Denne Independent Health Visitor Advisor

Mary Brown Principle Lecturer CCCU

Jane Greaves Research Fellow CoP project

Appendix 2 Literature Search Outcomes

Original Literature Search 2014

Journal of Health Visiting	Community Practitioner
<p>Baldwin, S. (January 2013) The importance of leadership development for Health Visitors Journal of Health Visiting 1(1) : 39 - 43</p>	<p>Jarrett,P;.Barlow,J.(Feb2014)Clinical supervision in the provision of intensive home visiting by Health Visitors Community Practitioner Volume 87 Number P32-36</p>
<p>Bailey,B.(November 2014) Health visiting research: Taking action Journal of Health Visiting › Volume 2 Issue 11</p>	
<p>Barlow, J. Coe, C. (Jan 2013) New ways of working: Promotional interviewing in health visiting practice Journal of Health Visiting 1(1) : 44 - 50</p>	
<p>Chambers, C.(June 2013) Taking a lead in compassionate care: The challenge for s in responding to the six Cs Journal of Health Visiting Volume 1 Issue 6</p>	
<p>Ebeid, A (May 2013) Facilitating Health Visitors' learning and normative practice Journal of Health Visiting 1(5) : 297 - 300)</p>	
<p>Machin, A. Pearson, P (Jan 2013) Health Visitors' interprofessional working experiences: Implications for their collaborative public health role Journal of Health Visiting 1(1) : 31 - 38</p>	
<p>Seal, J. (April2013)Exploring perceptions of listening, empathy and summarising in the Health Visitor–parent relationship Journal of Health Visiting › Volume 1 Issue 4 p226-232</p>	

Updated literature review July – November 2015

Journal of Health Visiting	Community Practitioner
Bailey B (November 2014) Health visiting research: Taking action <i>Journal of Health Visiting</i> Volume 2 Issue 11	Burchill,J.; Pevalin,D.:(July 2012) Barriers to effective practice for health visitors working with asylum seekers and refugees <i>Community Practitioner</i> , 2012; 85(7): 20–23.
Bishop,P. Gilroy, V. (2015) Maintaining and developing prescribing practice: Non-medical prescribing by s in 2015 <i>Journal of Health Visiting</i> Volume 3 Issue 6 pp 328-335	Drea, C.; Lumsden,V; Bourne, J.(2014)Using practitioners' feedback to contribute to organisational development in health visiting <i>Community Practitioner</i> 87(12): 30–33
Halonen,H.(2015)Greater wellbeing for migrant families <i>Journal of Health Visiting</i> Volume 3 Issue 3	Haydock,J.; Evers, J.; (June2014) Enhancing practice teachers' knowledge and skills using collaborative action learning sets <i>Community Practitioner</i> 87(6): 24–28.
Lawrence, D.; (February 2014) Working with refugees and asylum seekers: The role of the health visitor <i>Journal of Health Visiting</i> February 2014 Volume 2 Issue 2	Richards,J.;Kliner,M.;Brierly,S.;Stroud,L; (September 2014) Maternal and infant health of Eastern Europeans in Bradford, UK: a qualitative study Volume 87 Number 9 <i>Community Practitioner</i> er 4
Hollingshead,J.;Stirling,L.; Kerr,P;Massey, D.:(April 2015)Developing a successful community of practice to improve service delivery <i>Journal of Health Visiting</i> Volume 3 Issue 4	Swift,L.(April 2014) Online communities of practice and their role in educational development: a systematic appraisal <i>Community Practitioner</i> Volume 87 Numb
Murphy,M .(November 2014) The crucial role of compassionate resilience Editorial <i>Journal of Health Visiting</i> Volume 2 Issue 11	Teshome Tesfaye, H. Day,J.(January 2015) Health visitors' perceptions of barriers to health and wellbeing in European migrant families <i>Community Practitioner</i> 2015; 88(1): 22–25
Oshikanlu R (Mach 2015) What is your purpose at work? <i>Journal of Health Visiting</i> Volume 3 Issue 3	
Sherry, M.; Baldwin ,S; Trish Kelly, (July 2015) Health visiting hub: One year on <i>Journal of Health Visiting</i> Volume 3 Issue 4	
Other journals	
Brook, J; Salmon,D.; (2015) A qualitative study exploring parental perspectives and involvement in health visiting services during the Health Visitor Implementation Plan in the South West of England <i>Health and Social Care in the Community</i> doi: 10.1111/hsc.12308	Hogg, R. de Kok,B.; Netto,G.; Hanley,J.; & Haycock-Stuart,E.:(2015)Supporting Pakistani and Chinese families with young children: perspectives of mothers and health visitors <i>Child: care, health and development</i> , 41, 3, 416–423

Appendix 3: Guide to the Early Years Profiles

Supporting interpretation and use of early years profiles data March 2014

Health Indicators	Impact of effective early years services
Under 18 conceptions*	Can be reduced by, for example, health visitors supporting teenage mothers to take up contraception and avoid future pregnancies
Infant mortality#	Can be improved through antenatal work with mothers to support quitting smoking and substance misuse and maintaining a healthy weight.
Low birth weight of term babies*	
Smoking status at time of delivery*	
Breastfeeding (prevalence at 6-8 weeks)*	Can be improved by antenatal support and by early identification and responsiveness to a mother's concerns.
Vaccination coverage*	Can be improved by outreach to parents who do not take up vaccination.
Child development at 2-2 ½ years* (placeholder)	Can be improved through delivery of evidence-based parenting programmes and through close working with children centres and local authority early years teams.
School readiness*	
Excess weight at 4-5 years*	
Tooth decay in children age 5*	Can be improved through encouraging breastfeeding and healthy weaning in line with the guidelines, as well as healthy family nutrition.

Appendix 4: Six High Impact Priority Areas for HV Public Health Outcomes (DH 2013c) and Linked to Healthy Child Programme (DH 2009)

Six High Impact Priority Areas for Health Visiting Public Health Outcomes		Details
1.	Transition to parenthood and the early weeks	Including early attachment and development
2.	Maternal mental health (PND)	Assessing maternal mental health according to NICE guidance
3.	Breastfeeding	initiation and duration
4.	Healthy weight	to include nutrition and physical activity
5.	Health and wellbeing at 2 years of age	development of the child two year old review (integrated review) and support to be 'ready for school')
6.	Managing minor illness and reducing accidents	(reducing hospital attendance and admissions)

Appendix 5: The 4,5,6 model situated within a range of organisational taxonomies in health visiting



Appendix 6 Ethics governance paperwork submitted and approved



27 January 2014

Ref: 14/H&SC/CL71

Mrs Jane Greaves
Department of Nursing and Applied Clinical Studies
Faculty of Health and Social Care

Dear Jane

Confirmation of compliance for your study "Implementation and evaluation of Communities of Practice (Health Visiting) Kent and Medway."

I have received an Ethics Review Checklist for proportionate review of the above project. Because you have answered "No" to all of the questions in Section B, and have submitted appropriate supporting documentation, no further ethical review will be required under the terms of this University's Research Ethics and Governance Procedures.

In confirming compliance for your study, I must remind you that it is your responsibility to follow, as appropriate, the policies and procedures set out in the *Research Governance Handbook* (<http://www.canterbury.ac.uk/Research/GovernanceandEthics/GovernanceAndEthics.aspx>) and any relevant academic or professional guidelines. This includes providing, if appropriate, information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct of the study over its course should be notified to the **Research Office**, and may require a new application for ethics approval. [You are also required to inform me once your research has been completed.](#)

Wishing you every success with your research.

Yours sincerely

A handwritten signature in black ink that reads "Roger Bone".

Roger Bone
Research Governance Manager
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Email: roger.bone@canterbury.ac.uk

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Received:

ETHICS REVIEW CHECKLIST

Sections A and B of this checklist must be completed for every research or knowledge transfer project that involves human or animal¹ co-researchers. These sections serve as a toolkit that will identify whether a full application for ethics approval needs to be submitted.

If the toolkit shows that there is **no need for a full ethical review**, Sections D, E and F should be completed and the checklist forwarded to the Research Governance Manager as described in Section C.

If the toolkit shows that a **full application is required**, this checklist should be set aside and an ***Application for Faculty Research Ethics Committee Approval Form*** - or an appropriate external application form - should be completed and submitted. **There is no need to complete both documents.**

Before completing this checklist, please refer to *Ethics Policy for Research Involving Human Co-researchers* in the University Research Governance Handbook.

The principal researcher/project leader (or, where the principal researcher/project leader is a student, their supervisor) is responsible for exercising appropriate professional judgement in this review.

N.B. This checklist must be completed – and any resulting follow-up action taken - before potential co-researchers are approached to take part in any study.

Type of Project - please mark (x) as appropriate	
Research	Knowledge Exchange
<input checked="" type="checkbox"/>	<input type="checkbox"/>

Section A: Applicant Details

A1. Name of applicant:	Jane Greaves
A2. Status (please underline):	Staff Member
A3. Email address:	Jane.greaves@canterbury.ac.uk
A4. Contact address:	CCCU EG40 ,North Holmes Road, Canterbury . Kent CT1 1QU
A5. Telephone number	01227782343

Section B: Ethics Checklist

Please answer each question by marking (X) in the appropriate box:

		Yes	No
1.	Does the study involve co-researchers who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning disabilities), or in unequal relationships (e.g. people in prison, your own staff or students)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	Will the study require the co-operation of a gatekeeper for initial access to the vulnerable groups or individuals to be recruited (e.g. students at school, members of self-help groups, residents of nursing home)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	Will it be necessary for co-researchers to take part in the study without usual informed consent procedures having been implemented in advance (e.g. covert observation, certain ethnographic studies)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	Will the study use deliberate deception (this does not include randomly assigning co-researchers to groups in an experimental design)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	Will the study involve discussion of, or collection of information on, sensitive topics (e.g. sexual activity, drug use)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to human or animal co-researchers?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	Does the study involve invasive or intrusive procedures such as blood taking or muscle biopsy from human or animal co-researchers?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	Is physiological stress, pain, or more than mild discomfort to humans or animals likely to result from the study?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	Could the study induce psychological stress or anxiety or cause harm or negative consequences in humans (including the researcher) or animals beyond the risks encountered in normal life?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	Will the study involve interaction with animals? (If you are simply observing them - e.g. in a zoo or in their natural habitat - without having any contact at all, you can answer "No")	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11.	Will the study involve prolonged or repetitive testing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12.	Will financial inducements (other than reasonable expenses and compensation for time) be offered to co-researchers?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13.	Is the study a survey that involves University-wide recruitment of students from Canterbury Christ Church University?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14.	Will the study involve recruitment of adult co-researchers (aged 16 and over) who are unable to make decisions for themselves, i.e. lack capacity, and come under the jurisdiction of the Mental Capacity Act (2005)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15.	Will the study involve recruitment of co-researchers (excluding staff) through the NHS or the Department of Social Services of a Local Authority (e.g. Kent County Council)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Now please assess outcomes and actions by referring to Section C →

Section C: How to Proceed

C1. If you have answered 'NO' to *all* the questions in Section B, you should complete Sections D–F as appropriate and send the completed and signed Checklist to the Research Governance Manager in the Research Office for the record. **That is all you need to do.** You will receive a letter confirming compliance with University Research Governance procedures.

[Master's students should retain copies of the form and letter; the letter should be submitted with their research report or dissertation (bound in at the beginning). Work that is submitted without this document will be returned un-assessed.]

C2. If you have answered 'YES' to *any* of the questions in Section B, you will need to describe more fully how you plan to deal with the ethical issues raised by your project. This does not mean that you cannot do the study, only that your proposal will need to be approved by a Research Ethics Committee. **Depending upon which questions you answered 'YES' to, you should proceed as follows**

(a) If you answered 'YES' to any of **questions 1 – 12 ONLY** (i.e. not questions 13,14 or 15), you will have to submit an application to your Faculty Research Ethics

Committee (FREC) using your Faculty's version of the ***Application for Faculty Research Ethics Committee Approval Form***. This should be submitted as directed on the form. The *Application for Faculty Research Ethics Committee Approval Form* can be obtained from the Governance and Ethics pages of the Research section on the University web site.

(b) If you answered 'YES' to **question 13** you have two options:

(i) If you answered 'YES' to **question 13 ONLY** you must send copies of this checklist to the Student Survey Unit. Subject to their approval you may then proceed as at C1 above.

(ii) If you answered 'YES' to **question 13 PLUS any other of questions 1 – 12**, you must proceed as at C2(b)(i) above and then submit an application to your Faculty Research Ethics Committee (FREC) as at C2(a).

(c) If you answered 'YES' to **question 14** you do not need to submit an application to your Faculty Research Ethics Committee. **INSTEAD**, you **must** submit an application to the appropriate external NHS Research Ethics Committee [see C2(d) below].

(d) If you answered 'YES' to **question 15** you do not need to submit an application to your Faculty Research Ethics Committee. **INSTEAD**, you must submit an application to the appropriate external NHS Research Ethics Committee (REC) or Local Authority REC, *after* your proposal has received a satisfactory Peer Review (see *Research Governance Handbook*). Applications to an NHS REC or a Local Authority REC **must** be signed by the appropriate Faculty Director of Research or Faculty representative before they are submitted.

IMPORTANT

Please note that it is your responsibility in the conduct of your study to follow the policies and procedures set out in the University's Research Governance Handbook, and any relevant academic or professional guidelines. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct over the course of the study should be notified to the **Faculty and/or**

other Research Ethics Committee that received your original proposal. Depending on the nature of the changes, a new application for ethics approval may be required.

Section D: Project Details

D1. Project title:	<p>Implementation and Evaluation of Communities of Practice (Health Visiting) Kent and Medway</p> <p><i>A Community of Practice consists of a group of professionals who engage in individual and collective learning to improve the health outcomes. This project follows two successful events (February 2013) with 150 Health Visitor practitioners involved in developing an initial direction for their Community of Practice as part of professional regeneration (DH 2011).</i></p>
D2. Start date	March 2014
D3. End date	September 2015
<p>D4. Lay summary (max 300 words <i>which must include a brief description of the methodology to be used for gathering your data</i>)</p>	<p>This project aims to enable <i>Health Visitor</i> practitioners develop communities of practice.</p> <p>Two related and interdependent approaches guide the project: action research and practice development.</p> <p>Action research is change orientated focussing on practical problems experienced by practitioners (Lewin 1947). It aims to simultaneously develop practitioners, practice and develop or refine existing theory.</p> <p>The facilitators of the project will be the two project leaders who will work collaboratively with two active (Dewing 2008) learning sets and 20 Health Visitors (the co-researchers) over 12 months to develop expertise in clinical leadership and practice development. In turn, the co-researchers will work with their respective teams and stakeholders across their localities to develop communities of practice.</p> <p>Action research and practice development are selected because they focus on practical action in the workplace that is systematically implemented and evaluated. Practice development's purpose reflects the key values driving contemporary health care culture – person-centeredness, patient safety and effective care. In addition, the processes linked to both approaches mirror the development of effective person-centred workplace cultures (Manley et al, 2011).</p> <p>Three methods will be used to support the 20 Health Visitors Senior Health Visitors practitioners: active learning (Dewing 2008), action learning (McGill & Beaty 2001) and critical companionship (Titchen 2000). Two active learning sets will be established comprising twelve x 3 hour monthly sessions run in two venues within Kent and Medway, facilitated by the project facilitators. A critical companion will also be identified for each participant to help co-researchers on an individual basis. Critical companionship is a helping relationship to assist with learning. Critical companions in turn will be supported through regular telephone conferences.</p> <p>Data will be generated from action spirals; e.g.; sources of data in action research (after Winter 1989; Waterman 1995; Stringer 1999) may include:</p> <p><i>Structured reflections, diary keeping, Participant observation field notes, Interviews (unstructured or semi-structured), Questionnaires/tools, Documents e.g. memos, minutes, records, official reports, policy statements, plans, evaluation reports, press accounts, public relations materials, information statements, newsletters</i></p>

Section E1: For Students Only

E1. Module name and number or course and Department:	
E2. Name of Supervisor or module leader	
E3. Email address of Supervisor or Module leader	
E4. Contact address:	

Section E2: For Supervisors

Please tick the appropriate boxes. The study should not begin until all boxes are ticked:

The student has read the relevant sections of the University's Research Governance Handbook, available on University Research web pages at: http://www.canterbury.ac.uk/research/governance/index.asp	<input type="checkbox"/>
The topic merits further investigation	<input type="checkbox"/>
The student has the skills to carry out the study	<input type="checkbox"/>
The participant information sheet or leaflet is appropriate	<input type="checkbox"/>
The procedures for recruitment and obtaining informed consent are appropriate	<input type="checkbox"/>
If a CRB/VBS check is required, this has been carried out	<input type="checkbox"/>
Comments from supervisor:	

Section F: Signatures

- I certify that the information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I certify that a risk assessment for this study has been carried out in compliance with the University's Health and Safety policy.
- I certify that any required CRB/VBS check has been carried out.
- I undertake to carry out this project under the terms specified in the Canterbury Christ Church University Research Governance Handbook.
- I undertake to inform the relevant Faculty Research Ethics Committee of any significant change in the question, design or conduct of the study over the

course of the study. I understand that such changes may require a new application for ethics approval.

- I undertake to inform the Research Governance Manager in the Graduate School and Research Office when the proposed study has been completed.
- I am aware of my responsibility to comply with the requirements of the law and appropriate University guidelines relating to the security and confidentiality of participant or other personal data.
- I understand that project records/data may be subject to inspection for audit purposes if required in future and that project records should be kept securely for five years or other specified period.
- I understand that the personal data about me contained in this application will be held by the Research Office and that this will be managed according to the principles established in the Data Protection Act.

Principal Investigator	Supervisor or module leader (as appropriate)
Name:	Name:
Date:	Date:

Section G: Submission

This form should be returned, as an attachment to a covering email, to the Research Governance Manager at roger.bone@canterbury.ac.uk

N.B. YOU MUST include copies of the Participant Information Sheet and Consent Form that you will be using in your study (Model versions on which to base these are appended to this checklist for your convenience). Also copies of any data gathering tools such as questionnaires.

Providing the covering email is from a verifiable address, there is no longer a need to submit a signed hard copy version.

Communities of Practice Health Visitors CONSENT FORM

Title of Project: Implementation and Evaluation of Communities of Practice (Health Visiting) in Kent and Medway

Name of Researcher: Kim Manley and Jane Greaves

Contact details:

Address:

Tel:

Email:

Please

initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that any personal information that I provide to the researchers will be kept strictly confidential
4. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Copies: 1 for participant
1 for researcher

TITLE OF RESEARCH PROJECT

COMMUNITY OF PRACTICE (HV) IMPLEMENTATION AND EVALUATION ACROSS KENT & MEDWAY: An action research project

PARTICIPANT INFORMATION SHEET

What is the project about?

Following the successful launch of the community of practice for health visitors across Kent & Medway, practitioners were enthusiastic about taking this concept forward. This project therefore aims to embed the community of practice concept into everyday practice across all localities in Kent and Medway. This will be done by helping experienced health visitors inquire into, evaluate and develop their practice both individually and collectively, as well as demonstrating their contribution to service users, community and public health outcomes.

The project will be facilitated by Jane Greaves and Kim Manley of Canterbury Christ Church University (CCCU) and commences in March 2014

What will the project involve?

Experienced health visitors will be invited to attend a year long programme comprising monthly three-hour active and action learning sessions. In these sessions health visitors will become co-researchers of their own individual and collective practice and at the same time they will acquire skills in practice development and clinical leadership. Co-researchers will be helped by project facilitators and dedicated critical companions to use their own practice and workplace as the main resource for learning, development and inquiry so as to achieve:

better outcomes for patients, public health and families,

better placements for students

a vibrant and dynamic health visitor culture and workforce

transformation of care and services that are person-centred, safe and effective

What will I be required to do?

In the project you would be involved in a number of practice-related activities that include:

reflecting on your practice as a health visitor and clinical leader, individually, with your critical companion, as well as, collectively in the sessions, then taking back your learning to your team and workplace

using practice development tools to gather information and insights about your practice and its impact on service users, colleagues and students

analysing and identifying new insights about HV practice in relation to achieving better outcomes for service users, colleagues and staff and gathered these into a portfolio of evidence

What are the criteria for participating in the action research project?

There are four criteria, you:

voluntarily apply to participate and therefore would sign a consent form that would be based on your willingness to participate in the project, your willingness to attend the 12 sessions and your agreement that data emerging from the study could be used anonymised in reports and publications. This consent will be an on-going process throughout the project and so you can decide at any time to withdraw from the project and also have your data withdrawn

have discussed the project with your line manager and they are willing to support you both in attending the 12 sessions and undertaking work related activities related to the project

are a HV practitioner of at least 3 years post qualification Band 6 or Band 7

are prepared to undertake activities to develop practice as part of the co-researcher role e.g participant observation, field notes, structured reflections and diary keeping

What dates are the sessions to be held and where?

The dates are provided separately for 2 different cohorts at two different venues. One cohort will be held at Canterbury Christ Church University Medway Campus

and the other at the Canterbury campus. Travelling expenses will be reimbursed for standard travel costs by car or public transport.

What will you do if the project is oversubscribed?

There are 20 places available in two cohorts. The project team will need to ensure that every locality is represented overall. If there is more than one person applying per locality and all the criteria are met by each applicant then, one person would be randomly selected and the remaining co-researchers would be logged on a waiting list.

How will data and personal data be stored?

All data and personal information will be stored securely within CCCU premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by the Principle Investigator Kim Manley and the Research Fellow Jane Greaves. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

How will the project be monitored and disseminated?

A Steering Group will be established and comprised of local managers, national experts in the field and service users. The project team and facilitators will be accountable to the steering group which will meet four times across the project period. The project is funded by HEE/KSS and a final report will be available in a range of different formats for dissemination in September 2015. A number of collaborative presentations and publications by co-researchers would also be anticipated

Deciding whether to participate?

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact either.

Jane Greaves, Research Fellow email: jane.greaves@canterbury.ac.uk or telephone 01227782343

Kim Manley, Principle Investigator email: kim.manley@ekht.nhs.uk

Should you decide to participate, you will need to complete a brief expression of interest form but will be free to withdraw at any time without having to give a reason.

Appendix 7: Application flyers for recruitment and application for set 1&2

Faculty of
Health and Social Care

Communities of Practice: Health Visiting

Implementation & Evaluation: Communities of Practice in Health Visiting

Calling Registered Health Visitors in Kent & Medway

[We have very few places left for the first Action Learning Set now commencing 26th March](#)

Following the successful launch of the Community of Practice for Health Visitors across Kent & Medway, practitioners were enthusiastic about taking this concept forward. This project therefore aims to embed the community of practice concept into everyday practice across all localities in Kent and Medway. This will be done by helping experienced Health Visitors inquire into, evaluate and develop their practice both individually and collectively, as well as demonstrating their contribution to service users, community and public health outcomes.

- ✓ Are you a Health Visitor who has been qualified for a minimum of 2 years?
- ✓ Are you interested in developing HV practice for effective service delivery?
- ✓ Would you like to participate in an Action & Active Learning Set over 12 months?

**If your answer is YES to these questions then
Please consider applying to participate in this research project**

Benefits of Participating:

- ✓ Develop a Portfolio that can contribute to Level 6 or Level 7 Masters credits as well as NMC revalidation
- ✓ better outcomes for patients, public health and families
- ✓ better placements for students
- ✓ a vibrant and dynamic health visitor culture and workforce
- ✓ transformation of care and services that are person-centred, safe and effective

Next Steps:

- Can you attend all the following dates in the morning for 3 hours?
- Complete the attached application form and have it signed by your Line Manager

Action learning sets cohort 1 Hall Place Canterbury: Thursday

1.	26 th March 2014*Weds
2.	15 th May 2014
3.	12 th June 2014
4.	17 th July 2014
5.	18 th September 2014
6.	16 th October 2014

7.	13 th November 2014
8.	4 th December 2014
9.	15 th January 2015
10.	5 th February 2015
11.	5 th March 2015
12.	19 th March 2015

e: postregandfd-healthadmin@canterbury.ac.uk t: 01227 782 418
www.canterbury.ac.uk/health
Canterbury Christ Church University, North Holmes Road, Canterbury, Kent CT1 1QU



Communities of Practice: Health Visiting

Implementation & Evaluation: Communities of Practice in Health Visiting

For further information please contact Jane Greaves at jane.greaves@canterbury.ac.uk or on 01227782343 or Kim Manley at kim.manley@ekht.nhs.uk

To apply to take part please complete the below application form and send to your Locality Manager for consideration by 21st February 2014. Please also send a copy to health.visiting@canterbury.ac.uk

Title and full name			
Locality Line Manager Name & signature			
Contact email			
Contact telephone number/s			
Professional qualifications			
Date of registration as a Health Visitor			
Do you have a minimum of two years' experience as a Health Visitor?	(Please tick)	Are you employed at Band 6 or 7?	(Please tick)
Applicant Signature: _____		Date: ___/___/___	

e: postregandfd.healthadmin@canterbury.ac.uk t: 01227 782 418
www.canterbury.ac.uk/health
 Canterbury Christ Church University, North Holmes Road, Canterbury, Kent CT1 1QU



Communities of Practice: Health Visiting

Implementation & Evaluation: Communities of Practice in Health Visiting

Calling Registered Health Visitors in Kent & Medway

Following the successful launch of the Community of Practice for Health Visitors across Kent & Medway, practitioners were enthusiastic about taking this concept forward. This project therefore aims to embed the community of practice concept into everyday practice across all localities in Kent and Medway. This will be done by helping experienced Health Visitors inquire into, evaluate and develop their practice both individually and collectively, as well as demonstrating their contribution to service users, community and public health outcomes.

- ✓ Are you a Health Visitor who has been qualified for a minimum of 2 years?
- ✓ Are you interested in developing HV practice for effective service delivery?
- ✓ Would you like to participate in an Action & Active Learning Set over 12 months?

**If your answer is YES to these questions then
Please consider applying to participate in this research project**

Benefits of Participating:

- ✓ **Develop a Portfolio that can contribute to Level 6 or Level 7 Masters credits as well as NMC revalidation**
- ✓ better outcomes for patients, public health and families
- ✓ better placements for students
- ✓ a vibrant and dynamic health visitor culture and workforce
- ✓ transformation of care and services that are person-centred, safe and effective

Next Steps:

- Can you attend all the following dates in the morning for 3 hours?
- Complete the attached application form and have it signed by your Line Manager

Action learning sets cohort 2 Hall Place Canterbury. 0900 - 1300 Wednesday

1.	1 st October 2014	7.	25 th March 2015
2.	15 th October 2014	8.	22 nd April 2015
3.	19 th November 2014	9.	20 th May 2015
4.	17 th December	10.	17 th June 2015
5.	28 th January 2015	11.	15 th July 2015
6.	25 th February 2015	12.	23 rd September 2015

e: postregandfd.healthadmin@canterbury.ac.uk t: 01227 782 418

www.canterbury.ac.uk/health

Canterbury Christ Church University, North Holmes Road, Canterbury, Kent CT11 1QU



Communities of Practice: Health Visiting

Implementation & Evaluation: Communities of Practice in Health Visiting

For further information please contact Jane Greaves at jane.greaves@canterbury.ac.uk or on 01227782343 or Kim Manley at kim.manley@ekht.nhs.uk

To apply to take part please complete the below application form and send to your Locality Manager for consideration by 15th September 2014. Please also send a copy to health.visiting@canterbury.ac.uk

Title and full name			
Locality Line Manager Name & signature			
Contact email			
Contact telephone number/s			
Professional qualifications			
Date of registration as a Health Visitor			
Do you have a minimum of two years' experience as a Health Visitor?	(Please tick)	Are you employed at Band 6 or 7?	(Please tick)
Applicant Signature: _____		Date: ____/____/____	

e: postregandfd.healthadmin@canterbury.ac.uk t: 01227 782 418
www.canterbury.ac.uk/health
 Canterbury Christ Church University, North Holmes Road, Canterbury, Kent CT1 1QU



Appendix 8: Template to analyse applications to action learning sets with managers



Implementation & Evaluation of Communities of Practice in Health Visiting

Transparency About Criteria

Senior Health Visitor Y [] N []

Qualified for a minimum of 2 years Y [] N []

Locality

• Kent _____

• Medway _____

Qualities of Applicant

1. Ability to influence others	1	2	3	4	5
2. Potential to inspire others	1	2	3	4	5
3. Passion for Health Visiting in practice	1	2	3	4	5
4. Potential to develop/enhance	1	2	3	4	5
5. Leadership skills that can contribute to the success of the project	1	2	3	4	5

Appendix 9: Revised dates and programme for action learning sets to bring groups together

Future dates and times for the combined sessions of the Community of Practice

Please note Cohort 2 start and finish times

Please note Cohort 1 April is not viable so using May instead

ALS COHORT 2	Agreed content for Cohort 2 (25March 2015)	Dates & time	ALS Cohort 1&2		Content for joint sessions
Cohort 2 session 7	<ul style="list-style-type: none"> • Culture collage and effective workplace culture • Narrative around staff anxiety(Susan) • Revisit what is a COP? • Revisit use of Emotional touchpoints 	22 nd April 2015 9.30-1pm			
Cohort 2 Session 8	<ul style="list-style-type: none"> • Visit research themes and analyse notes 	20 th May 2015 9.30-13.30	20th May 2015 2-4pm		<ol style="list-style-type: none"> 1. Broadening the COP & exploring continuity 2. Planning masterclasses 3. Working on publications
Cohort 2 Session 9	tbc	17 th June 2015 9.30-13.30	17th June 2015 2-4pm		<ol style="list-style-type: none"> 1. Broadening the COP &exploring continuity 2. Planning masterclasses 3. Working on publications
Cohort 2 Session10	Preparing for reflective review	15 th July 2015 9.30-1pm			
Cohort 2 Session11	tbc	23 rd September 2015 9.30-13.30	23rd September 2015 2-4pm		<ol style="list-style-type: none"> 1. Broadening the COP &exploring continuity 2. Planning masterclasses 3. Working on publications

Appendix 10: Draft Shared purpose framework for health visiting practice v3

Enablers	Attributes	Consequences
<p>Individual:</p> <ul style="list-style-type: none"> • Wealth of knowledge, experience and passion • Peer Support • Willingness to engage with change • Role clarity, with a focus on delivery not role e.g 360 degree feedback <p>Team:</p> <ul style="list-style-type: none"> • Safe, supportive work culture • Effective communications system between and across teams • Management support in words and actions and expertise <p>Organisation:</p> <ul style="list-style-type: none"> • HV role is recognised within the wider public health arena and working to the national HV agenda • Adequate resources, appropriate staffing • Joined- up systems between agencies and IT support 	<p>1. Building Family²-centred relationships</p> <ul style="list-style-type: none"> • Inspiring and supporting families • Working with families in a person-centred way to improve outcomes³ • Using holistic assessment skills in partnership with families • Developing a care plan to be implemented (by team) and evaluated <p>2: Improving public health of families, parents, carers and communities</p> <ul style="list-style-type: none"> • Engaging groups and communities • Enabling health and happiness through working with groups and communities using a team approach <p>3: Improving services⁴ using evidence</p> <ul style="list-style-type: none"> • Developing partnerships and integrated ways of working with multi-agency colleagues and partners • Utilising communication and feedback with colleagues and partners • Influencing commissioners and CCGs • Networking with Health visitors, professional bodies and other partners to share best practice 	<p>Children, parents and families</p> <ul style="list-style-type: none"> • Happy, healthy families and parents, enjoying their children • Healthy children, ready for school • Best start for all children, regardless of where they are born/family culture • Better parenting <p>Team members</p> <ul style="list-style-type: none"> • Value learning and effectiveness • Flourishing culture <p>Community</p> <ul style="list-style-type: none"> • Improved public health • Improved public perception of services <p>Organisation</p> <ul style="list-style-type: none"> • Fewer calls for help – less A&E visits • Motivated staff and staff retention • Happy workforce enjoying job

² The term family encompasses children, parents, carers and external family members

³ Health outcomes encompasses physical, psychological and social health

⁴ Services encompass the provision of support to achieve the best start for children

Appendix 11 **Template for Capturing Attribute Activity v4 (Modified form Cassandra Matrix)**

NAME:

Category: Caseload Health Visitor

(Tick) HV Specialist with clinical caseload

HV Specialist without clinical caseload

DAY: 1 2 3 4 5 6 7 8 9 10 (Circle as appropriate)

HEALTH VISITING FUNCTIONS		Interventions	Context												TOTALS					
			NOT done	Home visit: first	Home visit:	Clinic	Children's centre	General practice	Council offices	Telephone:	Office	email response	Case conference/ Telephone/	MDT meeting/ response to		Urgent review (unplanned)	Support group/group	Travel & Work		
Attribute 1:	Inspiring and supporting families	• Promoting self-management																		
		• Biographical disruption (e.g. change to being a parent)																		
		• Body image/psycho-sexual (e.g. pregnancy)																		
		• Mediation of relationships/conflict resolution																		
		• Lifestyle changes & social adaption																		
		• Domestic abuse																		
		• Promoting/maintaining safety																		
	Working with families in a person-centred way to improve outcomes ⁶	• Rescue work (physical/devices/drugs/i atrogenic)																		
		• Rescue work (anxiety)																		
		• Anxiety management																		
		• Supporting clinical choice and meeting information needs																		
		• Shared decision-making																		

⁵ The term family encompasses children, parents, carers and external family members

⁶ Health outcomes encompasses physical, psychological and social health

	<ul style="list-style-type: none"> Dealing with distress 																		
	<ul style="list-style-type: none"> Communicating significant news 																		
	<ul style="list-style-type: none"> Management of enduring mental health issues 																		
	<ul style="list-style-type: none"> Finance/benefits advice/housing 																		
Using holistic assessment skills in partnership with families	<ul style="list-style-type: none"> Physical assessment 																		
	<ul style="list-style-type: none"> Weighing, measuring, head circumference 																		
	<ul style="list-style-type: none"> Symptom assessment 																		
	<ul style="list-style-type: none"> Continence assessment 																		
	<ul style="list-style-type: none"> Observing children 																		
	<ul style="list-style-type: none"> Psychological assessment 																		
	<ul style="list-style-type: none"> Mental capacity assessment 																		
	<ul style="list-style-type: none"> Perinatal mental health 																		
	<ul style="list-style-type: none"> Social assessment 																		
	<ul style="list-style-type: none"> Health needs assessment 																		
Developing a care plan to be implemented and evaluated	<ul style="list-style-type: none"> Promoting physical activity between mother and baby 																		
	<ul style="list-style-type: none"> New infant feeding support 																		
	<ul style="list-style-type: none"> Child behaviour and management 																		
	<ul style="list-style-type: none"> Safeguarding 																		
	<ul style="list-style-type: none"> Prescribing medication 																		
	<ul style="list-style-type: none"> Requesting/recommending medications 																		
	<ul style="list-style-type: none"> Medicines education (client) 																		
	<ul style="list-style-type: none"> Referring for investigations/assessment/therapy 																		
	<ul style="list-style-type: none"> Review results and act on these e.g A&E 																		
	<ul style="list-style-type: none"> Continence promotion/management 																		

		<ul style="list-style-type: none"> Advanced care planning – end of life 																	
		<ul style="list-style-type: none"> Clinical admin (linked to client) 																	
Attribute 2:	Engaging groups and communities	<ul style="list-style-type: none"> Building community capacity 																	
		<ul style="list-style-type: none"> Promoting interaction and development 																	
	Enabling health and happiness through working with groups and communities using a team approach																		
Attribute 3:	Developing partnerships and integrated ways of working with multi-agency colleagues and partners	<ul style="list-style-type: none"> Advocacy 																	
		<ul style="list-style-type: none"> Brokering care on behalf of client 																	
		<ul style="list-style-type: none"> Social referrals (holding/containing) 																	
		<ul style="list-style-type: none"> Referrals clinical 																	
		<ul style="list-style-type: none"> Referrals other e.g. equipment 																	
		<ul style="list-style-type: none"> Referrals other e.g. equipment more than one 																	
		<ul style="list-style-type: none"> Professional activity e.g. regular meetings 																	
		<ul style="list-style-type: none"> Medicines advice (to staff) 																	
	Utilising communication and feedback with colleagues and partners	<ul style="list-style-type: none"> Service development/management 																	
		<ul style="list-style-type: none"> Data entry (not including this data) 																	
Influencing commissioners and CCGs	<ul style="list-style-type: none"> Supervising/mentoring staff 																		
Networking with Health Visitors, professional bodies and other partners to share best practice	<ul style="list-style-type: none"> Leadership work monitoring standards, vigilance, role modelling 																		
	<ul style="list-style-type: none"> Informal and formal teaching 																		
	<ul style="list-style-type: none"> 																		

⁷ Services encompass the provision of support to achieve the best start for children

Travel time/driving when work isn't being done																										
TOTALS																										

Master classes for Health Visitors Communities of Practice

All Health Visitors in Kent Community Health Care Foundation Trust are invited to attend the following series of Masterclasses as part of the development in Kent and Medway of a Community of Practice in Health Visiting

<p>Friday 1st May 2015 Ashford International Hotel</p>	<p>HV CELEBRATION DAY KCHT <i>Celebrating the achievements of the Kent and Medway Community of Practice 1 year on</i></p>
<p>Thursday 18th June 2015 9.30-11 am Richardson Room HPf 09, Hall Place Harbledown CT2 9AG</p>	<p><i>Leading culture change across Health Visiting Teams</i></p>
<p>Thursday 16th July 2015 9.30-11am Richardson Room HPf 09, Hall Place Harbledown CT2 9AG</p>	<p><i>The power of Emotional Touchpoints as an evaluative tool in Health Visiting</i></p>
<p>Thursday 22nd October 2015 9.30-11am 9.30-11am VENUE TO BE CONFIRMED</p>	<p><i>Influencing national Health Visitor agenda through the 3-8 Model</i></p>

For further information please contact Jane Greaves at jane.greaves@canterbury.ac.uk or on 01227782343

Kim Manley at kim.manley@ekht.nhs.uk

RSVP to apply to attend and **indicate if you will require parking** please email or telephone

Sarah.chapple@canterbury.ac.uk or health.visiting@canterbury.ac.uk
0122778292 to book your place

Master classes for Health Visitors Communities of Practice

All Health Visitors in Medway are invited to attend the following series of Masterclasses as part of the development in Kent and Medway of a Community of Practice in Health Visiting

Wednesday 17 th June Time: 9-10.30 Venue: Ambley Green	<i>Celebrating the achievements of the Kent and Medway Community of Practice 1 year on</i>
Wednesday July 29 th Time:9-10.30 Venue: Ambley Green	<i>Leading culture change across Health Visiting Teams</i>
Wednesday September 9 th Time:9-10.30 Venue: Ambley Green	<i>The power of Emotional Touchpoints as an evaluative tool in Health Visiting</i>
Wednesday October 21 st Time: 9-10.30 Venue: Ambley Green	<i>Influencing national Health Visitor agenda through the 3-8 Model</i>
November ??	<i>To be confirmed</i>
Wednesday December 16 th Time: 9-10.30 Venue: Ambley Green	<i>To be confirmed</i>

For further information please contact Jane Greaves at jane.greaves@canterbury.ac.uk or on 01227782343 or Kim Manley at kim.manley@ekht.nhs.uk

These sessions will take place at the beginning of Health Visitor meetings in Medway please contact Hayley Ince for more information hayley.ince@nhs.net

Appendix 13: The Community of Practice 3-8 Model: enablers, performance and outcomes

Three(3)Enabling iHV factors

Individual Health Visitors are resilient inquirers who are clear and confident about their role & knowledge, are open to change & passionate about person-centred care

Happy teams develop safe, challenging, supportive & person-centred workplace cultures which enable everyone to flourish through leadership

Values of the organisation in the form of words and actions support and celebrate the contribution of the workforce in achieving objectives

Four (4) Levels of Service

Five (5) entitled & mandated elements

Six (6)Public Health High Impact areas

Adapted from

<https://vivbennett.blog.gov.uk/wp-content/uploads/sites/90/2015/03/4-5-6-Model.pdf>

(accessed 22nd April 2015)

Seven Perform(ance) Indicators

Positively engage with service users, & partners to shape the future of integrated services

Enable & build family centred relationships by inspiring & supporting them to achieve improved outcomes

Review and improve services using evidence and innovation

Focus on using holistic assessment skills in partnership with families to identify health needs; plan, implement and evaluate care

Outcome improvement of public health by engaging individuals communities and populations using a team approach

Reflect on, share and influence best practice and innovation across the health and social care economy

Multi-media networking to share best practice

Eight (8)outcomes

Children are happy and ready for school irrespective of their circumstances

Healthy confident relationships between parents and children

Improved public health outcomes and perception of services

Learning and development cultures are valued and supported across teams and organisations

Development of supportive, cohesive and caring communities

Recruitment and retention of a motivated and highly skilled workforce

Efficient and effective use of resources

Nurturing capacity in families and NHS improves individuals, groups and communities

Appendix 14: Emotional Touchpoints tool developed for use with students, colleagues and service users in health visiting



Kent & Medway:

Health Visiting

Community of Practice

Emotional Touch points in

Health Visiting

March 2015

EMOTIONS – cards to be used with staff as descriptors

Happy	Calm	Confident
Content	Safe	Proud
Hopeful	Pleased	Grateful
Curious	Relieved	Overjoyed
Excited	Empowered	Inspired
Trusting	Welcome	Understood
Valued	Needed	Encouraged
Respected	Involved	Supported
?	?	?

Sad	Lonely	Anxious
Unsure	Worried	Bored
Useless	Powerless	Depressed
Numb	Guilty	Disappointed
Frightened	Annoyed	Overwhelmed
Shocked	Frustrated	Angry
Intruding	Unimportant	Hopeless
Embarrassed	Belittled	Ignored
?	?	?

Emotional Touchpoints for use with HV Students

Being a learner again	First day in practice
Find their way around	Working in Community
Working with PT	Attending case conference
First home visit on own	Answering phone
Visiting people's homes	Hot desking
Working with Children's Centre staff	Working with Policies & Procedures
Working with Mentor	?
?	?
?	?
?	?

Emotional Touchpoints with Staff - HV Team

Hot desking	Work with allocation	Completing ANV Contract
Supporting vulnerable families	Record keeping	Completing NPV Contract
Working in the bigger team	Completing 2 - 2.5 review	Completing 6-8 week review /MMA Contract
Crucial conversations	Computer access (IT)	Completing 10-12/12 review
Referrals	?	?
?	?	?
?	?	?

Emotional Touchpoints for Team Leaders and Co-ordinators

Managing team dynamics	One to one (1:1)	Managing incidents
Attending partnership meetings	Meetings	Chairing team meetings
Performance management	Co-ordinating commissioned services	Administration
Authorising expenses and annual leave	Disseminating information	Workload
Celebrating	Appraisal	Risk assessment
?	?	?
?	?	?

Name:
[Optional]

Date Recorded:

Recorded By:

Touch Point:

Emotion Words:

Description:

Actions Taken: