AN EVALUATION OF THE PROCESSES AND OUTCOMES IN TWO INTERAGENCY PUBLIC HEALTH TEAMS WORKING IN DEPRIVED AREAS.

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Contents

Introduction and background

The project

This project resulted from a successful proposal through the South West Regional Public Health Academic forum and was set up in response to recommendations in the *NHS Plan* (2000) and *Shifting the Balance of Power within the NHS* (DOH 2001). These proposed the need for effective partnership working between local authorities and PCTs in order to promote health improvement in local communities. The project was designed to address some of the skills

deficits in practitioners that have been identified nationally, which include an increased understanding of inequalities in health and practice development.

The objectives of the project included:

- To agree shared aims, objectives and responsibilities for the practitioners/agencies involved
- To focus the activities of the learning set on a relevant, real public health improvement issue, as agreed by the members of the learning set
- To enable the development of knowledge and skills within the learning set members appropriate to the chosen public health improvement issue

Evaluation Methods

Methods used in the evaluation included:

- Participant observation in team meetings, steering group meetings and the joint team meeting
- Written notes taken at meetings/minutes and action points
- Copies of materials used at the beginning of the project such as the HDA Skills audit 2001,
- Semi-structured interviews with participants
- Analysis of relevant policy documents.
- Practitioners' reflective sessions
- Debriefings with the Project Facilitator after meetings

The project areas

The **W Team's** area consists of eight parishes which varied in their scores on the DETR Indices of Deprivation (2000). This was a survey of 8414 English electoral wards, with rank 1 being the most deprived. The project ward ranks varied from 2582 to 5261, and from 31 to 107 in the county ratings from a total of 152 wards (www.neighbourhood.statistics.gov.uk)

For the most deprived parish, the Health and Social Needs Assessment identified crime and fear of crime, costs associated with childcare, inadequate or inappropriate accommodation, noise, pollution, social isolation, the effects of low self esteem and increased stress as being particular problems. Policing and tackling the drug problem were also big issues. (LSP report 2003.) However there are more positive aspects to life in this area e.g. the church group at the venue where the team meets has recently completed a new youth facility, including a huge indoor skate ramp, pool tables and 'chill-out space'.

The **Team G** area is a small pocket of deprivation comprising a large social housing estate within an affluent and predominantly elderly population. It has a large population of young people without adequate facilities and a relatively high rate of teenage pregnancy. It was in the 20% most deprived wards in the country in the DETR Indices of Deprivation in 2000. However a Residents Association has been set up in the past few years that has since won a Queen's Award for its achievements

Establishment and membership of the teams

The teams operated in separate localities in areas controlled by the same Strategic Health Authority in the south west of England. Members of the longer-established **Team G** include a Community Health Visitor, (CHV) initially called the 'Public Health HV' but whose title was changed because 'they thought I was coming to inspect the drains'. It also includes a health Promotion Officer, a school nurse, social worker and primary mental health worker employed and funded by Primary Care Trusts. Representatives from education, ie. a local head and Deputy Head teacher, also attend regularly. Other practitioners have attended on a one-off basis, e.g. the nurse from the Youth Advisory Centre (YAC). This team first met in January 2003 and has now met on approximately 16 occasions.

Team W has now met on ten occasions, beginning in October 2003 and a total of 15 practitioners have attended, in addition to the facilitator and researcher from the University. The team includes officers from the Local Authority (LA) including Estates and Environmental Health, the Housing Benefits Welfare Officer (HBWO), and from other agencies, the Adult Social Services team leader, a health visitor who is also a member of the PCT, and the floating tenancy support worker from a key local Housing Association. Members from the voluntary sector also attend, including the Healthy Living Centre lead. New members from this sector include the project lead and community enabling workers from WHERE (W Health Education Resource Enterprise).

Most members are practitioners but the team also includes members who were working at strategic level undertaking communications reviews, and who are members of the Professional and Executive Committee (PEC) of the Local Authority. Three officers from the LA have been invited to attend on a one-off basis to inform the team about the council's housing strategy.

Each team initially chose a different focus for their work. **Team G** decided to concentrate their efforts around improving teenage sexual health and the prevention of teenage pregnancy. **Team W** initially chose to address improving communication within and between council departments and other agencies and the severe shortage of affordable housing in the area. This focus however, has developed, focusing on supporting vulnerable adults in the area.

The Skills Audit (HDA 2001) in which practitioners assess their ability in the skill clusters below was distributed at the first meetings of both teams. It is proposed to repeat this process at the end of the facilitation of the project in December 2004 in order to focus on whether team members felt they had gained skills through their involvement. These skill clusters were:

- Personal skills
- Leadership
- Workplace management
- Policy and strategy
- Management implementation

. Underpinning principles
. Professional and technical

Practitioners were also asked to indicate the level of expertise or understanding essential for their role as well as their actual level of skill in the subsets of each skill cluster. The Skills Audit has been used to inform future training sessions as well as to monitor individual progress.

Project resources that supported both Teams

The contact list of all team members has been distributed and is kept updated in order to facilitate the networking process.

Detailed minutes are distributed after each meeting. These now include action points to make explicit what needs to be done and who needs to do it.

The generation of **ground rules** at the first meeting helped the teams run according to the wishes of their members and should provide a safe environment in which to share issues.

Academic papers were distributed to both teams to support their work and develop practitioners' knowledge of the evidence base.

Attendance by a team member from each team at the United Kingdom Public Health Association (UKPHA) **Conference** was paid for from project funds. Notes taken by one team member on the keynote speeches at this conference were distributed to the rest of the team and informed discussion.

Formal taught sessions on areas outlined as needs, including IT skills, conflict management and change management.

The teams in action: Main issues discussed and work planned in Public Health

Team W.

Improving communication processes

Due to the large number of members from the Borough council **(**BC), the emphasis was initially on improving processes within the Council. The issue of insensitive or threatening computer-generated letters from BC to vulnerable tenants was raised. Proposals for improving letters were made, including review by groups of mental health service users or MIND. At subsequent meetings there was discussion and action proposed on how all agencies and voluntary bodies could improve their communication with each other and with clients.

Work around affordable housing

Concern was expressed that the group should achieve something tangible and the severe lack of affordable housing in the area was suggested as an important issue to work around. It was pointed out that there were two opportunities coming up for the group to influence policy in this area: the Housing Best Value Review and the Community Planning Exercise.

The Homelessness Unit

A Homelessness Officer for the BC then described the seriousness of the current situation. There were many more people on the waiting lists than the council had vacancies for and the situation had deteriorated substantially over the last ten years. He explained that local authorities such as Harrow had been given beacon status for innovative practice in dealing with homelessness.

This LA has identified the biggest causes of homelessness as family breakdown and the end of short-hold tenancies. It had major problems with

20 families in bed and breakfast for at least two years but now they had not put anyone in this sort of accommodation for four months.

Senior Housing Officers were invited to a subsequent team meeting. They explained that there were a number of action points in the housing strategy including support to prevent relationship breakdown. Mediation will try to help 16-17 year olds. The team discussed issues of who could be referred and who could refer to mediation. The team subsequently wrote to ask the HO to allow other agencies to be funded to make referrals to Mediation and so help to prevent homelessness in the area.

Team Aims and focus: **Networking and improving communication**
At a subsequent meeting the team identified the aim of the group as working better together and preventing people slipping through the net. The focus would be on sharing what was available to meet needs. Team membership gives practitioners improved knowledge of other agencies' roles and it was valuable for key staff to meet in order to support vulnerable adults in the area.

Progress towards joint visiting and joint assessment procedures
Homeless and other vulnerable people often have multiple problems. A single assessment process would be useful for picking up on issues and for professionals learning about each other's roles. At present different agencies were all doing their own assessment on families but joint visits e.g. with social workers and GPs would represent an improvement in services for clients.

The team's Housing Benefits Welfare Officer's (HBWO) role was to verify claims and also to act as a Welfare Officer. He was rather an 'untapped resource', since his role provides a way in to hard-to-reach groups and he often has information about tenants that other agencies could make use of. He gave a progress report on joint visits to parents on low incomes. He was meeting with health visitors and district nurses who also need to be kept up to date with benefit advice**.** He had attended Luncheon clubs with the Pension service and been involved in setting up care packages with Care Direct (a single number that directs callers to appropriate sources of help and advice).

The WHERE project (W Health Education Resource Enterprise)
The WHERE project leader attended a later meeting of the team. The scheme is a national pilot funded by TOPSS England (Training Organisation for the Personal Social Services) for new social care roles and links up voluntary and statutory services. WHERE have appointed seven new community enablers to assist vulnerable people. Their current client group is the over-65's, disabled people and people with mental health difficulties.

They are working with the PCT, secondary care and the 'Supporting People' initiative to investigate the outcomes of early intervention. They also publish a directory of local organisations.
WHERE have developed a café project to run in the week. It will encompass physical activity, courses and conferences as well as an information centre and small workshops. The Time Bank, which is similar to LETs (local economy trading scheme) will also run on two afternoons a week from there. They found premises for this and began to offer the service in August 2004.

Planning a Networking Event

It was proposed that all frontline staff should come together to do a pilot workshop, to ask what the most important issues were for practitioners and residents and come up with an action plan that would be the start of the joining-up process. Both voluntary and statutory services would benefit from attending this workshop. The team felt that the workshop would need to be repeated annually because of the pace of change and staff turnover.

The Directory

A directory was also planned which will be an aid to partnership working and the services that are available. It will help to identify client pathways and common issues and will include signposting services such as Care Direct and the Citizens Advice Bureau.

Welcome and information packs for new residents

The team identified the fact that a new local resident needs to know where to go to access services so it was agreed that WHERE would prepare a draft information pack. This has been done. There are many activities taking place in the area that need to be more widely publicised The development of the pack represents the benefits of sharing information and bringing it together for the benefits of the community.

Case referral to team

The team could be seen as somewhere to bring the difficult issues that serve as anonymous case studies. They also highlight how joined-up services actually are for clients and the team's function as a safety net.

The HBWO has come across a complex case of a woman fleeing domestic violence, who has given permission for information about her case to be shared. A possible avenue of help was that people could self-refer to tenancy support at the team's HA, under the 'vulnerable adult' category. She was subsequently referred to Care Direct. A problem of infestation in a vulnerable person's home was also discussed and solutions suggested which were later acted upon.

Changing role of Health Visitors
The Health Visitor informed the team that all HVs have now been designated as specialist public health nurses. In some PCTs HVs have dropped routine work to free up time for public health work. Changes to the role meant that they were being encouraged to do more community-based work but it was hard for them to find suitable premises in the area.

Loss of services: proposed closure of the Community Office
The valuable role of the Community Office in the ward and its possible closure were discussed although it was later clarified that its advice function would remain. As a result the team agreed to create a proposal to set up a Community Centre incorporating the future of the Community Office.
The team thought that the town centre was looking increasingly poverty-stricken with many charity shops and others boarded-up. Post offices and the Job Centre had also closed. It was suggested that these ideas and concerns should be fed into the Community Plan as a formal vehicle.

The Community Planning exercise for the team area

It was reported that local residents were not discussing the big issues such as homelessness in the Community Planning exercise. Last time major issues were raised but the community appeared apathetic now. It was agreed that the team needed to investigate the avenues that are open to it through the community planning process and that the team should attempt to inform strategy. A member of the community planning team attended a team meeting to hear issues as experienced by local people and residents particularly relating to communication and the need for local premises for health improvement activity. Team members were asked to forward information, which should be a synopsis of what is there now and what the vision is, together with costings. It was agreed that the team should aim to secure high-level support from the Strategic Partnership. They can influence resource allocation and in turn are influenced by what people on the ground say.

The teams in action: Main issues discussed and work planned in Public Health Team G.

All original members of **Team G** took part in the skills assessment through the Skills Audit (HDA 2001).
Individual training needs: one person has undertaken research training.

Group needs were identified as
- Facilitating meetings
- Managing conflict
- PowerPoint and IT skills. These were all addressed through the project.

Access to information

An issue for team members was that much of the information that they need, for example to add substance to one of the many bids that they need to put in to fund projects, is confidential or at least hard to locate in a useable form e.g. at ward level. There appeared to be a central core of people with information who were reluctant to release it. The PF proposed to pursue the team's information needs through the Public Health Network**.**

The Teenage sexual health strategy

As described earlier **Team G** originally decided to work around reducing teenage pregnancy. Accordingly there was considerable discussion and mapping of existing provision, followed by proposals for improving the care and support of girls considering and following termination of pregnancy.

Existing provision for teenagers:
Going to the YAC (youth advisory centre) was an issue for young people in the ward because of its limited opening hours of two nights a week. More clinic days were needed, as the YAC services the whole of the area**.** The in-town facility was open at more convenient times than the YAC i.e. Saturday morning and every evening and was located approx. seven miles from the ward.

The role of the school nurse
Teenagers do not come to their school nurse after a termination because the service is not set up to promote that use. It would be useful for school children to access help through the school nurse since the subject of abortion was often taboo at girls' homes and someone on site was often the best option. The nurse proposed that information should go up in the girls' toilets. . There were problems with photocopying a leaflet for every child after the PSE talk in school, since she has been told that there is no longer funding to do this or to laminate posters. Lack of funding for important everyday activities was a common difficulty brought to team meetings.

Developing proposals for the young people's drop-in
As a result of discussion in the team and the mapping of existing provision the team investigated funding possibilities to set up a drop-in centre at the local secondary school. This facility would address a wide spectrum of pupils' information, advice and support needs, and not just sexual health. This will be modelled on an existing NHS beacon site in Paignton, Devon, the Tic-Tac Centre, (teenage information centre, and teenage advice centre) and a drop-in centre already set up in a local school, while taking local conditions into account.

The teams' visit to the TIC-TAC centre, organised through the project, took place in May 2004. Useful resources such as their constitution and business

plan were distributed. The team also visited the drop-in at the local secondary school on its open day in July 2004. Possible funding sources sites and buildings for the drop-in were discussed at a number of team meetings. Copies of funding sources for projects for children and young people were distributed. The team helped the local High School to bid successfully for money to support this development, which is now planned for 2005.

Public health team steering group

A number of the issues raised within the team were put to the project's steering group, at a meeting in April 2004, which consisted of the Directors of Public Health (DPH) and of Nursing as well as team members.

The role of the mental health worker

The team had written to members of the steering group to raise concerns about the role of the Primary Care Mental Health Worker (PMH). This practitioner had been a member of the team who expressed their concern that lessons should be learned from her experience. Robust supervision and care of practitioners needed to be in place. Issues included the fact that the appointment was 0.5 FTE, an amount that was clearly inadequate in an area of high deprivation.

Lack of suitable accommodation was a particular problem in supporting this role and levels of privacy and confidentiality for sensitive telephone calls were inadequate. The post-holder was asked to operate a waiting list, which she believed was inappropriate since the rationale behind the development of her role was easy accessibility and early intervention for children and young people. There was now an evolving policy framework that supported the development of the PMH role. The role had collapsed just as the new National Service Frameworks (NSFs) have identified the need for community access mental health workers (CAMHs) workers, which
PCTs will in future be measured against.

In response the DPH explained that this post was not alone in not being entirely sorted. However a number of factors were now coming together to better support the role. There was accommodation available at a local school and an administrative base in the HVs' space and administrative support would be provided. Furthermore the new practitioner appointed to the role is now full time and is also be the team leader for all primary care mental health workers in the county.

Developing the Health Visiting and District Nursing roles

The team presented their work to the health visitors in the area to highlight the possibilities for new ways of working. The project also supported the public health role of the school nurse. There are proposals in the new Workforce Development plans for health visitors to develop their public

health role. Room to reflect on changing roles was needed and it was agreed that the PF would facilitate development sessions with this group. It was clear that the District Nurses and HVs needed help in developing their roles and mentoring skills to help new recruits.

Resources that supported the team's work

A number of outside resources were used by team members ?? and felt to be vital to their work with residents. These included STEPS to Excellence for Personal Success STEPS and the one-two-three magic video programme.

The STEPS programme

STEPS courses are organised, lobbied for and tutored by the ward's CHV who is also a team member. STEPS is a 20-25 hour course devised by Lou Tice of the Pacific Institute, and partially taught by him via 12 videos. It is based on cognitive behavioural psychology 'to help change people's patterns of thinking and thus their behaviour.' and is designed to improve people's self-esteem and self-efficacy. Past students testify to the changes that it has helped them to make in their lives, such as leaving an abusive relationship, passing their driving test and improving relationships with children. A resident who has been through the course has trained as a facilitator and has set up a club so that the group can continue to meet after the end of the course. This is important because it is often hard for students to sustain change once courses are over. The courses also bring out community issues such as drug taking and represent an interesting mixture of personal and community development, incorporating both individual and group support approaches.

Adult Education has supported the last five STEPS programmes. However, at the September meeting of **Team G** it was reported that Adult Education was unable to fund the next one. The Manager of the local Children's Centre where STEPS runs then made substantial efforts to secure new funding, attempting to put together a package from a number of sources. This support may not have been forthcoming without the team, since the funding problem became a team problem rather than an individual one.

The 'one-two-three magic' video programme

The school nurse described the 'One-two-three magic' video programme that she has been showing to groups of parents. The SN reported that at the last showing parents had been very involved with the content. These videos, for parents of 2-12 year-olds, are about stopping obnoxious behavior and starting good behaviour and are solution and task-focused.

The videos need to be seen as a resource for all children and not just for 'problem' kids and families. The advantage of the video is that parents do

not have to share personal stories if they do not want to, they can discuss the situations shown in the video.

The videos profile school nursing as being a link further developing this role. They can present, answer questions and refer on parents who come to the drop-in at the Infant and junior schools once a month.

Community Partnership.
The Community Strategy Officer for the Community partnership (CP) attended the team's meetings from May. He explained that there were seven action groups that made up the partnership. His role was to help support these groups, which included Environment, Travel and Access, Health and Care and Support for young families, to develop action plans. The CP had links to the county Strategic Partnership and the Local Strategic Partnership (LSP) which is countywide.

The Network Event

It emerged at a number of team meetings that all practitioners were not aware of the resources that are available in their area and needed time to catch up with new initiatives. A networking day was therefore proposed to remedy this. There were many matters to consider for organising the day and a need to focus on what services are available and what their remit is.

The Network Event was held in October 2004 with the format of posters and presentations of five minutes each. The day could become an annual event and facilitate the updating of agencies' details in directories or websites.

Mapping services

Services for children and families in the area were listed by team members and others; the list will go out to all services for alteration and additions. This work would have been carried out anyway but was more widely publicised though the team. These listings and contact details were also given to members of the Team W at the joint meeting, which might help promote similar initiatives there.

The evidence base
The PF distributed a paper *Promoting Teen Spirit*, which proposed that the big successes in reducing teenage pregnancy and substance abuse lay in reducing social exclusion through youth projects, rather than spending money on projects specifically designed to prevent these problems. As a result of the findings of this paper, provision for youth projects in the area was discussed and this may have had an effect on developing practice.

Disseminating the work

Conference attendance

Team members presented their work at a number of conferences including The Changing Practice conference for primary care workers held at the university in June 2004. The HV and a resident who had benefited from the course presented on the STEPS programme and the practitioner involved presented the public health school nursing role. The work of the teams was also presented at the UKPHA 12th Annual Forum in April 2004.

The joint meeting

This meeting reflected on the processes and outcomes in each team. Team members were also able to describe their work, thus providing useful comparisons and models of alternative ways of working. The attendees were the older-established members of both teams.

Evaluation

Evaluation is defined most economically as 'the process that will enable us to learn from experience' (Turner et al 1989, quoted in Oakley 2001.)

Because of the way that the project was set up it, did not set out with a predetermined focus to make practitioners accomplish a particular task. It was designed to act as a space for reflection and support, as well as developing practice. The evaluation will examine how well this strategy worked. The team process, including initial recruitment and recruitment of new members as well as the management of meetings, formed a major
aspect of the evaluation. It was also considered important to investigate how crucial the interpersonal aspects of developing teams were in facilitating change and developing practice.
Key papers such as the Barr et al (2001) publication for the Joseph Rowntree Foundation on a Scottish research project tested the potential of community development approaches in community care. The findings that are likely to be of most relevance to this project are:

- Local partnerships of community organisations can be effective in promoting supportive communities
- Effective partnerships require mutual trust and confidence. These are built on clarity of purpose, committed participation of all partners, open and honest communication, realistic goals and identifiable progress in their achievement .
- Community development skills are a prerequisite to establishing and sustaining such partnerships
- Senior managers need to embrace a culture of participative, accessible governance and joined up inter agency and inter sectoral practice. Rigorous distinctions between strategic and operational management can work against this approach

The Skills Audit (HDA 2001)
Most team members felt that although it was useful in theory, they hadn't had a chance to go though it properly and thus gain full benefit from it. One practitioner described how it had made her realise that networking was crucial to successful inter agency working and not a luxury

Another thought listening skills should be in the list because these were skills he used all the time in his job and in the team. A joint session was planned on Managing Change with a change consultant in the NHS, which was a concrete outcome from the Skills Audit in that it addressed an area identified by the **Team W**.

Main similarities and differences between the teams

Membership

One of the main differences between the teams was that **Team G** did not originally have local authority membership but a representative from the local community partnership attended their last three meetings. **Team G** had more members from 'health' and chose a health focus for their work, i.e. reducing teenage pregnancy, albeit one that needed to take full account of social factors. This developed into having more educational input to the team because of the work to develop the young people's drop-in.

Team G's core membership has always been smaller than that of **Team W** since the model that this team has adopted is of some members from education being invited for the last hour of a two-hour meeting. This seems to work well in striking a balance between keeping the core team and having a wider input for specific aspects of the work e.g. setting up the teenage drop-in. This set up is fluid and the Deputy head of a Children's centre has recently joined the team as 'a full member'.

Social activities such as having lunch together were important to team building and networking.

Team processes
Perhaps one of the most important differences in terms of process was that **Team G** had a closely-knit core of three female members and there were several others who were involved for shorter periods of time. They appeared to offer each other mutual support and be closer personally than the practitioners in **Team W** .The core membership of **Team W** was from the Local Authority, but not all practitioners originally knew each other. It is fair to say that these team members were more task than process or support oriented, possibly because this was the dominant culture in the LA. It seemed likely, and in keeping with the findings of Barr et al (2001), that the mutual trust and confidence facilitated the work of **Team G**.

Improvements in personal contacts and networking

Members of **Team G** were relatively optimistic about what the team had achieved at least in terms of laying the foundations of future work. For a member of **Team W**, the situation was seen rather differently. Networking was too nebulous an outcome to justify the staff time involved; her service needed concrete outcomes. However other **Team W** members stated that they valued the networking e.g. the HBWO and the development of contacts to assist in the development of joint visiting and assessment process. They also now had a better insight into what the various other groups and charities on the team actually did.

Choosing the team focus

Team W initially chose housing and homelessness as their focus. From the point of view of gaining information and an insight into how policy might be changed, the visits of the LA's Housing Officers (HOs) were probably of more use to team members outside the LA.

Some members of this team later suggested that choosing housing had been something of a blind alley, because there was nothing that the team could do to influence provision. This was also an issue of levels of working e.g. can the team influence what happens at strategic level and was it possible to work across both strategic and frontline levels. The Barr paper was distributed to both teams to improve understanding of these issues. Some team members who were used to working at strategic level were somewhat impatient with the limitations of what the team achieved. But the team has no statutory powers; it has therefore to rely on persuasion and commitment. To sum up, housing was a large and complex issue to choose and in retrospect possibly not the most suitable issue for **Team W** to tackle, as they themselves later recognised.

Later new members to **Team W** queried whether the main focus of the group was networking, feeding into community planning, or trying to co-ordinate processes. It appears that some had difficulties coming to terms with unclear boundaries, evolving work and multiple objectives. However it is likely that a complex and flexible team is the most rational response to a complex and constantly changing environment. The team has now chosen to focus on supporting vulnerable adults across different agencies.

Team G initially chose teenage sexual health as their focus and a concrete proposal arose from this which was developing the proposal for a young people's drop-in. Although the evaluation ended at the beginning of September 2004, the project was ongoing and the drop-in is being funded and established. In any event it acted as a useful focus for the team, engaging people's energies and helping to build a cohesive team**.**

A recommendation to future teams would be that there should be consideration and discussion about what can realistically be achieved before adopting a team focus. This is in keeping with Barr et al's (2001) finding that there should be realistic team goals and identifiable progress in their achievement

Key issues in team membership and processes

At the joint meeting on reflection on team processes, it was agreed that new members needed to join the team as people move on and when relevant new posts are created in the teams, so a number of questions arose about how it is best to manage this process. It was agreed that a proposal should be put to the teams on whether the proposed new practitioner was appropriate. It might also be difficult for the team to absorb too many new members at once and the basis on which people are invited to a team meeting should also be clarified.

Other issues discussed were the ideal balance in team meetings between education e.g. academic papers, websites, and training opportunities versus planning on the ground work. Members were divided on whether they would like to have more input and evidence from academics or to concentrate on work on the ground. The difficult issue of how it was best to translate discussion into action was also raised although there were a number of action points per meeting with practitioner's names against them.

(Ann – having deleted a phrase this sentence doesn't make sense)

Facilitation of the team

The project facilitator (PF) whose role is to develop public health practice, has a non-directive facilitation style, which gave participants space to reflect on their own practice, and chose the aims that are most appropriate for the local area, in keeping with project objective 3.

Participants felt that it was helpful that facilitation and support from the University was slightly separate. That way the team was removed from local politics. They felt that the PF had an extensive knowledge of what was happening in public health both at a strategic level and at the level of government policy. Her involvement with the SHA's public health network was also very helpful in this regard and her knowledge of the evidence base also helped underpin the work of the teams.

A challenge for the facilitation process was then how directive to be about the work of the team. The difference between leadership and facilitation was raised in one interview:

I think she's facilitated it really well. There's no criticism at all. Because it was facilitating, it wasn't leading, I think that's been fine.

The philosophy behind the project was that it would not work to try and impose a focus because so much was imposed from above, so the teams should come up with their own.

Main functions and achievements of the teams
In interview team members described what they thought their team had achieved and the value of team membership to them. This included more meetings with colleagues and the fact that the project funding of the school nurse's role development meant that she was now available to take part in a number of important initiatives such as the obesity and parenting projects.

One **Team G** member summed up a development that had come about as a result of the work that was also mentioned by the other two team members involved.

Yes, I am just thinking with the obesity project although not directly, because obviously we discussed it as an issue through the development team. We have then gone off and worked on addressing that so that has been an impetus for us to try and address that and things are moving really quite fast on that.

Two **Team G** members would now be having their mobiles which they used for work paid for, after raising the issue at the steering group. However this was unfortunately not the case for the school nurse who was employed by a different PCT.

An achievement of **Team W** was that the health needs of the community were considered, e.g. WHERE were developing services and seeing where these fit into the bigger picture. The PF pointed out that developments happen outside meetings that have been triggered by the team process or events organised by the team. These are particularly difficult for the evaluation process to monitor since they will not always be bought back to meetings for discussion.

Issues to consider were the levels of engagement and continued PCT funding (indirectly for practitioners to attend in their working hours). The researcher's role ends at the end of September. The DPH explained that the PCT worked 12 months at a time but that they had a commitment to supporting the team. For the PCT this Public Health Team was also top priority. He thought it would be a ten-year programme to change radically the approach of all the different agencies broadly engaged with public health.

Key Learning, what questions do teams need to ask from the beginning in order to inform their development?

1. Sharing the learning so far, asking the right questions
   - What are the health needs of the community or clients you work with? Do you need to find this out or has this work been done?
   - Are there any inequalities in access or inequalities in health in this area?
   - Do you need to refocus what you do, drop some things and pick up others?
   - Do you need to work with local residents or refer to different agencies to tackle these needs?
   - Do you need to provide services in a different place, at a different time or in a different way?
   - What is 'best practice' for tackling this area, what have other people done?
   - How is your practice, as a team or as an individual , meeting the needs of your local community?

2. Learning from facilitating the team development

- No route map!!!
- Tends to be a crisis of focus at around four to five months/four to five meetings
- Learning v. doing, getting the balance right
- How best to make the process and actions relevant for everyone around the table
- Networking meetings are inside our comfort zone, changing the way we work is less comfortable!!

3. Changing how/where/when people work requires the **following:**

- For them to feel the way they work needs changing
- For them to feel supported in making changes
- For them to feel that working together differently is important and will improve the outcome for residents/clients
- For their institutions to recognise they need support and that resources/organisation of work may need to change to help people work together effectively

3. Challenges for team members in developing their roles

(these areas relate to the Skills Audit undertaken)

- Lack of IT access and training for practitioners involved in the team
- Variation in skills relating to research and evaluation

- Lack of local accommodation to enable role development

Conclusion

The ongoing exchange of information about local, voluntary and statutory services became more important as the teams evolved. There has been sharing of information about funding sources, services and planning.

Participants in **Team G** are concerned about what will happen when the involvement of the facilitator and the project ends. Bringing people together in the team had promoted reflection on their work. These were small steps but different agencies were learning from each other and could effect change in some areas. It was acknowledged to be an uncomfortable process for some practitioners to sign up to hear these messages and change the way they practice. The work was a constant challenge and some areas were frustrating but this was part of the process. The team could also reflect on its achievements. There were few other mechanisms for them to express concerns or reflect on positive developments together across different agencies.

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Appendix A

1. Summary of Proposal

Project : The development and evaluation of two interprofessional/agency action learning groups to take the public health agenda forward (see multi disciplinary action learning group - programme of bids)

Through the recommendations made in the NHS Plan (DOH 2000) and the strategies developed within the Shifting the Balance of Power within the NHS document (DOH 2001) it is apparent that there is now an opportunity to develop a new, local focus for public health within primary care. This shift has created a significant opportunity to refocus and re-energise the public health delivery system (Lord Hunt, speech Nov 2001), and enable practitioners, and other agencies within local areas to develop strategies with local residents, which are relevant and meaningful for local communities.

2. Project Rationale – Aims / Objectives

A potential method of successfully achieving this shift in focus and priority within the actual and potential Public Health workforce is through effective facilitation of action learning groups. This forum will allow practitioners within Primary Care Trusts and other local agencies to learn skills and develop strategies together in order to carry forward the public health agenda.

Within the Institute action learning groups have been used, evaluated and developed to facilitate learning in practice for undergraduate health care professional and social care students, and for continuing professional development. The Institute has also, over recent years, developed expertise in the facilitation and evaluation of interprofessional/agency action learning groups through involvement in the following projects.

Educational Facilitator Project (2002, Interprofessional Learning in General Practice)
and
Regional Interprofessional Education Project (2002, Improving Health and Social care through Interprofessional and Multidisciplinary Learning) see enclosed documents.

The two action learning groups proposed here will be developed and facilitated through a partnership between University and two local Primary Care Trusts (The groups will be based within two deprived local areas, The facilitation of the groups will be undertaken by the Practice Development Fellow in Public Health with the active support of the Directors of Public Health and Practitioners within the two areas. The evaluation of the groups will be undertaken by a researcher, who will work under the direction of the project steering group. This group will consist of the Directors of Public Health, the university Practice Development Fellow, and the research assistant.

The potential knowledge and skills development facilitated through the groups, following discussion with clinical and academic colleagues, will focus on;
inequalities in health,
practice development, focusing on working with local residents, and
needs and health impact assessment
all of which are relevant to the two deprived localities within which the groups will be focusing their activities, and have been identified as potential skill deficits for practitioners. Further focus for these development activities will be identified following an initial skills audit which will be undertaken at the commencement of the project. The skills assessment will be developed with reference to the Health Development Agency Skills Audit, 2001, and the Amazing Journey Toolkit, NHS Publications 2002.

The aim of the project
The aim of this project is to establish and evaluate two interprofessional/agency action learning groups, within two deprived local areas.

The objectives of the project
To engage local public health practitioners and practitioners from other local agencies in the establishment of two action learning sets
To agree shared aims, objectives and responsibilities for the practitioners/agencies involved
To focus the activities of the learning set on a relevant, real, public health improvement issue, as agreed by the members of the learning set
To enable the development of knowledge and skills within the learning set members appropriate to the chosen public health improvement issue
To evaluate both the process and outcomes of the learning sets, with the active agreement and involvement of learning set members involved in the study

3. How does the proposal support the delivery of national targets and/or agreed local service plans

National targets relating to reducing inequalities in health are unlikely to be met without effective locality based partnership working (HAD 2001). Both the Health Act of 1999 and The

|Report of the Chief Medical Officers Project to Strengthen the Public Health Function 2001 state |
|the need for effective partnership working between local authorities and Primary Care Trusts to |
|achieve health improvement within local populations. |
| |
|The provision of continuing post qualification education and development for professionals during |
|their service careers to support the implementation of Saving Lives: Our Healthier Nation, the NHS|
|Plan, and Shifting the Balance of Power has received much attention. The following publications |
|clearly link the role of education and practice with needs focused service provision: |
|Working Together – Learning Together: a framework for lifelong learning in the NHS. Department of |
|Health, HMSO 2001. |
|Primary Care Workforce Planning Framework, Department of Health, |
|http://www.doh.gov.uk/pricare/pcwpf.htm. 21.5. 2002 |
|These documents highlight that professional development programmes should be based on the |
|principles of interprofessional and multi-agency teamwork. |

4. Evidence of Chief Executive, National Service Framework lead and stakeholder support

|This bid has had the active involvement and support of the Director of Public Health |

5. Expected Outcomes

|To identify strategies for the development of effective locally based public health teams. |
|Lessons and learning from the methods of facilitation used. |
|Testing out the public health team model in practice. |
|Emerging themes in terms of public health shared competencies among different groups |

6. **Collaboration, Multi Professional / Inter-Disciplinary Elements (where appropriate)**

| |
|Please refer to Sections 1 & 2 above. |
|The potential participants within the learning sets may include representatives from health, |
|(health visitors, school nurses, community nurses, midwives and mental health practitioners) and |
|from the local authority (community development workers, social workers, environmental health and |
|education officers) and from voluntary organisations as appropriate within the two localities. |

7. Evaluation Tool, Process for Sharing Results

| |
|The evaluation will have several elements: |
|Action learning group participants will be asked to complete a skills assessment at the |
|commencement of the learning group, and again at the end of the twelve-month period in order to |
|focus on whether they felt they had gained skills through their involvement. This skills |
|assessment will include insights into, inequalities in health, developing policy and practice, |
|needs and health assessment, partnership working, management skills and research and evaluation |
|skills (as outlined in the short term action plan for developing the public health workforce in |
|the south west). The skills assessment will be developed with reference to the Health Development |
|Agency Skills Audit, 2001, and the Amazing Journey Toolkit, NHS Publications 2002. |
|Data will be collected from each action learning group meeting, and will include the agenda, |
|minutes and action points. |
|Mapping changes in practice, or service provision/organisation which have been as a result of |
|development of the action learning group; this will be done through meeting transcripts and |
|interviews with participants, at regular intervals during the project. Primary data analysis and |
|clarification of emerging issues will be undertaken with action learning group participants |

Appendix B

Ground rules of W Public Health Team

They proposed:

> Constant attendance e.g. the same person should come to every meeting. Please send your apologies if you can't come.

> Any issues regarding commitment and interest and the effectiveness of the team for you should be shared.

> Confidentiality - what is said in meetings to be kept within the team.

> Allowing others to finish what they are saying.

> Trying to be non-judgmental and honest.

> Trying not to personalise any criticisms of the service that you are representing.

> As team members are from different professional backgrounds, it is important to respect each other's perspectives.

> Time limit on meetings of two hours.