Establishing a public health nursing project

This article, the second in our three-part series on public health, describes the development and operation of two public health projects in Stockport. The authors place these projects in the wider context of public health nursing and highlight some of the benefits of using the approach as a framework for community project work.

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Public health nursing has its foundations in primary care and as such, forms the natural public health lead in local communities and primary care teams. Public health aims to develop health services through commissioning and attempts to reshape society by addressing environmental and cultural determinants of health. Health service commissioning is increasingly being devolved to primary care teams as a result of the drive for a primary care-led NHS. Public health input to this process is needed.

Schools, local organisations, local subcultures and peer groups create social norms which influence socially human behaviour. Health promotion measures not involving local communities, or entirely focused on individuals, are less effective than if reinforced by addressing local norms as well.

Environment is also important to health, perhaps requiring local action in an effort to, for example, protect local 'green space', object to health damaging planning applications or promote local traffic calming schemes.

The geographical emphasis placed on public health nursing does not, however, conflict with the practice orientation of GPs. Most practices identify with a geographical area and GPs have found that neighbourhood strategies allow practices to work together.

In Stockport, this approach to community health has led to the development of two projects.

COMMUNITY DEVELOPMENT

The case for community development

Organisations invest in community development for the benefit of the organisation and the direct contribution to the health of the people.

Creating a community which can address its own problems and where people work together, establishes more effective partnerships with authority. For example, the people of Brinnington, Greater Manchester, responded to the drug problem within their neighbourhood with a local volunteer-run needle exchange scheme. Community development also led to food co-operatives in several neighbourhoods and safety equipment purchasing schemes helped local parents to afford important items such as stairgates and fireguards.

Such a community will also be a healthier place in which to live, because of the impact on poverty and social networks. Credit unions and local economic transfer systems (LETS) schemes reduce poverty by conserving local resources. Social networks benefit health directly – the Alameda County study (Burkman and Syme 1979) showed a threefold difference in mortality between people with the strongest social networks and those with the weakest. This well documented relationship is not adequately explained, but might be related to the manner in which social support diminishes the effect of stress.

Community health workers

Health visitors have a tradition of being involved in public health work, especially group work. In Stockport, for example, health visitors have been seconded to local authority housing and leisure departments. The latter role has produced Exercise, Football and Arts on Prescription projects, and Women and Drama courses for mental health patients. Five years ago, nurse managers biased caseloads to reflect deprivation and established ‘first parent visiting’ (a system of developing parenting skills). Subsequently, the director of public health, head of community nursing and director of health promotion discussed some deployment from caseloads into community development. Consultations lead to the development of the community health worker role.

Based in clinics and health centres, working alongside generic and first parent visitor colleagues, community health workers (Swann et al 1994, 1995) add a new dimension based upon collective action. In 1994, the team became multidisciplinary in composition, and in 1995 it was expanded with the appointment of a non-nursing health promotion worker.

Community development addresses inequalities in health by improving access to information, services
Box 1. Examples of project work carried out by community health workers

- Health needs assessments
- Fruit and vegetable co-operatives
- Community cafés
- Support groups
- Crèche co-operatives
- Cook and taste sessions
- Work with tenants groups
- Community newspapers
- Women’s support groups

and resources for communities. It includes:
- Social support networks
- Targeting marginalised groups
- Process, which is as important as outcome
- Partnership with residents
- Residents identifying their own needs and helping to determine how they should be met
- Social, political, economic, environmental influences upon health.

Initial training from an expert in community development instilled confidence in the workers and answered the question: ‘What will I do differently on Monday morning?’ The team then gained experience actually performing the role and a range of project work is now undertaken by team members (Box 1).

Community development assistants A successful development bid made it possible to add four assistants to the team. As community development recognises the skills and knowledge of local people, an essential criteria was that assistants should be a resident of the neighbourhood in which they were to work and therefore familiar with its norms and culture.

The role supports those who use community development in their work. This means not only community health workers and community development dieticians, but also community resource workers employed by the Metropolitan Borough Council, and the neighbourhood health strategy co-ordinators.

Two assistants are supervised by community health workers from within the neighbourhood and two by workers from outside. An evaluation report was released in March 1997. Initial findings suggest however, that residents employed in this way contribute positively to local community projects.

NEIGHBOURHOOD HEALTH STRATEGY PROJECT

This project encouraged and enabled all agencies concerned with the health of a geographical neighbourhood to contribute to a common strategy to support the Health of the Nation (DoH 1992) and the Stockport Health Promise (1994) within 16 neighbourhoods. Health visitors acting as public health nurses devised the strategies after consultation with local agencies, police, the clergy, teachers, Citizens Advice Bureau staff, GPs, district nurses, local employers, community groups, pharmacists, library staff and other interested parties. The recommendations drawn up as a result address health issues of greatest local relevance.

The underlying principles are co-ordination, cooperation, collaboration, community action and community development:
- Co-ordination – health promotion interventions are less effective when undertaken in isolation than when similar and related interventions from different sources interact. For example, information about stopping smoking is made available not only in health centres and GPs’ surgeries but also in schools, libraries, shops and pharmacies. This ensures that residents see the same message simultaneously throughout their neighbourhood
- Co-operation – different agencies actively help one another. The school nurse may gather information about teenagers to benefit GP practices
- Collaboration – one agency provides a service with, or for, another, for example liaison teachers providing parenting skills training
- Community action – the strategy addresses environmental issues and can promote a community or collective approach. The development of community spirit is central to this aspect
- Community development – the process encourages residents to identify common issues and concerns, and supports and empowers them in action.

Community development links the two projects. The strategy is launched via a multi-agency implementation group meeting convened by a health visitor co-ordinator. The co-ordinator enables the health promotion activities in the strategy to be organised, co-ordinates the work of the local implementation group and manages the strategy budget for the neighbourhood.

Examples of practice using this approach are given in Box 2.

Mitchell and Whitelaw (1996) highlighted the importance of project evaluation, suggesting that certain issues need to be considered:
- Frameworks for prioritising targets in the strategies
- A communication strategy emphasising hard to access groups, especially GPs
- A gap between strategy formation by public health nurses and implementation by neighbourhood health strategy co-ordinators.

The neighbourhood health strategy project’s benefits included (Mitchell and Whitelaw 1996):
- Positive perceptions among those involved
- Generation of new and innovative health promotion activities
- Promoting a positive image of a public health-led initiative
Community

Box 2. Examples of Neighbourhood Health Strategy practice

- A first aid course for women
- Information and advice service within GP surgeries
- 'Fitkid' courses (exercise programmes designed specifically for children)
- Carers groups
- Complementary therapy courses
- Strollers group for the elderly
- Provision of smoke alarms to the over 65s
- Counselling service at a local high school

- Favourable resource allocation and positive devolution of budgets to neighbourhoods
- Strong local alliances
- Personal and professional staff development
- Strong peer support among public health nurses.

Finding the resources

Stockport's community development project was established using existing health visiting resources. Reducing routine child surveillance and introducing first parent visiting made resources available and released health visitors from caseloads.

The neighbourhood health strategy project used the 10 per cent of public health time available from health visitors, consolidated to establish many of the co-ordinator posts, and £150,000 of development funds voted by the health authority over two different contracting years to fund the budgets and the remaining co-ordinator posts, plus £40,000 generated from efficiency savings contributed by the trust. The community development dieticians were funded initially from development funds. Subsequently, the catering service was reorganised and some of one catering manager's time was made available. The community development assistant project was funded by development funds.

From all these resources, Stockport has assembled an annual budget of £326,000 of recurrent money to fund community development and public health nursing. This is only 0.3 per cent of the total budget, and is equivalent to less than one intensive care bed. It is also less than the sum Stockport Health Authority must spend on fundholders' management allowances.

Grass roots action can attract outside resources. For example, the health and green space project attracted £50,000 per annum from the Countryside Commission, while Brinnington 2000 involves the local community using a large sum of urban regeneration money. Community representatives can influence planners and local government officials allowing local ideas to figure prominently in project development.

Lessons learnt

Change management, good planning, clear direction, leadership and estimation of timescales are vital to this type of project work. Initially, in the community health worker project there was confusion about the role and some resentment by unaffected staff. Consequently, more planning time was invested in the Neighbourhood Health Strategy project. Health visitor development days raised awareness about the project. Although only 16 staff became co-ordinators, all staff could form part of the impact group, so everybody had to understand the philosophy. There was a gradual introduction – four neighbourhoods were committed every six months to develop 16 in two years – which allowed staff to learn from colleagues and cope better with the changed role.

Community development work does not suit everyone. Team members must be committed to the process and the philosophy. Opting in to the project creates a strong team, including self-starters, high motivation, capacity to inspire people, the ability to take risks, determination and persistence.

In the case of the Neighbourhood Health Strategy project, fundholding meant co-ordinators had to be recruited from health visitors with public health time included in their contract. This is not ideal, however, evaluation showed that staff developed both personally and professionally in the role.

Combining caseload and public health work

Community development can seem less urgent than caseload work. The two do not mix. Unfortunately, neighbourhood co-ordinators face this tension and have experienced some difficulties, such as competing time and inflexibility.

Support

Key elements of a supportive environment include realistic timescales, time to learn, team working across disciplines, a committed management and a committed organisation. Zone co-ordinators are health visitors with a wealth of public health experience who advise and support a group of neighbourhood co-ordinators and community development workers. The professional adviser in public health nursing provides an intermediate level of support between field staff and the clinical nurse manager. A steering group strategically plans both projects.

Freedom of speech

Public health work can be controversial. It creates change in society, services, organisations, human behaviours and environments.

Freedom of speech is written into the contract between Stockport Health Authority and Healthcare NHS Trust. Community development workers also have a clause in their contract of employment: 'The prime responsibility of a community health worker is to the health of the community served and to the empowerment of that community; the community health worker will be guaranteed freedom of speech.
Table 1. Guidelines on public health practice in politically contentious fields

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<tr>
<th>LEGITIMATE</th>
<th>ILLEGITIMATE</th>
<th>GUIDELINE</th>
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<tbody>
<tr>
<td>1. Stating public health facts, even if they embarrass the powerful</td>
<td>1. Manipulating public health data to embarrass the powerful</td>
<td>1a. Have scientific justification for statements</td>
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<td></td>
<td></td>
<td>1b. Do not suppress facts</td>
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<td>2. Making recommendations that will clearly benefit people's health</td>
<td>2. Putting public health support behind political positions unrelated to</td>
<td>2a. Be clear on the health objectives</td>
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<td></td>
<td>promoting health</td>
<td>2b. Be open minded about alternative ways of achieving it</td>
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<td>3. Ensuring that advice is made public and reiterating it if necessary</td>
<td>3. Using Crown resources to campaign for political causes or oppose government policy</td>
<td>3. In contentious issues if there is a danger of overstepping this line, use official mechanisms to place issues in the public domain where others can make what use of the data they wish</td>
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<td>4. Advocating changes of policy</td>
<td>4. Implementing unauthorised use of resources contrary to policy</td>
<td>4. Distinguish advocacy of a position from its implementation and recognise that authorities are entitled to reject your advice</td>
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<td>5. Offering scientific and professional support to those working for health promoting causes</td>
<td>5. Using Crown resources selectively for the benefit of a particular political group</td>
<td>5a. Always be prepared to work with all political parties if working with any</td>
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<td>6. Facilitating a community identifying its own needs and campaigning for them</td>
<td>6. Stirring up a community to do what you want</td>
<td>5b. Offer scientific and professional support directly but be careful about offering political parties any other resources</td>
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Guidelines on public health practice in politically contentious fields form part of the professional approach throughout the Stockport Public Health Network (Table 1).

A free speech clause has failed if it is regularly invoked in conflict with managers. Ideally, it should reflect the values of the organisation that free speech is generally accepted and shapes the employment relationship so that people feel more confident.

When organisations use community development, they invest in the long-term benefits of a trusting relationship with the community. Building that relationship is more important than short-term issues, and loyalty to the organisation consists of keeping faith with that trust, not in adopting a short-term emphasis. A professional freedom clause declares that the organisation understands this, and also understands that human frailty requires it to protect staff against it temporarily forgetting.

Setting up budgets Community development workers and Neighbourhood Health Strategy coordinators require budgets. But should the money come from trust budgets or authority budgets? The trust lacks powers to make grants to local authorities or voluntary organisations, so every time the community development worker wants to make a grant the trust has to adjust its contract with the health authority to give money back to the authority to allow it to make the grant. A procedure has been set up for this, so it is not in effect as complicated as it sounds, but it still generates unnecessary bookkeeping entries. Therefore, the neighbourhood health strategies used health authority budgets. But this gave different problems with trust employees holding authority budgets. Direct accountability for the budget was established from the co-ordinator to the director of public health, and the trust and the authority agreed that the trust would treat a breach of the fiduciary duty to the authority as seriously as a breach of duty to the trust itself. There is no legal ban on health authorities entrusting budgets to persons not employed by them, but auditors are concerned by the general lack of sanctions. Eventually, the health authority auditors accepted that the links with the trust, reinforced by the contract clause, were strong enough.

In the event, most spending was authorised by line managers, committed by the trust and recharged to the authority because it was easier for co-ordinators to fill in the trust requisition book in the clinic and have it signed by a manager than to come to the public health department and sign it themselves.
Box 3. Features of successful public health work in Stockport

- A supportive management which understands the long-term nature of the work
- One manager to whom trust public health workers are accountable
- An accessible public health department
- A history of healthy alliances
- A steering group who support the project politically and strategically
- Being part of a larger public health network
- Supportive centre for health promotion
- Staff willing to take risks
- Public health work being an integrated part of the health visiting service
- Access to a budget
- Long-term funding
- Workers with the ability to access training and determine their own training needs
- A strong multi-agency joint health planning teams structure based around the Health of the Nation (DoH 1992) targets

Apart from the health authority/trust problem, there was the problem of giving budgets to relatively junior staff who would then spend them in unusual ways. Trust accountants were suspicious of requisitions for payments to church halls or the purchase of art materials, and clear directions from the authority were necessary to allay unease.

EVALUATING COMMUNITY DEVELOPMENT PROJECTS

Barriers to evaluating community development include coming to terms with the work itself, lack of time available, when to start the evaluation process, that is, at what stages does a meeting of residents constitute a project and when does a project end? There is a feeling that evaluation detracts from the work itself. Despite the difficulties community health workers experience in undertaking effective evaluation of their work, it has long been recognised that nurses cannot afford to relegate evaluation to second place. It is not optional.

The process of community development is as important as the outcomes. The aims of a project cannot be determined too tightly since they change in response to the needs of residents. Residents should be involved in determining how the project will be evaluated. Negotiating the aims and objectives of a project with residents is essential, so everybody involved understands why they are meeting and misconceptions are avoided.

Record keeping is the key to evaluation. Information recorded includes who is in attendance and his or her position within the group, interactions between group members, levels of participation and how people are working together, what happened and decisions made. A timetable of events indicates the long-term nature of the work. Other useful evidence includes minutes of meetings, letters, photographs and testimonies from residents. Evaluation reports to date have used interview techniques, focus groups and questionnaires. Features in Stockport which make for successful public health work are given in Box 3.

CONCLUSION

The Stockport public health nursing project focuses on wider public health to address cultural and environmental determinants of health. It has not examined commissioning, had an impact on the planning of health services or the contents of purchaser plans. Considerable resources were being devoted to the project and had to produce direct health gain rather than being a management or planning structure.

Nonetheless, the project's success and growing emphasis on primary care-led commissioning, leads fundholders to demand a public health contribution to fund management. Health visitors as public health practitioners can claim their involvement in commissioning. But nurses may then be drawn away from promoting directly the health of the people just as public health departments had their priorities distorted into commissioning rather than pursuing health. It would be unfortunate if public health nursing had to justify itself by a commissioning agenda, given the limited contribution health services make to health.