Implementing new health visiting services through action research: an analysis of process

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Implementing new health visiting services through action research: an analysis of process

An action research project based in a single fundholding practice on the South Coast of England aimed to identify needs relevant to families with resident children, then to use the contracting system to redirect health visiting practice to meet those needs. The naïvety of this plan was well recognised, so the processes that occurred during implementation of the proposed changes were recorded throughout. An analysis of these participant observation data revealed various organisational constraints and facilitators that arose during contract negotiations. Two new full time health visiting posts were established, each with an innovative and somewhat controversial focus. One health visitor was employed to establish a community development project in an underserved area of the town, while the other was to provide a home visiting service for the families of school aged children. The processes involved in structuring decisions about 'health needs' and how these are best met are analysed for each of the two new posts. The analysis reveals powerful influences that affect the implementation of new health visiting services.

Keywords: action research, community development, decision making, health needs, health visiting, home visiting, participant observation, structural processes

INTRODUCTION

This paper reports one aspect of an action research project based in a single fundholding practice on the South Coast of England; it was set up at the time that general practitioners (GPs) had just been empowered to purchase community nursing services. The plan was to identify needs relevant to families with resident children, then to use the contracting system to redirect health visiting practice to meet those needs. Despite the closeness of this plan to the intentions stated in national policy, its naïvety was well recognized. A subsidiary aim was formed, therefore, to observe the processes that occurred during implementation of the proposed changes and to identify any organisational constraints to the process. This paper reports the complexities involved in implementing changes to health visiting services; the multiple processes involved in structuring decisions about 'health needs' and how

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these are best met are unravelled and analysed. First, a summary is provided of the larger project of which this paper forms a part and the relevance to current policy changes is explained.

Family health needs project

The overall aim of the Family Health Needs Project was to use the GP contracting system to enable the delivery of a participative, 'needs-based' health visiting service. The project was initiated in response to the changes in policy which allowed GP fundholders to set contracts for community nursing services [National Health Service Management Executive (NHSME) 1992]. Health visitors expressed concern at the possibility of adverse effects on their service as a result of this move [Health Visitors' Association (HVA) 1994], which was one more change in a time of great turbulence following introduction of the NHS and Community Care Act 1990. This legislation introduced an internal market in health care, and separated purchasers (health authorities and GP fundholders) from units that provided services. Provider units were enabled to become free standing 'NHS Trusts' instead of remaining under the direct management control of the health authorities. A further change entailed introduction of a strictly defined division between responsibilities accorded to health and social services. The 1990 legislation has just been revised [Department of Health (DoH) 1997], as the Health Act 1999 was approved by parliament in July this year.

This latest legislation has already set in train another round of major organisational changes, intended to reduce the bureaucracy associated with the internal market and to break down barriers to co-operation between health and social services. Primary Care Groups (PCGs) are governed by a board comprised mainly of GPs, but they include lay representation, a member from social services and one or two community nurses. These PCGs have largely taken over the functions of the former purchasing authorities and GP fundholders, initially working as committees of Health Authorities to establish collaborative, multi-agency Health Improvement Programmes (HimPs) across local areas. Potentially, PCGs may develop over time to become Primary Care Trusts, which will encompass commissioning and some service provision (DoH 1997). The huge amount of change and some of the positive intentions in this revised policy mirror the situation that pertained in the early part of the decade, as the NHS and Community Care Act 1990 was being rolled out.

The quasi-market introduced under the 1990 Act was explicitly aimed at promoting the easier introduction of services based on consumer views, on identified needs, on partnership and participation (DoH 1989a, b). The researchers set up the study reported here in conjunction with a senior manager/head of health visiting in the local NHS Trust and a GP fundholder, in the hope that enhanced communication would enable this positive potential of the policy to be realised. Action research was chosen for the study to maximise its flexibility and responsiveness in a time of instability and change. Following the tenets of this approach, the Family Health Needs Project began with a loosely defined research protocol, which was subsequently clarified and redirected as the project progressed through a series of cycles. The cycle of fact-finding, planning, implementation and evaluation is repeated until the action research is complete (Heart and Bond 1995).

In the first, fact-finding part of this study a profile of health needs was compiled for use in the practice, incorporating the views of local community practitioners, health commissioners and managers. The multiple sources of data were aggregated following Yin's (1994) case study approach; the method has been reported elsewhere (Billings 1996a, b). In the next, planning phase of the cycle, the main carers in 50 families with resident children registered at the practice were interviewed to elicit their views about health and health needs. These views were analysed and integrated with the practice profile to identify which health needs to prioritise, so that a decision could be made about how they would best be met. This led to the implementation phase, which is the focus of this paper. Evaluation is built in to the process of action research, since each phase of the cycle is reviewed in order to inform the next.

ACTION RESEARCH

A major function of action research is to implement change (East and Robinson 1994, Elliott 1991). The idea is that research data are gathered as the change is implemented and used to generate practice-based knowledge about the processes as they develop (Holter and Schwartz-Barcott 1993, Meyer 1993). At the start of the study, it was presumed that the professionals (i.e. the health visitors) would implement the change and the main 'change agent' would be the senior manager/head of health visiting who informed the contract setting process at the start of the study. The researchers would, therefore, be working at the level of organisational change, as typified by the distinguishing features outlined by Hart and Bond (1995). Their description of action research with an organisational focus makes an implicit assumption that managers are powerful within the organisation, whereas clients and practitioners are (at least relatively) disempowered.

Another assumption embedded within this 'consensus model of society' type of action research is that identifying a common aim will promote unity in working towards a chosen end. This mirrored an important underlying premise in the project that, having identified the most pressing needs in the practice list and the best known approach to

meet those needs, all parties would agree that approaches to health visiting practice should be changed accordingly. However, organisational constraints tend to hamper the implementation of participative approaches to practice (Gott and O'Brien 1990, Cowley 1997). Therefore, while the beginning assumptions were deliberately kept in their naïve form, a plan was formed to observe the contracting process in an attempt to unravel and expose some of the structural issues that helped or hindered the change process.

Data collection

Participant observation to collect data about the contracting process began as soon as the study commenced, and was maintained for the whole period of the study. Noting its closeness to 'fieldwork' in social research, Guba and Lincoln (1985) explain that participant observation requires of the researcher the dual roles signified by the term. As an observer, the researcher is responsible to persons outside the milieu being observed, but is a genuine participant nevertheless, having a stake in the group's activities and outcomes. In this study, the researchers were heavily involved as participants in some activities which were also being observed, but were 'detached' from other situations and involved in a more casual way.

Yin (1994) suggests that the main strengths of participant observation lie in its ability to capture reality and context and its ability to generate full insights into interpersonal behaviour and motives. Against these strengths, he suggests the weaknesses lie in its potential for selectivity, reflexivity and bias due to the researcher's manipulation of events. However, in action research, such reflexivity and manipulation is a major function of the study. Participative action researchers (Stringer 1996) and fourth generation evaluators (Guba and Lincoln 1989) argue that it forms an integral part of the process of constructing the knowledge that constitutes 'reality' at the particular moment, time and place under review.

The researchers remained 'outsiders' who could influence and persuade in the interests of change, but they had no formal position within the organisation. Neither they, nor any of the key staff involved, were charged with a formal responsibility to implement any proposed changes. A major aim of the observation, therefore, was to faithfully interpret and record the reality lived by the managers, purchasers and practitioners as they grappled with the new ideas for practice proposed by the research.

A series of working groups and meetings with varying degrees of authority and formality met throughout the project period with the explicit purposes of contributing to the needs assessment, advising the project team or enabling the change process to occur. These were used as opportunities to record field notes of comments or non-verbal behaviour that appeared significant to the contracting process. In most instances, notes were written on return from the research site, although there were exceptions. At times, field notes could be recorded contemporaneously with the consent of the participants, which provided the opportunity to enhance the validity of notes by allowing the respondent to check the information recorded at the end of the interview.

Ethical issues

At each meeting, participants were reminded of the purpose of the study, as there seemed no ethical justification for carrying out covert observations. None of the participants ever commented or alluded to this in any way, and it is difficult to know whether or not they had registered that their attitudes, comments and demeanour within the meeting were a source of research material. In view of this, considerable importance was attached to maintaining anonymity and obscuring identities in the final report, and some otherwise useful data have been omitted to protect identities.

Research should never cause distress, although Meyer (1993) points out that this ideal is problematic in an action project since the turbulence associated with the change process is rarely pain-free. It is not always possible to determine whether distress stems from the research or from the context into which the change is being implemented. Furthermore, a consequence of the deliberate stance that stakeholders retain control in action research is that researchers relinquish governance over the detail of implementation. This lack of clarity and power does not absolve researchers of responsibility, however, and the observation data were partly intended to track and avoid distress as far as possible. The later analysis attempted to unravel and separate distress arising from the context of the study and any attributable to changes directly consequent upon the research project.

Analysis

The rough, unabridged observations collected in field notes were gradually refined, initially through recurrent themes entered into the margins. Reflection of observed events occurred throughout, where efforts were made contextually to interpret, compare and contrast the interactions and comments made by the participants. Key themes were sought in the observation data, but no attempt was made to seek additional information if an idea was inadequately conceptualised by analysis of the field notes. In some instances, ideas could be checked with the persons concerned, but this was not always possible or desirable (e.g. if a sensitive or upsetting observation had been made); nor were other confirming data sought to assure the reliability of observations. Instead of seeking a 'single truth', therefore, individual

interpretations and perceptions are accepted as alternative versions of the same event within the analysis.

Once the study was complete, the observation data, reflective comments and early analytic ideas were revisited and subject to a more intensive and detailed examination. It became apparent that concepts elicited by Cowley (1991) in a study of health visiting practice were relevant to the data in this study. Theoretical concepts can be developed by their cumulative application to different research contexts, because added dimensions of the concept are articulated and clarified through use in a variety of empirical settings (Wiseman 1994); this adds to their predictive power. Thus, no claims are made for the generalisability of reported events that are specific to a place and time, but the descriptive narrative and interpretation of the change processes provide some potentially wider insights. The conceptual analysis offers an explanation that may well apply elsewhere; such 'applicability' is viewed as a rough analogue of external validity (Guba and Lincoln 1985).

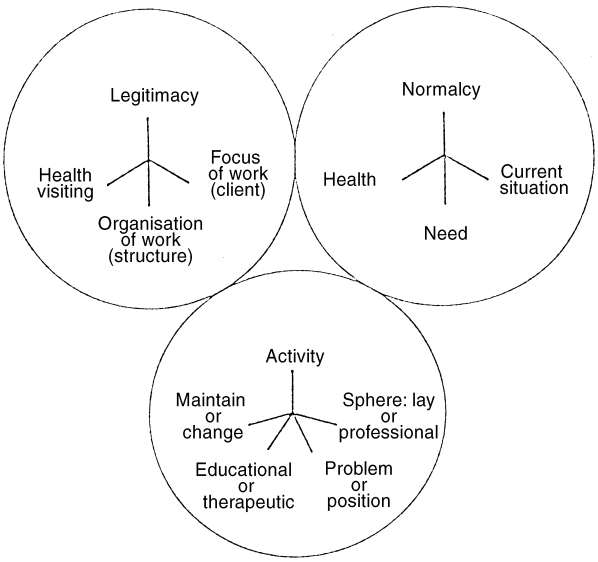

Figure 1 Structural conditions of awareness context (Cowley 1991).

DEVELOPING NEW SERVICES

The original intention of the project had been to establish new approaches to practice among existing staff. In the end no change was achieved in current health visiting practice, but two innovative posts were established. One post involved a home visiting service for families with school aged children and the other focused on a community development project. Both posts were full time, and were filled by experienced, qualified health visitors.

On many occasions, negotiations and discussions directed at developing these positions were thrown off course by intervening events or issues. The study began just as the local provider unit gained NHS Trust status. This had involved a major structural re-organisation in which the community and hospital services were combined into a single Trust; two further managerial restructurings occurred during the first year of the project. Some 80% of local general practitioners (GPs) moved to fundholding status at that time too; the following year saw a merger of two purchasing authorities into a larger health commission prior to a further amalgamation with the co-terminous Family Health Services Authority (FHSA) a year later. Severe resource constraints were evident at all levels of the services. As the research project was drawing to a close 2 years later, re-organisations began to occur within the cash-strapped Local Authority Social Services Department and another re-structuring commenced within the NHS Trust.

The number of redundancies overall appeared quite small, but each restructuring involved some job losses, numerous side way moves, and changes in role and function; a sense of insecurity and vulnerability prevailed across the whole local area. These multiple service reconfigurations and financial cutbacks had no direct connection with the project. Unsurprisingly, however, they occupied the time, energy and concentration of significant stakeholders in the process, at times making it extremely difficult to assess which influences came from the changing context and which from changes proposed as a result of the project.

As the analysis of data progressed, it seemed apparent that the processes of implementation reflected the key conditions that structure the approach individual health visitors opt to use in any particular situation in practice (Cowley 1991). Figure 1 shows how the aspects of *normalcy*, *activity* and *legitimacy* were summarised in that study; they will be explained briefly before using them to examine the multiplicity of competing agendas and power differentials that were revealed as this project progressed. It was only when these structural conditions were openly satisfied that it became possible fully to establish the new services.

Awareness and structural processes

The term 'structural process' derives from Glaser and Strauss' (1965, 1967) seminal works about dying. The term links the notions of structure and process together to reflect the constantly changing dynamic that occurs within a given sociological context (that is, in the substantive area of interest for the sociologist). Glaser and Strauss suggest that the relationship between structure and process is both more complex and less firmly fixed than either of the individual concepts if they are considered separately. An awareness context is a particular kind of structural unit that can account for the process of interactions occurring

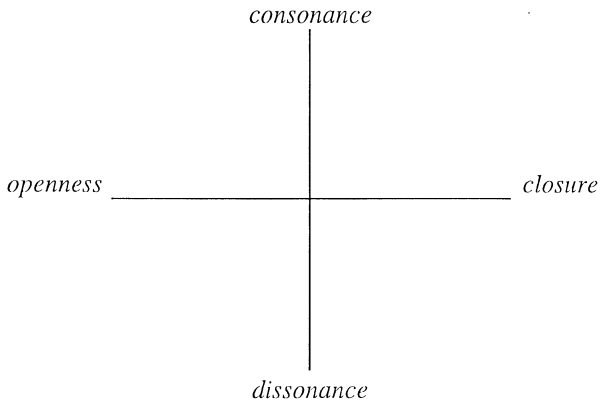

Figure 2 Dimensions of awareness (Cowley 1991).

within it; the term indicates the total combination of what each interactant in a situation knows about each other. The awareness context surrounds and affects any interaction that occurs between them and can, therefore, account for both structure and process.

Cowley (1991) illustrated these ideas with reference to a baby clinic, which might take place within the concrete, physical context of the health centre; activities will be affected by the dimensions (e.g. walls, room size) and structural conditions (e.g. opening times, staff available). Likewise, interactions in the more abstract and social 'awareness context' will be affected by dimensions (such as the extent of openness or consonance about issues to be discussed, see Figure 2) and conditions (including the knowledge, perceptions and beliefs of the interactants) that structure the interactions between health visitor and client in any setting. The interactive process ensures that the awareness context is constantly changing, but understanding the dimensions and conditions from which it is constructed allows the changes to be explained.

Figure 1 illustrates the specific structural conditions that explain how the various approaches that health visitors use in practice are constructed according to the different perceptions and awareness of the interactants involved (Cowley 1991). They can be described separately, but need to be considered simultaneously since they form part of the whole context under consideration. In this study, the structural processes affecting the potential to change health visiting services across a practice area were the focus of interest. They were likewise part of the whole context, although different aspects of the process could be elicited and described separately. The wide range of stakeholders involved was made explicit by the action research, but each held different levels of awareness, interest and power to influence the processes of change.

The elements shown in Figures 1 and 2 were expanded and clarified during the analysis, as summarised in Table 1. They will be used to explain the different processes involved in decisions about each of the two new services in turn. The events involved and extent of dissonance or consonance about the proposals differed widely between the various stakeholders in each case. Once the structural conditions were openly satisfied, it became possible to progress to the final stage and establish the new positions. Before detailing these processes, a brief description will be given of the needs identified in the town and at the GP surgery where the research was sited.

MEETING IDENTIFIED NEEDS

The profile revealed a picture of wide deprivation in the town. Chronically high levels of unemployment, low car ownership and associated poor physical and psychosocial environment were very apparent. Features were poor mental health, above average numbers of smokers, poor mortality rates and excessive rates of long-term, limiting illnesses. There was twice the national incidence of detected child abuse in the local area, with associated behavioural problems, self-mutilation and attempted suicide among young people, apparently due to family tensions and bullying. Illicit drugs seemed readily available, and high levels of juvenile crime co-existed with a perceived increase in school bullying, truancy and classroom disruption. Changing family structures were perceived as creating instability, difficulty in coping and a lack of social support for increasing numbers of single parents and rising depression rates among pre- and post-natal mothers.

Table 1 Structural conditions and the establishment of new services

Normalcy	Activity	Legitimacy
e.g. • perceptions of what normally constitutes 'health' and health work • perceptions of what would normally count as a 'need' • how health and need are jointly construed in the current situation	e.g. • prioritise views from lay or professional sphere • influence position of target group or focus on presenting problem • maintain status quo or seek change • select educational or therapeutic approach	e.g. • whose work — health visitor/someone else? • organisation of work and acceptability to various stakeholders • focus of work — individual client, community as client, specified age range

Home visiting for school-age children

Normalcy

'Normalcy' refers to the process involved in gaining acceptance that something is considered normal. There was wide agreement that the profile accurately reflected the situation in the town, but some issues for children and young people were regarded as lying normally outside the 'health' field by certain stakeholders. Implementation of the NHS and Community Care Act 1990 led to widespread adoption of the economists' view that a 'need' is an ability to benefit from care (Stevens and Gabbay 1991). Under this formulation, a health need exists only if care is to be provided by the health service. Thus, health visitors, school nurses and general practitioners, whose daily practice brought them into contact with families experiencing difficulties stemming from the conditions outlined above, recognised their diverse problems as normal, everyday 'health needs'.

In the earliest stages of negotiations, Trust contract managers were invited to project meetings, but attended only once. Given the prevalent resource constraints, heavy influence of hospital clinical directorates within the Trust and a widespread view that the NHS is concerned with established illness rather than prevention, it is perhaps unsurprising that, unlike the community staff, they considered that children's behaviour in school and crime were not a problem for the health service and were not, therefore, 'health needs'. This view appeared widespread among health commissioners as well, except for one who took a particular interest in the difficulties of conceptualising health needs in relation to well families and the preventive agenda.

Activity

It is quite hard to conceptualise the idea of a 'need' in the abstract. McWalter *et al.* (1994) recommend always asking 'need for what?', so discussions shifted to decisions about which activities should be developed to meet these health needs. The shortage of input for school aged children was very noticeable; interviewed parents of this age group expressed a wish to have a home visiting service like the health visiting service they remembered receiving. The idea for this service stemmed initially, therefore, from the lay sphere, but was eagerly embraced by the GP fundholders at the research site. The idea of being able to target help directly on a group who often presented with problems in their surgery struck an immediate chord and they welcomed the idea of a resource to which they could refer such families.

However, the local services were already fully stretched; health visitors were only involved with families of pre-school children and the school nurses could barely cope with the school-based demands on their time. The idea of expanding the services to encompass this age range was opposed by some local health visitors. Being aware of many unmet needs among the families of pre-school children on their caseload, they were keen for the researchers to support the 'status quo' in the type of service provided, and press for additional funds to enable it to be delivered more consistently.

Certainly, American studies (Olds *et al.* 1986a, b, 1988, 1994, Kitzman *et al.* 1997) support the potential for improve health outcomes in disadvantaged families and pre-school children as a result of systematic home visiting to educate parents. There is no similar research evidence to show whether improvements occur if such services are directed at school children; this creates clear difficulties in securing help for families of this age group. Potentially, waiting until problems present may reduce the effectiveness of the intervention, since the optimum period for preventive education has passed. However, the therapeutic focus of the health service is such that responding to established problems is generally acknowledged as necessary. Once the specific service response was identified and approved by the GP fundholders, expressions of doubt about whether these families really had 'health needs' diminished, but implementing the proposed service remained controversial.

Legitimacy

Once the GP fundholders decided the idea was worth pursuing, events moved rapidly and confidently. There was no possibility of increasing the school nursing service equitably and sufficiently to develop a home visiting service to this age group across the town, and GP fundholders were not empowered to set contracts for school nursing services. In any event, they did not associate school nurses (of whom they had no first hand experience) with home visiting; this was regarded as a health visiting function. The only choice, from their perspective, was to decide whether to employ a health visitor directly to carry out this function, or to set a contract through the local Trust. Priority access to the Primary Care Director soon ascertained that the Trust would be willing to be contracted to provide a health visitor to undertake this role; the post was advertised and filled within four months of the idea first being floated.

The economic imperative was such that the Trust's management agenda was focused almost entirely on ensuring services were purchased by GPs. Locality managers lacked the power to facilitate change, except to meet the requirements of GPs, whose wishes were to be regarded as paramount; their sense of disempowerment was enhanced by this rapid development. Efforts had been made fully to inform community nurses Trust-wide of the developments that culminated in the post. However, although school nurses in the area had heard about the new post, they were not officially informed until their locality manager began to arrange an orientation

programme for the new post holder. They clearly viewed the arrangement as an encroachment on school nursing territory, and expressed their anger about the unacceptability of the arrangement in no uncertain terms.

Likewise, health visitors based in the study site had been dealing with apparently unending organisational changes, a perceived reduction in their own and their managers' professional influence, heavy and difficult caseloads to manage. Seeing their views about the need to increase home visiting to pre-school children rejected left them feeling powerless and angry; this was compounded when they were asked to accommodate the post-holder within an already cramped office. This dissonance was reflected in unhappy working relationships; the new post-holder was effectively disabled through their non-cooperation and mistrust. Despite making significant advances in service provision, she soon left the unhappy situation to take up a post out of the area. In time, another post-holder was recruited and rapidly accepted, but the initially speedy progress was hampered by this 'false start'.

Community development project

The home visiting service for the families of school aged children was directed at a fairly specific group with established needs. To complement this service, a community development project in one of the most underserved areas of the town was proposed, to begin to tackle the underlying causes of ill health at a far more fundamental level. Negotiating for both posts began at the same time, but followed a very different process.

Normalcy

The central relevance of poverty, social disruption and poor living conditions within the local area was widely acknowledged as relevant to health, but that did not lead to acceptance that there should normally be a health service role in attempting to reverse those conditions. The NHS is highly influenced by the government policy and central direction. It might be easier to gain recognition for the relationship between health and the social circumstances that create them now, given the new emphasis on public health, poverty and social exclusion (DoH 1998). However, at the time of this project, the former government regarded needs as 'health' or 'social' depending on which service was expected to meet them and emphasised individual rather than collective responsibility for health. Unsurprisingly, this view was reflected in opinions expressed by some influential stakeholders in the local area.

Health visitors in the local area were interested in the idea, but emphatic that no time was available from within existing service numbers as the service was already perceived as grossly over-stretched. The commissioner most directly involved with community nursing contracts suggested that community work was not part of the normal health visiting role, which she described through practice-based tasks. Furthermore, a community project run by social services already existed in the local area. This supported the initial consensus that community development was a nice idea, but not practical and not really anything to do with 'health'. The ability of locality managers to influence change, as indicated above, was minimal; more senior Trust managers maintained a polite distance, often sending apologies to the project planning meetings held to consider the way forward. Once more, it was clear that it would be important to engage the interest of the GP fundholders.

Activity

Despite some interest, health visitors based in the research site remained mistrustful lest the researchers suggest changing their current practice of home visiting, and substitute community-based work instead. The idea of community development work is to change the living conditions for the local population, rather than settling for the 'status quo' of a poor physical and psycho-social environment by targeting only established problems. The commissioner who was interested in prevention had carried out his own survey of local residents and became convinced of the need to involve people in developing and changing their own circumstances. The empowering focus of community development provided a mechanism to effect changes in health care that would fit with the views that had been expressed in the residents survey. This commissioner became a useful facilitator and strong advocate for the idea, emphasising the support from the lay views he had elicited, as well as those identified in the action research project.

Persuading the GP fundholders of the value of community development necessitated shifting their understanding of health visiting work from one of therapeutic 'problem-solving' to a more educationally-based empowerment stance. One committed GP at the study site was invaluable in lobbying individual colleagues. Once interest was aroused, a seminar was held to explain how targeting the situation in which people live, rather than focusing on identified problems, could potentially reduce practice workload through the development of greater social support, coping abilities and knowledge across the local area. Gradually opinions were swayed and the GP fundholders agreed to support the project by funding a full time community development worker. However, in contrast to the home visiting for school age children service, developments remained slow and tortuous for several more months.

Legitimacy

The GP fundholders had been prepared to fund a full time post to enable this work to progress, alongside the service

for school aged children. However, funding and responsibilities within the health service are focused upon individuals. The use of 'patient-focused' or 'capitation-based' payment systems obscures the fact that there is no mechanism for recognising responsibility towards a community. This is problematic for funding an approach in which the whole community is regarded as a 'client' and targeted for development and partnership working (Anderson *et al.* 1986). The GPs discovered that they were not empowered to use their funds to pay for a project that encompassed all the residents on the chosen estate, since only 20% of the population were registered with their practice.

Even so, their continued agreement to meet this percentage of the requisite funding allowed serious discussions to be opened with other interested parties. The health commissioner lobbied his colleagues and, eventually, the local social services entered discussions. At this point, their community project had come to an end, and they viewed this proposal as a potential replacement. The local NHS Trust agreed to support the management costs and after several months of negotiation, a 'coalition' was formed collectively to meet the total costs of the post.

However, the need for the post holder to be a health visitor was disputed by social services; their disbanded project had not had a health focus and they believed different skills were needed for community development. Eventually, agreement was reached that both health and community work skills would be required in the post holder; the post was advertised in the national press rather than professional journals and any suitable professional qualification was deemed acceptable.

However, this kind of work is becoming increasingly prevalent within health visiting, and the approach is increasingly reported in their professional literature (e.g. Boyd *et al.* 1993, Suppiah 1994, Craig 1996, Gilbert 1996, Billingham & Perkins 1997, Brown 1997). In due course, an experienced health visitor was appointed to the position. She eventually took up her post at the same time as the second health visitor appointed to work with school aged children and was rapidly accepted by all parties.

CONCLUSION

This paper has presented an analysis of the processes of change observed in an action research project, as two new, innovative posts were developed and implemented. Action research with an organisational focus (Hart and Bond 1995) assumes that managers are in a position of power and able to drive through change; this was not the case here. Perhaps current typologies of action research need to be amended for health care studies, to take account of the overwhelmingly powerful position of medical commissioners (whether GP fundholders or their successor Primary Care Groups under the new legislation), whose strengths draw from both holding the purse strings and controlling the dominant culture in the NHS. That the GP fundholders were influential in establishing two new services, neither of which are closely aligned with the bio-medical approach, may be seen as positive. The limiting influence of both formal and informal constraints upon the rapid introduction of the services might signify that an appropriate balance of power exists.

It was apparent in this study that the notion of 'health need' was closely conflated with the idea of 'use of GPs'; this led to the parallel of service planning directed at reducing demands on general practice time. There is no inherent problem with this, as it is similar to the idea of 'need for what?' proposed by McWalter *et al.* (1994). However, it would be very short step from that point to the more stigmatising attitude of 'good' and 'bad' service users and could potentially miss needs among the most excluded and disenfranchised members of the population, who have no access to primary care. Less positively, too, critics may point to the inequitable service provision established for only one group of school children in the town (those registered at the practice) and the distress caused as the service was being set up.

Three questions about the service for school aged children remain unanswered. First, would a school nurse have fulfilled the post as well or better, had it been possible for the general practice to set such a contract? Both occupational groups are equally well qualified to carry out the work, but custom and practice means that health visitors tend to focus on pre-school children, while few school nurses carry out home visits. Second, if a school nurse had been appointed, would this have avoided some of the distress expressed by both school nurses and health visitors? Similar questions might be asked of the community development post. Whether local social workers felt offended and distressed by the appointment of a health visitor to this position is not known, although the senior personnel were eventually satisfied. Not least, the ethical question arises of whether the upset created in any change process is justified in the interests of research, albeit in an action research project that aimed to implement such change.

The researchers were not in a position to alter the poor communication practices across the Trust, which appeared to stem mainly from the unending changes, job insecurity and vulnerability of senior personnel. Efforts to inform all concerned about the project did nothing to ameliorate the sense of betrayal experienced by practitioners who were already upset, stressed and angry about unconnected events. This may not be sufficient to excuse the part played by the research. Arguably, however, it would have been at least as bad, or possibly worse, to have ignored the lay perceptions and other imperatives that pointed to these services as preferred alternatives.

The analysis showed that it was possible to move forward with negotiations about significant issues as long as channels of communication were open, even where dissonance existed. This reflects the finding of Cowley's (1991) study of health visiting practice, in which it was clear that dissonance was, at times, a necessary part of the process even though it was not a preferred way of working. In that study, official agreement that a chosen focus or organisation of the work was approved as legitimate by employers was a pre-requisite to negotiating with clients about their perceived health needs and suitable activities to meet them. In this study about planning service provision, the legitimising process was the final stage of negotiation which confirmed that proposals could proceed.

Overall, the action project achieved a small shift towards consumer participation and the idea of establishing services according to identified needs. The two positions appear to be flourishing and there are plans to develop formal evaluations to inform future commissioning in the area. The analysis of the processes involved in introducing these changes adds to an understanding of how decisions about health visiting services are structured. The choices listed are not widely or consciously considered in decision making about service approaches, which tends to emphasise evidence of clinical effectiveness rather than social and political processes.

Another round of far-reaching organisational change is underway as proposals announced in the 'New NHS: Modern, Dependable' (DoH 1997) are being rolled out. A consideration of the processes identified in this analysis may highlight power imbalances, potential 'sticking points', or preferences in the acceptability of new ideas when changes in service provision are proposed.

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