Research Proposal

How can I/we support the development of family-centred public health, especially for reducing social exclusion and improving health through co-enquiry between health visitors, school nurses, our clients and other agencies?  

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Health visitors and school nurses in primary care are required to find new ways of working towards better outcomes for health in families in a climate of changing health needs and social challenges (*The NHS Plan*, DoH, 2002). To this end shifts towards greater involvement of individuals and communities in deciding their own health needs and care are integral to these expectations (*Strengthening Accountability*, DoH, 2003a). Individual and family work is also being drawn to becoming more integrated with community-based approaches to health through multi-agency partnerships in order to maximise the impact of family-based work (*Health visitor and School nurse practice development resource pack* DoH, 2001). The growing social, economic, ethnic and gender inequalities in health are to be tackled not only by addressing short term consequences of ill health but also the longer term causes of inequality, with people experiencing the greatest burden of ill health (*Tackling Inequalities*, DoH, 2003b). This shift in focus does not exclude assisting all groups in society from improving health but intends improving the health of the poorest fastest. Health visitors and school nurses who have traditionally undertaken policy defined tasks, with age groups universally across their communities, now want to understand how to put changing, sometimes competing expectations into practice in ways that are meaningful to the experience and wellbeing of individuals and communities.

This proposed innovative action research project intends developing new ways of approaching family-centred public health within a Primary Health Trust (PCT) by exploring the relevance of insights arising from my PhD self-study for other practitioners across the PCT (Pound, 2003). ‘Alongsideness’ is my way of explaining community practice that is envisioned as co-enquiry between community practitioners, all of their clients and others in the interdependent activities for both enquiring for shared understanding and practising. Understanding the relationships that promote shared enquiry and wellbeing are central to the enquiry in practice process. Health improvement activities focus primarily on needs identified by individuals in communities, with health targets in mind and multi-agency partnerships employed as appropriate for achieving desired results. This research project is expected to create a living resource of insights about family-centred public health arising directly from the experiences of practitioners and clients. It involves a collaborative initiative between B&NES PCT practitioners and the University of the West of England (UWE) to develop collaborative enquiring between colleagues and co-enquiry-as-practice with clients as a way of improving outcomes for individuals and communities.

**Aims**

- to find collaborative ways that we practitioners, can create relationships with families and communities that enhance their health and support personal growth and responsibility for healthy living to meet PCT social inclusion intentions.
- to support the generation of professional values as guiding principles for health enhancing relationships as they emerge and are tested in practical experiences.
- to illustrate the usefulness of collaborative enquiry with clients for enhancing health and social order of communities and between practitioners to develop professional practice.
- to establish a *living* resource network for family-centred public health practice for sharing understanding about public health practice.

**Background context**

This research differs from usual primary care research in that beyond identifying *what* enhances effective relationships, explanations of *how* and *why* change occurs is sought from collaborative reflection between professional colleagues and their clients. From reflection between

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1 By *living* I mean as lived and explained by practitioners in their daily practice. *Living* also means that practitioner explanations expand as new meanings emerge from diverse contexts and experiences.
professionals and all clients about lived experiences in practice, shared decisions can be made about how to proceed. The processes of developing understanding about what influences behaviour change can be noted in accounts of practical experiences as practitioners put theories into practice and generate new insights into how and why they do it. In this way evidence of changing insights and actions of both practitioners and clients is collected.

Community-based nursing intentions are informed by Department of Health priorities in the form of National Service Frameworks (NSFs), developed for tackling major causes of morbidity and death (A First Class Service, DoH, 1998). A tension arises between epidemiologically defined health priorities and the reality of the lives of individuals and communities whose motivation frequently lies in more immediate and complex influences on their own and their family’s wellbeing. Health visiting and School nursing skills lie in identifying the health needs of individuals and communities in order that appropriate health enhancing activity and disease prevention can be facilitated, and in child protection activity. Child protection and health promotion activities require different, sometimes contradictory styles of relationship in the degree of authority that the professional balances to achieve desirable results (Pound, 2003). Primary preventive activity, the focus of this study, is often with families who might not themselves anticipate or feel able to act on professionally predicted health concerns because of their own more immediate preoccupations. These families may avoid suggested healthy initiatives in favour of addressing their own concerns.

Community-based nurses while recognising those at risk of future disease may feel unable to approach preventive activity until they have addressed clients’ immediate concerns and influences on their wellbeing. Further, attempts at working in wider, community-based ways alone may risk not engaging the most socially excluded individuals and families who are isolated through longstanding inability to create and sustain relationships. Health visiting and school nursing have developed as relationship-based activities because of the importance of relationships to effectiveness of the work. The qualities of relationships are therefore central to the concerns of this research. The links between Department of Health expectations and the reality of people’s lives and health needs will be clarified by this enquiry process. By creating accounts of co-enquiry-in-practice individual practitioners will go further by generating their own guiding principles of practice relationships that improve health and wellbeing. From these individually held guiding principles it may be possible to identify values that are widely shared and of interest to the professional practice enquiries of others and extend the knowledge-base of family-centred public health.

Background research and underlying principles
Action research can be described as a family of research methodologies that pursue action (or change) and research (or understanding) at the same time through action and critical reflection. It is chosen here as a way of discovering how and why aspects of practice are important by reflecting, modifying and checking insights as they emerge from practice, with the people most affected – our clients. Co-enquiry intends creating effective ways of being that are health enhancing. Our clients may adopt similar principles in their own life enquiries. The values base of action research has become central and increasingly researchers are explaining how action research aims to be a living of values in practice (Mc Niff, 2002; Whitehead, 1989). It is therefore an added dimension of this research that we ask ourselves, ‘do we really act as we claim we do in our practice relationships?’ ‘why are our values hard to live sometimes?’ In this way values we claim to embody and live become personal standards of evaluation while also being a useful means of explaining what we are doing.

In my previous PhD research I asked how I could improve my health visiting practice supporting developing family relationships (Pound, 2003). I found that in attempting to meet the needs of individual parents and children who each have unique views of the world as they live unique lives, I recognised certain values as guiding principles appropriate for my effective working relationships. I call my personal constellation of developmental values ‘alongsideness’. Other practitioners appear to find their own resonance in values of alongsideness as they enquire into
questions such as, ‘how can I develop my practice?’ (www.actionresearch.net). Even though the full meanings of my beliefs and values that make up alongsideness are lost when abstracted from the practice in which they are grounded, I summarise them here. For me alongsideness is:

- founded on the worth of humanness, in that all people are valuable, have useful knowledge and are worth my respectful effort
- a belief that people are living in a ‘process of becoming’ and would prefer life to be better if only they knew how to achieve it
- belief in the creativity of people who are searching for solutions
- the value of self determination for growth and responsibility
- belief in a life affirming energy to be gained from connection between people.

I constantly need to ask myself, ‘do I live these values wherever I practice?’ This proposed research intends moving beyond my personal enquiry by inviting community practitioners across the PCT to join collaborative enquiries with each other and their clients for improving, understanding and explaining what we are all doing for improving health and wellbeing in our communities. Envisioning public health work as a process of co-enquiry, in which the knowledge, creativity and personal responsibility of all clients and professionals is valued, begins the task of tackling social inclusion and promoting health. My focus in this research is to support the development of co-enquiry process, in enquiring and in practise, towards the stated aims and to generate explanations of new insights emerging. As a research project the process therefore has two parts and two outcomes:

- Individual practitioners across the PCT will create accounts of their own practice development in co-enquiry with clients and communities.
- My research report in partnership with Glenys Hook will explain the enquiry process as a method of developing family-centred public health across a PCT and ask if there are widely shared values.

How will we do it?

Health visitors and school nurses across the PCT (around 60) will be invited to join a reflective action research project to improve and explain our family-centred public health role. The process is envisioned as creating co-enquiry between ourselves and families in their communities. Practitioners will meet in facilitated groups of eight-ten health visitors and school nurses fortnightly over a year, with the intention of undertaking enquiries beginning with questions such as, ‘how can we develop our public health practice?’ Utilising Glenys Hook’s (UWE) health visiting and group facilitation experience and mine in action research (Pound, 2003) our aim is to develop the process of co-enquiry with families as a way of understanding, improving, evaluating and explaining family-centred public health. Using an approach that is grounded in and values the knowledge and skill that each of us brings to what we do, we will use action reflection cycles arising from individual questions such as, ‘how can I understand, improve and explain what I am doing?’ (Whitehead, 1989; DoH, 2003c). Enquiry will:

- illuminate our understanding of the skills and ways of being that make a real difference for the health of families, particularly the most disadvantaged
- explore the benefits of co-enquiry as a way of working towards the social functioning and health of individuals and communities.
- collect evidence of our emerging understanding, changing ways of being and influence working with clients, that are grounded in practical experiences
- transform values as guiding principles into standards for evaluating individual practice as we ask, ‘do we live our values in what we do taking care of our own health and as we influence the health of others?’

Questions that stimulate action research

The research process enables practitioners to identify professional values we embody and intuitively ‘live’ in relationships and during decision making. The search for understanding of embodied values for healthy relationships continues in dialogue with clients throughout the process and emerges out of questions such as McNiff suggests (2002):
What is important in what I/we do and why?
For my colleagues’ individual enquiries and the research process, by identifying values motivating the way we approach our clients and make decisions we can begin to understand and account for our health promoting actions. We can ask, ‘how can we live our values more fully?’

What is my concern and why?
As we listen to our clients and review our practice we will identify health needs or aspects of health care delivery we want to improve. These might be concerns within families or communities, concerns about aspects of our practice or questions about the implications of health policies. Concern may arise when values are not lived fully or are hard to live in some situations. Exploration of contradictions when values are denied can expand meanings of values as explanations of practice, can change practice and extend the usefulness of insights for other contexts. I have found use in sharing my values with disadvantaged parents as they consider their own concerns.

What evidence can I collect to show why this is a concern?
The main record of reflective process is likely to be in reflective journals and reports (McNiff, 2002). However, evidence may be collected within usual professional records and screening tools. Some practitioners may also choose to use surveys, taped conversations or questionnaires (Pound, 2003). Initial evidence acts as a baseline for change and helps raise awareness and understand concerns. It is characteristic of action research that the direction and process is not prescribed at the outset but emerges from the requirements of the process. As this project focuses on understanding relationships involved in seeking change, evidence is more likely to be in the form of individual accounts of people’s perceptions of situations and their individual motivations for action rather than large scale surveys. Similarly, Glenys and I will collect reflective data about enquiry values and process. Ethical advice is sought for data collection beyond usual professional record keeping (see below).

What will I/we do about the concern?
Co-enquiry action planning respects all points of view, may involve other agencies, and is expected to progress in steps towards health goals decided by those most affected. Action and reflection is likely to be in similar cycles to Plan Do Study Act described by the National Primary Care development Team (DoH, 2003c). This research has the added dimension of reflecting on relationships of practice as a main aim.

Who will help us?
This research is supported by B&NES PCT with protected enquiry time for those involved and funded facilitation of groups. My experience supporting co-enquiry will be utilised facilitating groups, ensuring rigour in collecting and analysing data, keeping to timetable and producing a report of findings to inform future practice development-as-enquiry. Glenys Hook of UWE will facilitate groups, collect reflective data about the process and offer public health resources as needed.

How can I/we collect evidence to show that I/we are influencing the situation?
The purpose of collecting and analysing data is to provide evidence of new insights emerging, the meanings of values, changing practice and influence that is grounded in individual practice experience. Change centres on attempts to live values more fully. This process of insight, transformation of understanding and change in actions of practitioners and clients is recorded in field notes, reflective journals, reports and discussions (McNiff, 2002). Practitioner’s emerging insights are checked back with clients or colleagues in the enquiry groups and questions asked about the validity of assumptions drawn (Winter, 1989). Influence can be

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2 Screening tools such as Developmental Assessments, Postnatal Depression Scores, Family Health Plans
3 Survey, for example ‘Rapid Appraisal in Primary Care’ (S. Murray, 1999. BMJ. 318.pp.440-444)
demonstrated from evidence of clients showing new understanding, acting differently or claiming the benefits of change. Making sense of the data (called ‘analysis’ in different methodologies) means we are each generating evidence for our claims to know what we are doing and rigorously checking that it is believable and has relevance for others (Pound, 2003). Although it is expected that enquiry-as-practice is on-going for practitioners, evidence collection for exploring the concerns identified by individual practitioners and their clients will be drawn to a close for the completion of reports. The research report, from evidence similarly collected and checked, will be interpreted as an explanation of the co-enquiry process within the PCT and attempt to identify shared values that may inform future enquiries into the guiding principles of others.

**How can I/we assure safety for clients?**
Ethical and human rights considerations are central to our intentions to foster client participation and support enhancement of wellbeing through respectful relationships. Research methods and the collection of evidence suitable for representing new insights and processes of change beyond normal record keeping, must satisfy usual ethical considerations (DoH, 2003d). At the beginning of the project we will hold discussions with all practitioner enquirers to ensure that research-in-practice is capable of upholding ethical standards. Draft Research Contracts for practitioners, Patient Information Sheets and Information for GPs are prepared. Ethical approval is sought for the keeping of private reflective journals by practitioners. These journals will be anonymous and the use of data in reports will not be traceable to individuals. Particular care will be taken to protect individuals when reporting distinctive incidents in which people may be identified. Journals will not be computerised, will be kept in a safe place, and will be destroyed at the end of the project. The same degree of anonymity will be assured co-enquirers unless they choose to acknowledge one another by mutual agreement. Practitioner enquirers will seek their own separate ethical approval for interview schedules, questionnaires or other forms of data collecting.

**How will I/we ensure that any judgements we make are reasonably fair and accurate?**
New ideas of practitioners are checked by questioning assumptions at every stage of the process (Winter, 1989). Validation of claims to know our practice will come from collaborative critique, evidence of effectiveness in practice (especially when others integrate values as their own), and cohesiveness with established theories. Professional values, tuned by individual beliefs and experiences (Pound, 2000), become standards for testing claims. The process should demonstrate internal methodological consistency and rigour (McNiff, 2002).

**How can I/we represent the insights emerging from this enquiry?**
Narrative accounts will illustrate lived experiences, emerging insights and changing behaviour of those involved (Connelly and Clandinin, 1990). Professional values will become guiding principles for sharing explanations of practice.

Dissemination of this innovative co-enquiry approach to practice and research will primarily be through exploration of its usefulness across the PCT in this and later phases as we extend our questions. Booklets will be produced of individual reports for local sharing and placed on the internet for stimulating wider discussion. Beyond continuing reflection on my own practice, my involvement is to:
- create and sustain suitable ‘alongside’ support for practitioner enquiry in the PCT
- work towards publishing insights about the process of supporting practitioner enquiry
- collate insights about co-enquiry in family-centred public health suitable for publication
- create a national network as a living resource about family-centred public health as co-enquiry

<table>
<thead>
<tr>
<th>Timescale</th>
<th>Where are we now?</th>
<th>Where will we be in six months?</th>
<th>Where will we be in a year?</th>
<th>Where do we hope to be after two years?</th>
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<tbody>
<tr>
<td>Health visitors</td>
<td>Find it difficult to articulate what is</td>
<td>Practitioners have identified their own</td>
<td>Practitioners have each produced</td>
<td>Health visitors and school nurses across</td>
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### School nurses

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<th>Important in what we do for families in relationship–based practice. Unable to produce evidence of the influence we have on the wellbeing of our clients.</th>
<th>Questions of the kind, ‘What is valuable in what I do?’ How can I develop my practice? Each is writing accounts of practice experiences and presents to a group.</th>
<th>Reports about practice development they have undertaken, offered evidence of outcomes for clients and themselves and formed speculative insights about its relevance to family-centred public health.</th>
<th>The PCT all have the opportunity to join an enquiry group as a way of understanding, improving and explaining practice. Practitioners making findings public through conferences, publishing.</th>
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### All clients including socially disadvantaged

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<tr>
<th>May expect to be given answers or have their problems solved for them. May feel judged by professionals who have knowledge and power.</th>
<th>Have been consulted on their concerns about their family or community wellbeing Invited to join decision making to plan change.</th>
<th>May have been invited to consider effective relationships with professionals, within family and community. May have changed behaviour in line with new understanding.</th>
<th>May join community activities or play a part in planning action for change. May seek education or employment.</th>
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### Robyn Pound
**Co-ordinator co-enquiry and research**

| I intend building on the possibilities of co-enquiry as a method of working with clients and for researching family-centred public health in the PCT and in UWE. Supporting around sixty practitioners in co-enquiry groups with Glenys Hook. Produced an interim report describing the co-enquiry process and tentative insights emerging. | Supported a process for validating colleagues’ claims to know their practice. Produced a report on the process of supporting co-enquiry in practice, insights about family-centred public health and its wider relevance. | Findings published and conferences attended. Network created as a living resource for family-centred public health, action enquiry. Support action research at postgraduate level and continue as part time health visitor. |
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### Glenys Hook
**UWE lecturer**

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<th>Want to understand and support the development of family-centred public health. Want to learn from the process of enquiry with practitioners.</th>
<th>Supported the setting up of the enquiry groups. Join co-enquiry by asking own questions. Provide resources and skills as required by the processes as they unfold.</th>
<th>Understand evidence-based practice as both informing practice while also creating new evidence from practice. Student practitioners develop co-enquiry skills in their training.</th>
<th>Practitioner action research explored for post graduate research appropriate for creating knowledge about how and why practice can make the kind of difference that matters to clients.</th>
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### B&NES PCT

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<th>Want to do something to development more responsive family-centred public health to tackle social exclusion. Need to understand and account for practitioner actions.</th>
<th>Arranged venues and funding for protected time for enquiry groups if necessary. Invited insights to be valued, shared and questioned in professional forums.</th>
<th>Seminars arranged for the presentation of insights about family-centred public health. Continue to consider the implications of speculative findings on PCT policy and on public health.</th>
<th>Enquiry groups established for continuing to improve and extend public health across the PCT. Consider extending co-enquiry process to other nurses in the PCT.</th>
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### Conclusion

Practitioner’s individual research reports and the facilitators’ report as explanation of the overall process will explain new insights, guiding principles and practical developments about family-centred public health practice. The reports will develop co-enquiry for enhancing social inclusion through client participation and will be available for wider debate about public health in professional practice. Links between guiding principles of practitioner activity with individuals and communities and Department of Health priorities will be clarified.
References
Department of Health (1998) *A First Class Service*
Department of Health (2002) *The NHS Plan*
Department of Health (2003a) *Strengthening Accountability*
Department of Health (2003b) *Tackling Inequalities*

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