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# Appreciative Inquiry of Community Nursing Services for Children and Young People


Amanda Clayson (VoiceBox Inc)
Michael Lloyd (MLR)
Final Report - September 2015

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## Version & Revision Record

| Version | Date | Author | Checker / Approver | Description |
|---|---|---|---|---|
| Draft – Final Report | 27/08/15 | AC/ML | KL | Final Report –DRAFT FOR COMMENT (NOT FOR WIDER CIRCULATION) |
| Final Report | 30/09/15 | AC/ML | KL | Final Report |

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# 1. BACKGROUND

## Context

1.1 NHS South Cheshire Clinical Commissioning Group (CCG), NHS Vale Royal CCG and NHS Eastern Cheshire CCG are working alongside two independent external consultants (Michael Lloyd Research MLR & VoiceBox Inc) to better understand the current community nursing support provided to children and young people (CYP) with treatment needs that attend either 'special schools' or mainstream schools.

1.2 The CCGs commissioning this work are responsible for providing treatment services for nearly half a million people across Cheshire. NHS Vale Royal CCG covers a population of 102,000 people[1] and includes Winsford, Northwich and surrounding rural areas. NHS Eastern Cheshire CCG[2] is made up of 23 Eastern Cheshire based GP practices, covering a further 204,000 Cheshire residents, whilst NHS South Cheshire CCG includes a population of 173,000 people[3] within its boundary, including the well populated town of Crewe.

Following the decisions taken by local authorities to re-commission their 5-19 health offer, health service commissioners saw this as the **ideal opportunity to look at the children's community nursing provision** locally.

1.3 The provision of health and well being services for CYP is very complicated. Services are commissioned by NHS England, local authorities (LAs) or Clinical Commissioning Groups. The 2012 Health and Social Care Act[4] transformed commissioning responsibilities – for example, providing an enhanced role for local authorities in health improvement, shared leadership of the system through health and wellbeing boards, and a strong consumer voice through local Healthwatch. Following the decisions taken by local authorities to re-commission their 5-19 health offer (delivery of The Healthy Child Programme[5]) local health service commissioners saw this as the ideal opportunity to look at the children's community nursing provision locally - some of which is delivered by special school nurses, whilst other small teams of children's nurses also support nursing needs at people's homes.

1.4 This work is also timely in light of the changes introduced in September 2014 to improve support for children and young people with special educational needs and disability (SEND). From 1st September 2014, Part 3 of the Children and Families Act 2014 provides for a reformed SEND system. Across Cheshire there is a graduated approach to meeting special educational needs, in line with the Children and Families Act:

[1] For more facts and figures for NHS Vale Royal CCG, see: http://www.valeroyalccg.nhs.uk/about-us/who-we-are/facts-figures
[2] For more on the coverage of NHS Eastern Cheshire CCG, see https://www.easterncheshireccg.nhs.uk/About-Us/our-practices.htm
[3] For more facts and figures on NHS South Cheshire CCG, see: http://www.southcheshireccg.nhs.uk/about-us/who-we-are/facts-figures
[4] For more, see: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[5] For more on the Healthy Child Programme see: https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence

- **Universal provision** – caters for most special educational needs, being met within mainstream (universal) provision and services - this includes SEN Support.
- **Complex needs** – are met by other targeted services and support, within mainstream provision and services (this is also SEN Support). It is additional and different to the provider's usual offer.
- **Specialist provision** – is triggered by the multi-agency statutory assessment process. This may lead to an Education, Health & Care Plan. A small proportion of children/young people with SEND will be at this end of the graduated approach

1.5 It is the Clinical Commissioning Groups responsibility to commission treatment services and therefore vitally important to make sure that these services are available to children and young people according to their needs and that these services work effectively with other parts of the system. Demand for clinical services varies greatly from one location to another, according to individual CYP needs - ranging from nursing input with regards to daily medication and care, to notification (both to parents, educationalists and relevant health professionals) of any changes observed in a pupil's condition or behaviour, which can prove instrumental in improving their quality of life both at school and at home.

**Demand for clinical services varies greatly** from one location to another, according to individual CYP needs - ranging from nursing input with regards to daily medication and care, to notification of any changes observed in a pupil's condition or behaviour, which **can prove instrumental in improving their quality of life.**

1.6 The needs of the individuals placed in the nursing teams care can change on a daily basis. For example, medication adjustments may be required in response to a deterioration in health, emergency admission to hospital from school may take place, whilst common ailments like the common cold or gastroenteritis can be potentially life-threatening. Some children require oxygen, suctioning, gastrostomy feeds and medication – whilst complex cases have a mix of needs, treatments and risks.

1.7 Nationally it is well documented that working in a family-focused, holistic way is essential to the delivery of consistent, high quality care and to reducing inequalities in the health and well being outcomes for different groups. How this care environment looks through a localised lens is one of the key outcomes from this study. We are starting this work with an Appreciative Inquiry (AI) of the local community nursing provision for CYP with treatment needs.

## What is an Appreciative Inquiry (AI)?

1.8 An Appreciative Inquiry is a change management approach that helps organisations to connect with service users and other stakeholders to identify what is working well, understanding why it works well and then collaboratively working together to do more of this in the future.

1.9 In the late 1990s a '4-D model' of Appreciative Inquiry appeared and has

come to be strongly associated with AI. This traditional model states that there are four phases to AI research: discovery, dreaming, designing and destiny.

- '**Discovery'** is the start of the AI, concerned with identifying 'best' experiences rather than commencing from a problem focus. Although this phase aims at capturing best experience, it inevitably also gathers information about experiences that are critical.
- '**Dreaming'** changes the focus; asking participants to imagine how the subject under inquiry (for example, the nursing services response to special needs) might be improved. This enables the participant to link their 'best' experience to how things may be further enhanced.
- '**Designing'** involves the participant identifying practices, relationships and processes which might be necessary to support the 'dreaming' ideas and articulated as 'best' in the discovery phase.
- '**Destiny'** concentrates on what is needed to maintain and sustain the changes dreamed about and designed.

1.10 These guiding principles are commonly the foundation stones when building an AI, however they can be ambiguous when translated into an action planning framework and open to misinterpretation. As is detailed in the Methodology section of this report, for an AI to have maximum impact five components are often applied by AI experts[6] – these five 'components' are:

- **Conversations.**
- **Cooperation.**
- **Co-creation.**
- **Co-design.**
- **Continuation.**

*For an AI to have maximum impact five components are often applied:*
***~ Conversations.***
***~ Cooperation.***
***~ Co-creation.***
***~ Co-design.***
***~ Continuation.***

1.11 The activities completed to date (in June and July 2015) have:

- **Begun conversations** - with parent/carers, nurses and stakeholder groups, to establish a 'trust field' and create space for change.
- **Nurtured cooperation** - ensuring voices and ideas are heard, the vision for the future is 'owned', and laying the foundations for co-production.
- **Introduced co-creation** – exploring with stakeholders what ideas and imagination might help to develop the future intentions.

1.12 The Summative Events will begin the next phases of this work, that will extend from late September 2015 into 2016. The next phase of work will involve: identifying where gaps in conversation exist (bringing in new 'voices' if necessary); sharing ideas and honing propositions; clarifying the future vision; building skills and encouraging co-production and 'design thinking' – to basically create the arrangements for the 'Delivery' and 'Destiny' stages of the 4-D Model mentioned earlier in this section.

[6] See for example: www.appreciatingpeople.co.uk/

## 2. AIMS & OBJECTIVES

2.1 In the previous chapter the context and drivers for undertaking the AI are outlined. This is sometimes described as the 'definition' pre-cursor to the AI cycle - defining the project's purpose, content, and what needs to be achieved, to clarify the area of work to be considered. In this chapter the aim and objectives are summarised.

2.2 The aim of this AI engagement exercise is to understand what works well for individuals and their families, and to work together with users, families and carers and the providers of that care to ensure that the system continues to work well in future, to support individual needs and identify any areas for development and improvement.

The future provision of community nursing requires **a robust engagement and participation process to underpin current service delivery,** so as to:
~ **identify what works well;**
~ **match service provision against local need;**
~ **ensure that there is flexibility and personalisation** in the provision.

2.3 In applying appreciative inquiry methods, the objectives included:

- to build relationships with as wide a group of stakeholders as possible (including staff and families), so as to gain trust.
- to search for service strengths using a number of techniques, including observation and exploration of service user/staff/family stories (so as to identify beliefs and values about effective service).
- to identify and share strengths, and ask people to think about the elements they value, and what they would like to happen more often – and how this could happen.
- to work with a wide stakeholder group to find out what their dreams or aspirations are for the service.
- to develop in the Summative Workshop (the second workshop sessions), where relevant, provocative statements that express how they want their service to be.

2.4 A four side 'specification' for this study, drafted by the 'Starting Well' team in December 2014, outlines the changing commissioning landscape and requirement for a consultation and engagement programme. The Starting Well document notes that the future provision of community nursing requires a robust engagement and participation process to underpin current service delivery, so as to:

- *"identify what works well and what doesn't;*
- *match service provision against local need; and*
- *ensure that there is flexibility and personalisation in the provision".*

2.5 As described in detail in the Methodology, this initial piece of work is a first stage in developing understanding and moving towards co-creation of future services - to inform ongoing work post-September 2015. The purpose of this AI is not to find all of the answers - but to engage the stakeholders, understand their experiences, and to demonstrate that commissioners value their opinions. The AI strives to capture what is happening on the ground in terms of the services and how are they being experienced by the different stakeholders.

# 3. METHODOLOGY

## Scope

3.1 As introduced in Chapter 1, an AI approach has been adopted – focusing on what works 'best' and how stakeholders can work together to make that happen more often. The main benefit of conducting an AI will be in developing a collaborative way of working with service users, families and stakeholders to develop local future plans to enhance the quality, effectiveness and efficiency of local services, so that they will be better able to meet the needs of the local population in the future.

3.2 The power of Appreciative Inquiry is the way in which participants become engaged and inspired by focusing on their own positive experiences. Usually in a workshop setting, participants are encouraged to remember and relate personal experiences of success, identify the common elements of these experiences – to ultimately devise statements and action plans for making those experiences occur more often.

*"As an act of aspirational cognition, AI obliges users to* ***focus on increasing the supply of things they desire rather than confront error via conventional problem solving****"*

3.3 The service scope for this review - of community nursing provision for children and young people in the area, had a starting point of existing special school nursing services - in relation to the treatment needs of children attending special schools who might also be accessing services from the following teams -

- Complex Care Team provided by East Cheshire NHS Trust.
- Advanced Paediatric Nurse Practitioner provided by East Cheshire NHS Trust.
- Children and Young People's Home Care team provided by Mid Cheshire NHS Foundation Trust.

3.4 The participant list grew as the scope widened, with the commissioners keen to reach as diverse a range of stakeholders as possible in June and July 2015 – beginning with families/carers, nursing staff and stakeholders with an interest/involvement with community nursing provision. Children and young people who use the service were not forgotten – they will be included in engagement in the next wave of fieldwork, co-ordinated by the Young Advisors, post September 2015.

3.5 The stages to the methodology are graphically illustrated later in this Chapter – with initial communication and engagement activities beginning in May 2015 with:

- an invitation to stakeholders to attend Introductory Workshops in Winsford and Crewe on 9th and 11th June 2015.
- communication of activities and news via a bespoke website set-up by Michael Lloyd at MLR. www.researchmlr.co.uk/cheshireai-nursing
- invitation to participate in the engagement focus groups or one-to-one sessions, co-ordinated by Amanda Clayson from VoiceBox.

3.6 The fieldwork was undertaken primarily by Amanda Clayson, with support at workshops from the CCG Project Management Team and MLR representatives. Data collection and analysis by single researchers is an individual activity that requires an analytical or theoretical framework in order to ensure validity (Miles and Huberman, 1994[7]) – and this was set out to the commissioners as follows:

1. Establish the general 'fields'/parameters of inquiry:
- the rationale/criteria/scope and general focus forms the baseline/ overarching framework of the inquiry.
- 'set out' and trial in the launch events in Winsford and Crewe in June. Interaction/response at both events indicate if we are on the 'right track' (i.e. elicits rich discussion?, 'spoke' to the various perspectives?, provided clear themes for further inquiry?).
- Group the outcomes from the events.

2. Further 'investigation' from each perspective in one-to-ones/groups:
- This is driven by the responses to the original inquiry framework. As part of this, follow up on the broad themes collected through the launch events ('testing' them, clarifying, getting examples etc).
- This also includes exploring 'gaps', issues not mentioned (though the aim of an AI is to capture what is said, the degree of consistency, 'weighting', impact across the landscape - perspectives, geography etc).

3. Collation and 'curation':
- The 'investigator' keeps records of what is being collected (to inform AI).
- The collation/curation process is intentionally a summative process. It doesn't mean that information isn't being processed, but its final significance is clarified/reported on at the end of the collection process. This is why AIs are best carried out over a concise period of time. A 4/5 week window is ideal for this.

4. Reporting/ Feedback:
- The feedback loop is an important part of the process. The aim is to be involving /participatory.
- This means providing maximum opportunities for people to be involved (within the agreed scope of the inquiry). This relates to 'reach', focus and resource.
- The reporting/sharing/feedback process enables/supports 'respondent validation' - i.e. have we captured the right themes/ does this represent the main areas etc.
- Our Summative Workshop sessions will provide this, with webpage questionnaire a safety net for those not able to attend.
- It is also part of the reflective/summative part of the ongoing fieldwork conversations.

Data collection and analysis by single researchers is an individual activity that **requires an analytical or theoretical framework in order to ensure validity** – and this was articulated to the commissioners early in the process.

[7] Access here: https://vivauniversity.files.wordpress.com/2013/11/milesandhuberman1994.pdf

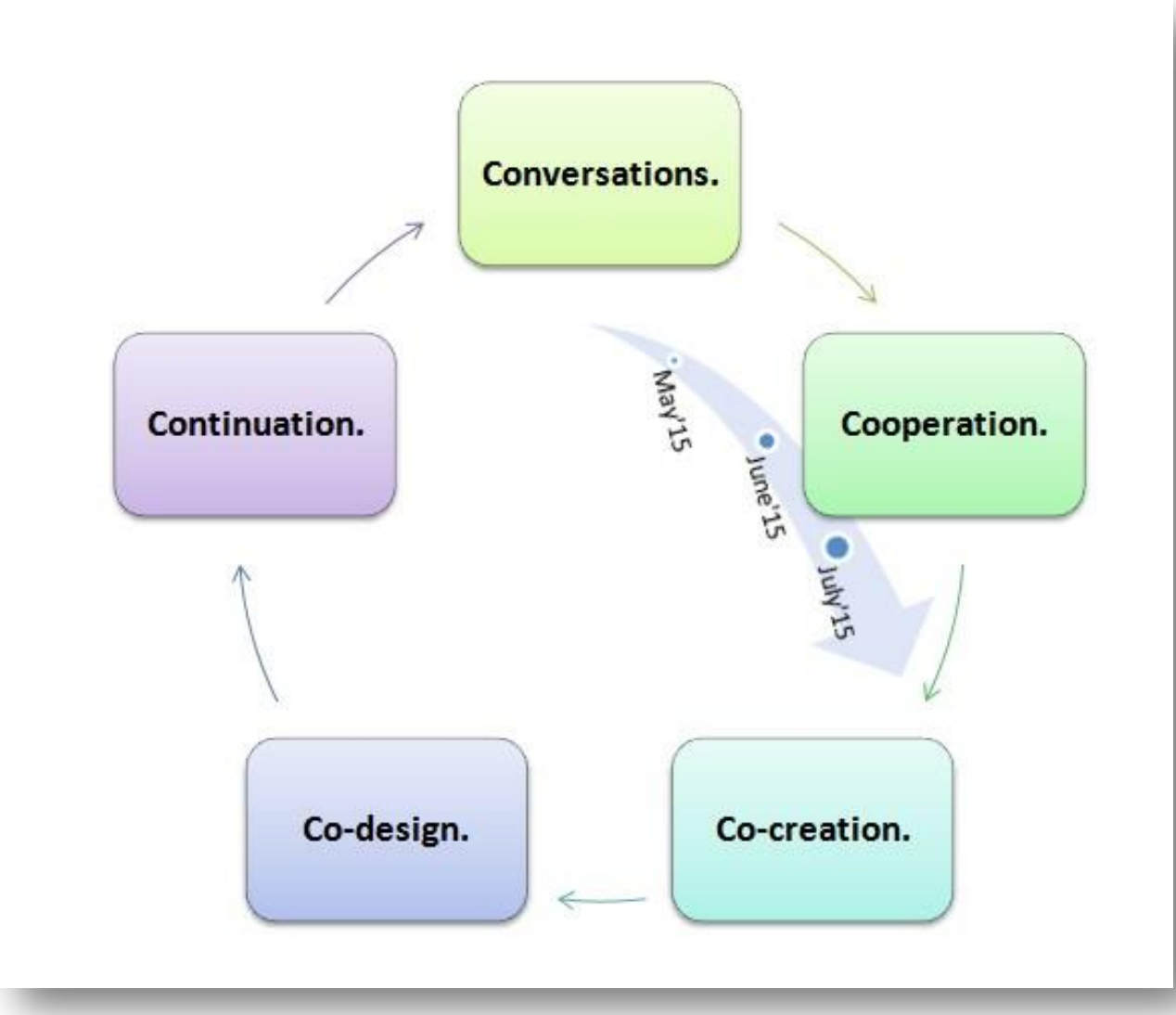
## Applying the 5 'C' components

3.7 As stated in the first Chapter, for an AI to have maximum impact five 'components' are needed:

- **Conversations.**
- **Cooperation.**
- **Co-creation.**
- **Co-design.**
- **Continuation.**

3.8 The AI activities completed in summer 2015, covered in this report, have developed conversations, nurtured cooperation and begun the process of co-creation (see graphic that follows).

***Figure 1: Applying the 5 'C's in AI activities***




*Adapted from [www.appreciatingpeople.co.uk](http://www.appreciatingpeople.co.uk) application of five AI elements.*

3.9 As will be communicated in the Summative Workshops taking place in Winsford on 15th September and Crewe on 18th September, the next phase of the work from October 2015 will develop:

- Co-creation: identifying the future vision, sharing ideas, and using imagination to develop the future intentions, and provocative propositions or future frameworks.
- Co-design: encouraging prototyping, co-production and 'design thinking', based on the intentions that emerged from the 'Dream' stage.
- Continuation: recognising that it's an ongoing process of building on intentions, supporting actions and frameworks developed, trusting the system, encouraging reflective learning and evaluation. It also includes celebrating the successes.

Guiding principles have been: to be inclusive; **to involve** as wide a group of stakeholders as possible; **to listen**; **to encourage** opinion-sharing; **to learn** from those with a lived experience**; to engage** fully and develop sustainable engagement for the future.

3.10 This Cheshire AI has been carefully balanced to ensure unrealistic expectations are not raised – a particularly important and sensitive issue in the current economic climate. Our guiding principles throughout the fieldwork and study period have been: to be inclusive; to involve as wide a group of stakeholders within the given timeframe; to listen; to encourage opinion-sharing; to learn from those with a lived experience; to engage fully and develop sustainable engagement for the future.

3.11 In devising our methodology, the intention was to ensure as many people as possible could participate (within the resource available) during this initial engagement 'window'. Different types of stakeholders were consulted, and these have been categorized in research materials under these three common headings to date (with an obvious expansion of this list in future months to include children and young people, as the next wave of engagement begins):

- parents/carers.
- nursing staff.
- wider stakeholder groups.

## Activity stages

3.12 The engagement activities in the AI were

- Introductory launch event Workshops (in June).
- Fieldwork with nurses, families/carers and other stakeholders (for example headteachers), in one-to-ones or groups.
- On-line questionnaire on MLR website, for those unable to meet or hold telephone conversations.
- Summative Workshop events (in September).

3.13 The stages when activities were applied are illustrated in the following graphic

***Figure 2: stages of fieldwork activities***


3.14 Each of the main stages of the methodology are explored in chronological order:

***Strategic introductory communication*** *[May'15]*

3.15 In early May 2015 an introductory email was circulated to local strategic stakeholders by CCG representatives on the Project Management Team, explaining:

- Why community nursing is being reviewed at this time.

- How work was beginning on an AI, and providing a 'frequently asked questions' addendum.
- Listing the contact details for MLR and VoiceBox Inc, explaining that there would be imminent contact regarding their participation.

3.16 The introduction email was sent to a list of stakeholders that was developed jointly by the CCG Project Management Team and the consultants, and which was reviewed and updated throughout the AI. This detailed dynamic AI contacts database is one of the significant outputs of the project, being a key resource for future participatory activities and feedback - containing some people who have recently become 'critical friends'. The database was built in stages, following an initial stakeholder mapping exercise in May when the CCG Project Team and the consultants reviewed 'who are the stakeholders?' and 'what part in the process do they influence or are affected by?'.

A detailed, **dynamic AI contacts database is one of the significant outputs of the project**, being a key resource for future participatory activities and feedback - containing some people who have recently become 'critical friends'.

***Introductory Workshops*** *[9th and 11th June'15]*

3.17 The two Workshops in Winsford and Crewe were convened to set the scene and context, lasting 2 hours each, at locations covering quite different parts of the geographical project 'patch'.

3.18 These sessions enabled the collaborative team introduce the question framework and helped reiterate the partnership approach to the work. The events helped to identify initial improvement themes, and avenues for the fieldworker to explore in greater depth during group and one-to-one sessions.

***Engagement with parents / guardians / carers*** *[June / July'15]*

3.19 Focus and Discussion Groups were held in three locations (one of which was requested by the CCG Project Team to be Hebden Green School) at different times of day to encourage attendance.

3.20 An offer of follow-up calls was made to those who could not attend, and a questionnaire posted on the webpage that could be accessed by those unavailable to meet or give verbal feedback.

***Engagement with community nurses*** *[June / July'15]*

3.21 The format of these sessions was again one-to-one discussion or groups, to draw out what works well and what can be built upon. Interviewees were identified from the stakeholder contact list, and offered a 'fallback' telephone call if they could not meet in person with the team.

3.22 The Introductory Workshops were attended by a significant number of nursing staff, which enabled immediate access and communication lines to be built early in the AI process to the nurses and schools.

***Engagement with 'wider stakeholder groups'*** *[June / July'15]*

3.23 Headteachers and a range of other stakeholders with an interest and involvement in community nursing were enthusiastic participants in the Introductory Workshops, and requested follow up conversations in person and on the telephone. In addition, a proforma of questions was posted on the project webpage, in case someone wanted to provide a written response rather than verbal feedback.

***Reporting*** *[from 27th Aug'15]*

The AI workshop 'sequence' is important – as these group **conversations create the space for change, identify possible opportunities, and lay the foundations for collaboration and creativity**

3.24 This evaluation report has been supplied in August 2015 to inform local clinical commissioning group meetings in October and to help in the summary process that will be the bedrock of the Summative Workshops. The report findings are based around thematic analysis, across stakeholder groups.

***Summative Workshops*** *[15th and 18th Sept'15]*

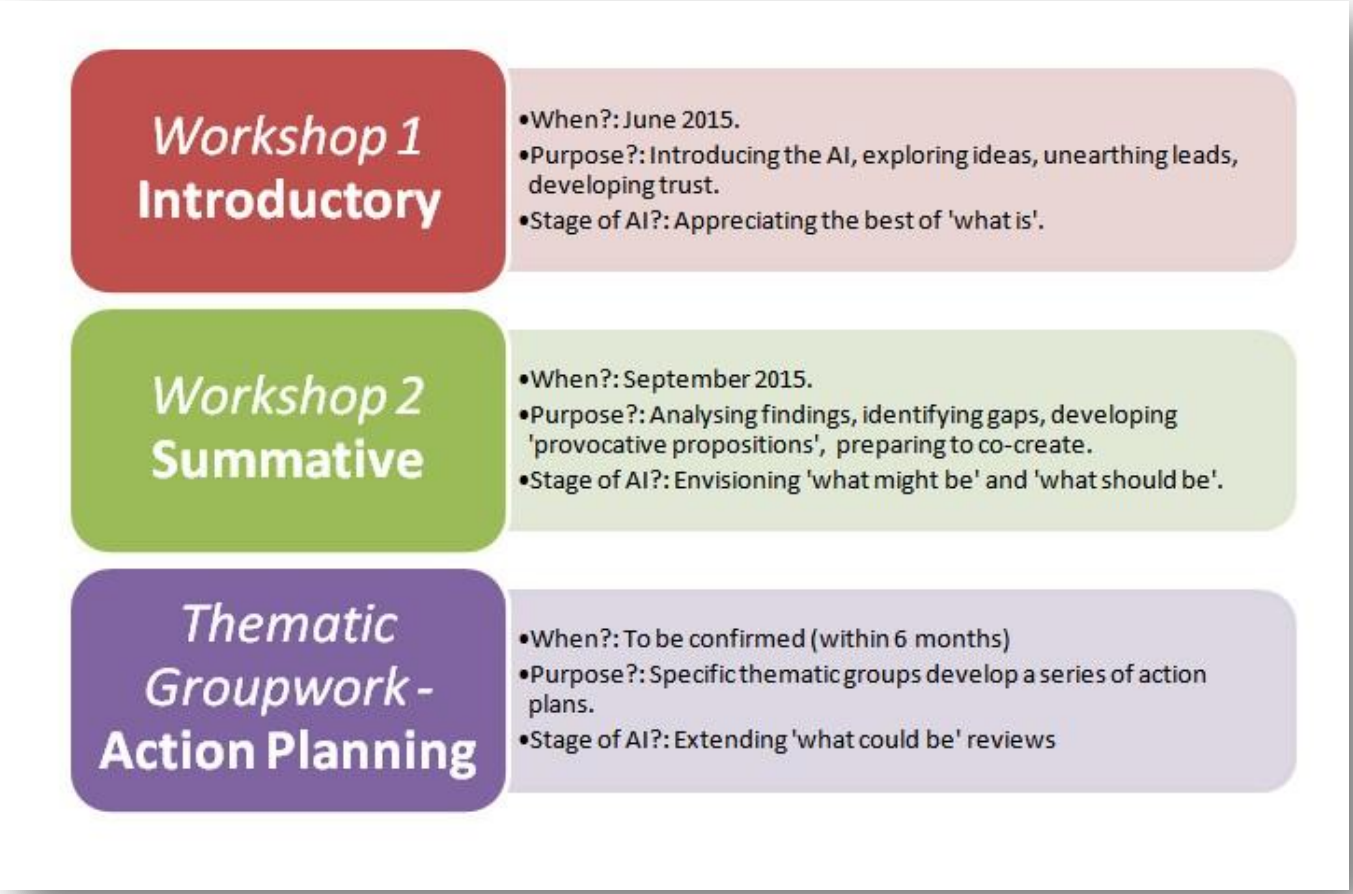
3.25 These sessions have been convened so as to be able to:

- Invite back a wide range of stakeholders who have participated in the study, to date, to further develop their feedback and involvement.
- Invite people who haven't had a voice to date, to embed their contribution within the next phase of work.

3.26 The event format will be based around initial review and critical challenge of the initial findings, before starting to scope the post-September process of co-design.

3.27 The value of workshop and group activities in an AI should not be underestimated. The sequence, from introductory sessions in June through to action planning events in the next six months, is summarised in the graphic that follows.

***Figure 3: Group work sequence proposed***



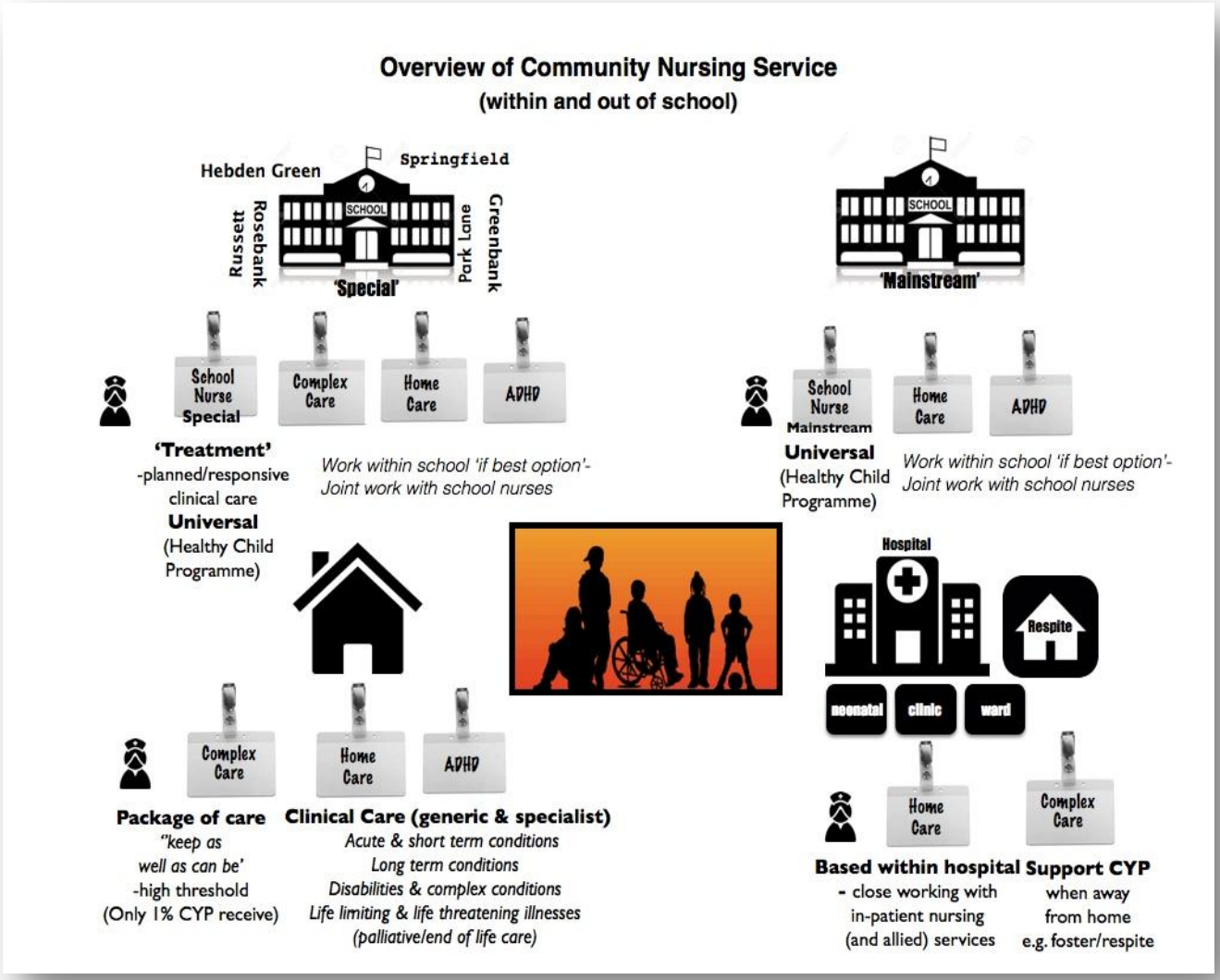

3.28 To conclude this Chapter it is worth highlighting the wealth of research materials, templates and 'proformas' contained in the accompanying Appendices to this report – with many of the activities being semi-structured. All engagement events and interviews were either recorded on dictaphone (where permissions allowed) or else detailed notes taken.

## 4. FINDINGS

### Range and nature of care provided

4.1 Detailed conversations across participating stakeholder groups initially sought to unpack the range and nature of care provided under the umbrella term of 'community nursing' adopted within the AI. The emerging picture highlighted the diversity and complexity in relation to the type, level and location of the provision being provided. Figure 4 (below) provides a general overview; See Appendix A for a more detailed summary of the specific activity undertaken by each team. Select quotes from interviews are dotted throughout this section, to illustrate working practice, scenarios and interactions – to help bring the service descriptions to life.

***Figure 4: Type, level and location of the community nursing provision***



4.2 A focus on individual circumstances reinforced the diversity of the individual needs of the children and young people accessing the community nursing provision. A series of pen portraits intended to bring the picture to life were captured during the fieldwork. A selection of these can be found in Appendix C. These are not intended to be wholly representative of the wide range of children and young people within the scope of the AI, but more reflective of those highlighted in conversations with special school nurses, education staff and parents and carers.

***School Nurses***

4.3 Attempts to 'unravel' the distinction between activities identified as 'treatment' and that of 'universal' was not straightforward. It was evident that a significant emphasis was, not surprisingly, on the needs of children requiring the more frequent and intensive levels of care.

'unraveling' the **distinction between activities identified as 'treatment' and that of 'universal'** was not straightforward.

*"What comes out is the seriousness of these children; you can get de-sensitised. When I first joined the team, I remember thinking, there's not enough oxygen canisters in the world to keep these children alive. You forget how poorly these children are; just sitting and listening to the work that goes into each one is so powerful."*
*Senior Manager (Community Nursing Team)*

*"X stopped breathing 3 times last week and needed urgent input. If the nurses weren't there what would the outcome be?* *Parent*

4.4 Focus groups with school nurses (practitioners and Manager) explored the relative resource taken up on the various activities. Although not intended as a formal quantified process, the estimates provide a helpful insight into the distribution of resource and energy (not always reflected in formal recording and monitoring processes):

- Around 70% of school nurse resource (time) is used to meet the needs of around 30- 40% of CYP who require intense daily input (planned and responsive). This includes activity both directly with and 'about' the child - liaison with parents/carers, other nursing teams, a wide range of health care providers on a daily basis.

Conversation between Parent and School Nurse
*Parent- "I spoke to the consultant on the phone last night, he rang me at 10pm when he got home. He's added 10mg to the dose – can you do it?*
*Nurse- "In theory no, we have to contact the hospital to get them to fax over the change. If we can't get it, you'll have to come in and administer the medication if we can't get it straight away but we'll do our very best not to get to this."*

Around 70% of school nurse resource (time) is used to meet the needs of around 30- 40% of CYP who require intense daily input (planned and responsive).

- The remaining 30% of nurse time is utilised for the remaining 60 – 70% of CYP. This includes those requiring emergency medical treatment, weekly 'treatment' (around 20% of CYP) and safeguarding. Whilst examples of more 'preventative' public health activity were described, the universal offer (as part of the Healthy Child programme) was described as 'opportunistic' and responsive, influenced by the need to prioritise the treatment and clinical needs.

*"Any child can come to us if they are physically able to. They know we are nurses (because of our uniform), they see us in class and know they can ask advice/disclose things.*
*Lots of children can't physically get to us though without a member of staff. They might see us in class so they know we're here, they can see what we do with other children but they don't see us."*
*School Nurse*

*"A young girl came last week who was having a bad time with her mum, having rows and wanted to speak with someone. Communication issues were significant because she found it difficult to say what she wanted to say. We did speak to her but then liaised with the education staff as we had to go to an emergency."*
*School Nurse*

***Complex care team***

4.5 The Complex Care team provides personalised packages of care for CYP with significant care needs, delivered in the home context (this may be respite or foster care). The eligibility threshold for the service is very high with only around 1% of the CYP within the special school cohort in receipt of the service. The service operates all year round. See Appendix C for pen portraits of CYP accessing complex care service.

***Home Care Team***

4.6 The service operates a key worker model of service delivery. The team provides a holistic approach to community based care for CYP with a range of nursing needs (see Figure 4). A broad range of specific specialist care is offered by 'expert practitioner roles', for example in dealing with epilepsy and cystic fibrosis. A major emphasis of the service is around supporting CYP and their families to manage their care needs - serving as an expert practitioner, advocate and expert resource at times. Appendix A provides a detailed overview of the service model and 'Triangle of Need" for Children's Community Services.

The key theme emerging so far from AI conversation is the value of **person centred, integrated, outcome based provision.**

## Impact and value of services provided

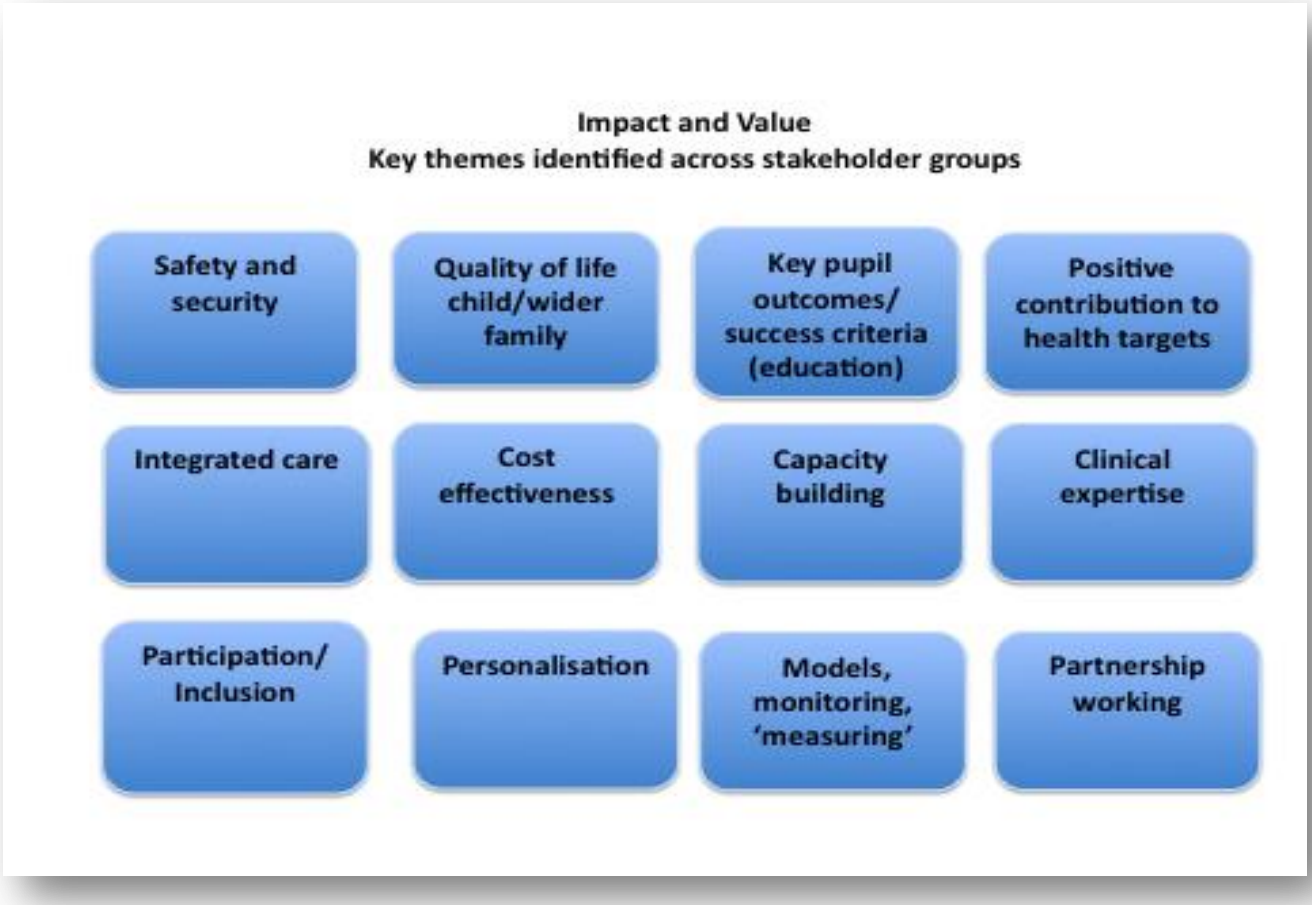
4.7 Engagement with all stakeholders who participated in the AI reflected the significant importance, value and impact of the services to those who receive them, provide them and otherwise come into contact with them. The emphasis of all conversations centred around the impact on the child/young person.

4.8 The examples here represent a small selection of the rich feedback provided, used to bring the emerging themes to life. Figure 5 (that follows) reflects the themes that emerged across the three stakeholder groups. It is important to note the high degree of consistency of themes highlighted by nurses, parents/carers and the wider stakeholders (predominantly those within the school setting). Opportunities to drill down into themes, identified during the launch event, was encouraged in separate 'stakeholder' conversations.

4.9 Although identified as individual themes, a clear message from the range of conversations point to the essentially integrated service vision or 'goal' of person centred, integrated, outcome based provision.

*"We're not bothered about who pays for what, how it's organised and managed. That's not our job – we're bothered about our child, our family and those people around us" Parent*

***Figure 5: Impact and value of services provided***




4.10 Each of these themes is explored in greater detail in the remainder of this section:

***Safety and security***

This was the primary impact and value identified. For many people the services, particularly the specialist school nursing service, was primarily about maintaining life. A strong message from all stakeholders was how children with frequently

fluctuating healthcare needs require high levels of clinical expertise to provide continuous responsive and proactive assessment, treatment and care.

> *"V was admitted to hospital because she was aspirating fluid. Changes to the care plan recommended thickened food and use of gastrostomy feeding, but no changes made to the oral medication. We need to 'spot' this and proactively follow up to prevent a serious situation."* School Nurse

***Quality of life for the child and the wider family***

Quality of life for wider family is an important outcome of a good nursing service - being able to feel confident enough to send their child to school, and to be able (as parents) to spend time with other members of their family or hold down a job.

Many parents spoke about the impact of being able to feel confident enough to send their child to school, and to be able as parents to spend time with other members of their family or hold down a job. They could do other activities with the confidence that they would be notified if there were any notable changes in their child's health.

***Key pupil outcomes and success criteria within education***

The nursing services are a key element of the school offer. The service impacts on the majority of key outcomes for pupils, including progress, attendance, wellbeing, access to education opportunities, self esteem, worth and dignity.

> *" P's mum sends him in here where she has said she wouldn't in other circumstances. His parents are very keen for him to get the most out of his education and know that we are all working to the same aim."* School Nurse

> *" The contribution of nursing care was singled out as an aspect of outstanding practice in an Ofsted Inspection and also highlighted on a wider CQC inspection."* Head Teacher (Special School)

***Positive contribution to health targets***

All the nursing service elements were able to describe ways in which they made positive contributions to health targets - for example, preventing attendances at

A&E and hospital admissions.

***Integrated care***

There were many excellent examples that illustrated an integrated approach to care and treatment delivery. For example, the Home Care Team operates a triage system that looks at where the best place is for an identified care or treatment intervention to be delivered. The schools were seen as a key venue to undertake clinical interventions and ongoing monitoring activity.

*"Having clinics at school was beneficial, in terms of not having to wait in hospital, reducing stress levels for everybody, less education time lost. Also the school nurse has provided support to parents to enable them to have the confidence to fully express their opinions or ask questions of the consultants". Parent Governor*

**Ongoing, continuous and up to date training is crucial** wherever the child is.

***Cost effectiveness***

As indicated in some of the themes above, there were a range of cost effectiveness aspects to the service, that were particularly identified by stakeholders in strategic positions in the schools. These were cognisant of the savings outside the direct cost savings to the schools themselves. Areas included - A&E attendances, families having to take days off work, children not being able to have the intervention they might need if it had to be delivered somewhere else. All of which it was suggested could form part of any future evaluations of effectiveness.

***Capacity building***

All of the community nursing teams make a significant contribution to this. Ongoing, continuous and up to date training is crucial wherever the child is (with parents, foster-parents, teacher) in order that responsible adults are up to date, confident and competent. It is important to stress that this is becoming an increasingly important aspect of the work of all of the nursing teams with ever evolving interventions, new diagnoses, treatments and care approaches.

*"J changes class each year, staff change each year. We have to do regular training to help staff recognize when he is ok and when to be concerned (and why). They have to feel competent and confident because if they do it wrong, there can be big implications".*
*We've had training from Reps on a new intervention to help control seizures. We're cascading that across education staff, family and foster carers and working with the Epilepsy specialist."* *School Nurse*

The **core values of all the nursing teams is about maximising participation and inclusion in the care and treatment,** as well as within education. Within the school context this is concerned with how the children can attend and fully participate.

***Clinical expertise***

There are examples across the services where the levels of clinical expertise are highly valued by the families and the wider stakeholder groups.
There is a strong commitment to continuous professional development and the development of service models built upon provision of an 'expert resource' that can be drawn upon across the community nursing service.

***Participation and inclusion***

The core values of all the nursing teams is about maximising participation and inclusion in the care and treatment as well as within education. Within the school context this is concerned with how the children can attend and fully participate. This includes training and support for CYP to be able to go on school trips. *"J has often been left in school because he is seen as too much of a risk, but training around medication and feeding have helped keep J within the class."*

***Personalisation***

Parent and education staff reported that the school nursing service is an essential service that is personalized to the needs of pupils and their families. This provides reassurance that they are being given a service that meets their specific needs, knows them well and cares for them.

***Models, monitoring and measuring***

There are a number of examples of practice highlighted as supporting the development of an effective approach to measurement and monitoring.
For example: the Home Care Team are developing and implementing a 'Triangle of Need' (see Appendices); the headteacher at Springfield School has developed a system and approach to recording the levels of nursing interventions within the

school planning and monitoring process.

***Partnership working***

Examples are abundant of partnership working through communication and liaison, shared use of resources, shared training and cross agency support and supervision.

## Factors that stakeholders most value

In one-to-ones and group work, headteachers, nurses and parents/carers addressed the question of **'what's working well' and what 'positive practice' meant for them.**

4.11 As part of the AI process each of the three stakeholder groups explored the question of '*what's working well?*' and '*what positive practice means for you?*' Outcomes of this process were the following for each of the stakeholder groups:

- ***Headteachers***: the ability to provide a positive learning experience, to include all children, ability to plan and manage their teams and to be involved in strategic planning.
- ***Nurses***: the quality of care, professional integrity, involvement in a professional network and sense of belonging to the school in which they are based.
- ***Parents/carers***: a service that promoted trust and joined up communication, a positive relationship with the child and a level of parental involvement that works for them. In relation to the care itself the key areas were continuity, flexibility and reliability with access to innovative up to date clinical practice.

4.12 The process from here was about matching current practice against what each would ideally like to see as described above. The emphasis was around capturing the positive practice and about drawing out the factors that contributed to this.

4.13 A series of notable practice mini-case studies can be found in the Appendices.

## Areas that are working well

4.14 There was a high degree of consensus across the stakeholder groups in relation to what was working well. The following were most lauded by the largest number of people across the stakeholders (see Appendices for greater detail):

- The quality and responsiveness of nursing care.

- The relationship between the practitioner and the wider practitioner network.
- The ability to include all children and provide a positive learning experience.

4.15 It is important to note however that many of the examples of positive practice appeared to be working well in spite of the system rather than because of it. There were many examples where things worked because of the person's desire to go above and beyond what they were expected to do.

There were many examples where **things worked because of the person's desire to go above and beyond what they were expected to do.**

4.16 A number of common factors emerged in relation to what was contributing to successful practice as a whole. For example:

- Where practice was most person centred.
- Where different parties were communicating effectively.
- Where key individuals worked collaboratively at all stages of the process.

## Areas that are working less well

4.17 In the course of identifying what was working well stakeholders inevitably identified areas that were in need of improvement. Although the focus within the AI approach is to emphasise the positives, the 'discovery' phase also gathers information about experiences that are critical – and it is important to listen to the views expressed by stakeholders about things that are not working so well and to integrate them into ongoing stages of the Appreciative Inquiry. Here the feedback was specific to individual groups.

***Headteachers***:

- There is no joint strategic planning across health and education which means that the resource for the nursing service is allocated and the headteachers are not aware of the process behind how such decisions are made. What this means in practice is that the headteachers are not able to factor in advance what resource they may need for activities, which leads to missed opportunities for working flexibly and responsibly.

- Whilst the practitioners are fully integrated into the school team the headteacher does not have any direct responsibility to provide supervision and support to the nurses. There appear to be unclear accountability arrangements as a result.

***Nurses***:

- There were differences identified across the various nursing teams. For the school nurses, a key area was their lack of involvement in a professional network. Although they are a designated team they rarely have opportunities to meet up as a group. They can feel

isolated professionally from their nursing peers despite working in some very complex situations.

- The complex caseloads, quality of care and ability of the Home Care Teams to deliver was a concern for this professional group. Working with increasingly complex children without an increase in human resource was a concern. The Home Care Team hours of service, staff ratios and opportunities for higher level expert nurses within the team (Advanced Practitioners) were also areas for future development identified by this group.

There were several concerns expressed - including that the generic title of 'community nurse' engendered that they were all the same and interchangeable.

- There was also an issue of concern that the generic title of 'community nurse' engendered that they were all the same and interchangeable. Across all of the nursing conversations it was evident that nurses knowing the individuals intimately and either having expertise or being close enough to draw upon relevant expertise as required, was a positive part of their role. There was some concern that 'generalisation' within a common title could negatively impact upon this.

***Parents/carers***:

- The main concern of the parents/carers who took part was more about what the AI would lead to in the future. The community nursing service is extremely well regarded and seen as a lifeline. Their involvement in future strategic planning and commissioning is seen as an area for future development. Consequently, there is a heightened level of uncertainty, confusion and mistrust amongst members of this stakeholder group but this reflects the centrality that the community nursing service plays in the lives of the children and their families.

- Parent / carer representative groups and forum were reported to not be as well developed as they might be across the whole system. However a key positive out of the AI has been the proactive engagement of parent representative groups, particularly Healthwatch.

## 5. CONCLUSIONS & NEXT STEPS

5.1 This Appreciative Inquiry has sought to better understand the current nursing support provided to children and young people with nursing needs, that attend either special schools or mainstream schools. The aim has been to understand what works well for individuals, families / carers and the services providing the care - to support ongoing planning, commissioning and delivery.

5.2 The initial stages (delivered between May'15 – July'15) of this AI has identified many good things that are happening in the areas of service delivery, and stakeholders have much to be positive about. Although issues and concerns emerged, they were offered in the true spirit of an AI and with the desire to develop the services in such a way that all stakeholders felt would move things forward.

The Cheshire AI has been positive, **engaged the necessary communities, identified a high level of commitment, passion for getting it right and willingness to continue to work together** to do that.

5.3 The Inquiry process itself to date has been positive, engaged the necessary communities, identified a high level of commitment / passion for getting it right and willingness to continue to work together to do that.

5.4 The active involvement of parent participation groups (e.g. Healthwatch) has opened up and developed relationships across the stakeholder groups which should be built upon further in future service planning and delivery. The sequence of group work proposed, beginning with the second round of events in September (the Summative Workshops) and concluding with the action planning sessions, should maintain this momentum.

5.5 As identified earlier in the report a key outcome of the AI process has been the active engagement and connection with key stakeholders. The process has seen a transition from a 'dry list' database of names or generic agency contact details to active engagement with people, their experiences and future hopes in such a way as to enable them to form an active part in the AI and to 'coproduce' the content for this report.

5.6 It should be recognized that the people who were the focus of this work have been children and young people with particularly complex needs, receiving a very specialist service. In addition to this however, is the full universal service offer open to all children and young people. How this is delivered in the future will need to take account of and integrate with this specialist nursing service. The children and young people receiving this specialist service should not be excluded for the universal offer by the very fact that they are receiving this service. From the AI process it is not clear that all children within the specialist school context are currently accessing the universal offer within the Healthy Child Programme. The message from the AI strongly indicates future commissioning and delivery needs - to place the children, young people and their families at the heart of the process, in

particular, this needs to address the specific access issues and the continuity of care, whilst avoiding unnecessary fragmentation.

5.7 A key area of the AI to date was to examine whether or not there was variability in the delivery of support within different locations (i.e. school and home). Although the AI did not unearth any significant issues in this regard during the process, that does not necessarily mean they are not there. The perspective obtained reflects the level of participation that was obtained during the process i.e. engaging with people working with those children with the most complex needs and their parents / carers. Moving forward it would be important to continue this process of engagement but with the wider group of children and young people in order to best reflect their diversity and needs accessing community nursing services.

The spirit of **openness and transparency should be built on in order to reduce anxieties associated with future change**. This is something that can be addressed successfully in the future development of co-creation and co-design in coming months.

5.8 It should be acknowledged that this is necessarily an area in which a lot of emotions are invested and some anxieties about outcomes of the work are understandable. People are aware of reductions in services in 'austere' times and unsurprisingly that causes worry, therefore further work needs to continue to take that into account and reassure where possible. The spirit of openness and transparency started in this inquiry should be built on in order to reduce anxieties associated with future change. Some people have had previous experiences of being involved in early stages of 'transformational projects' but not involved in what has happened afterwards. This is something that can be addressed successfully going forward given the foundations built by the AI process itself – and the future development of co-creation and co-design in coming months.

## Author contact details


**Michael Lloyd**,
Principal Researcher and owner,
Michael Lloyd Research (MLR)
~ Email: Michael@researchMLR.co.uk
~ Website: www.researchMLR.co.uk

**Amanda Clayson**
Director,
VoiceBox Inc.
~ Email: amanda@voiceboxinc.co.uk