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LEARNING AS WORK: Teaching and Learning Processes in Contemporary Work Organisations

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**‘What is the Vision for this Profession?’:
Learning Environments of Health Visitors
in an English City**

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ABSTRACT

This paper discusses the attempts by a group of health visitors in a provincial English city to reform their working practices in order to work more collaboratively and, hence, create a more expansive learning environment. The health visitors self-consciously sought to create a 'community of practice', a term they felt captured their ambition to move away from the historical conception of health visitors as professionals working largely on their own but under the direction of others. The paper shows that the outcomes of the health visitors' attempts to engineer changes to their work organisation were shaped by the constraints and opportunities offered by their relationships with a diverse and fragmented network of fellow professionals, including other health visitors, doctors, managers and personnel from other social care agencies. Our analysis contextualises the uncertain development of discretion and trust in the work organization of health visitors within the broader horizontal and vertical relationships of the productive system in which they are embedded. The paper argues that, whilst much was achieved and considerable learning took place, the group's vision was ultimately unsustainable due to the characteristics of the wider productive system.

**‘WHAT IS THE VISION FOR THIS PROFESSION?’:
LEARNING ENVIRONMENTS OF HEALTH VISITORS IN AN ENGLISH
CITY**

INTRODUCTION

Uncertainty about the role of health visitors has dogged the profession throughout its history (see Brocklehurst 2004a, 2004b). Confusion about their professional functions is reflected in radically different paradigms of practice within the professional literature (Twinn 1993; Craig and Smith 1998). A recent review of their functions, commissioned by the British government’s Department of Health, acknowledged that:

‘For some time now, there have been concerns that health visiting had lost its focus, or rather, there seemed to be too many foci for anyone, even health visitors themselves, to be able to define what health visiting was about and what health visitors should be doing’ (Department of Health 2007: 4).

This paper examines attempts by a group of health visitors in a medium sized-English city (MidCity) to forge an enhanced and dynamic professional mission. Our study followed the ups and downs of this project over a two-year period (Autumn 2005 to Autumn 2007), as the health visitors tried to forge a self-regulated, self-defined expansive learning environment (Fuller and Unwin 2003, 2004). The paper analyses the sources of their commitment to innovation, the obstacles they encountered and the structures and processes that thwarted their objectives. It will be argued that the breakdown of trust between health visitors and their managers, and the inability of the health visitors to find an organizational context that would respect the kind of professional discretion to which they aspired, was a function of their distinctive location within the productive system of English community health care. As a result, those aspects of their situation which generated their commitment to the creation of their own conception of an expansive learning environment were gradually undermined by their lack of appropriate institutional supports.

The group self-consciously referred to itself as ‘the community of practice’, echoing the work of Lave and Wenger (1991) and Wenger (1998) but in no sense slavishly following their model (see also Hughes *et al.* (2007) and Fuller *et al.* (2005)

for critiques of this concept). Since it had no formal organizational standing or title, we too will refer to the group by the name it gave itself; that is, ‘the community of practice’.

Our research adopted a variety of methodological techniques. Fifteen members of the ‘community of practice’ were individually interviewed in three sweeps: early 2006; Summer 2006; and Autumn 2007. All but one were interviewed at least once; most were interviewed at least twice. In addition an interim feedback meeting, which evolved into a focus group discussion, was conducted with ‘the community of practice’ in the Summer of 2006. The health visitors were also given disposable cameras and asked to take photographs to illustrate their working lives. These were used in the second sweep of interviews as catalysts for further discussion about how their work was organised and the role of learning in their everyday work activities. The health visitors were also asked to keep structured learning logs over an 8-week period in the Spring/Summer of 2006. The logs, which recorded the extent to which the health visitors felt they were learning through work and the extent to which they helped colleagues to learn, were also used to expand the discussion in interviews and in the focus group meeting. Additional interviews were held with a senior operational, a front-line operational and an HR manager within the Primary Care trust (PCT) and the directors of two Children’s Centres which were connected to the health visiting teams. All interviews were recorded and transcribed in full.

This study forms part of the multi-sector, *Learning as Work* (LAW) project, which is funded by the ESRC’s Teaching and Learning Research Programme.¹ The paper deploys the conceptual framework developed within the LAW project to analyse case studies of the relationship between the way people learn in the workplace and the way their work is organised. The conceptual framework features three dimensions: productive systems; work organisation; and learning environments.

The paper continues with a discussion of the history and status of health visitors. This is followed by an account of the development of new ways of working among a group of health visitors in MidCity, including a brief description of the

¹ For more details see: <http://learningaswork.cf.ac.uk>.

study's methodological approach. The next section analyses this history through the lens of the conceptual framework. The final section provides some concluding remarks.

THE ROLES AND FUNCTIONS OF HEALTH VISITORS

History and Organizational Context

Health visiting in England has its roots in the philanthropic public health movement of the 19th century, which aimed to reduce mortality and morbidity by teaching hygiene and household management to working class wives and mothers (Symonds 1991; Davies 1988). The employment status and organizational context of health visiting evolved over many years (see Dingwall 1977; Connolly 1980a, 1980b; 1987; Craig and Smith 1998). In the mid-19th century health visitors were employed by voluntary organizations, but were gradually absorbed into local authority service provision. Since 1962, entry to health visiting training has required a nursing qualification as a precondition and usually some experience in a senior clinical nursing post. In 1974, health visitors became part of the NHS. As a result, health visitors have become more closely associated with nursing and with primary care provided by GPs. They are employed on NHS scales and are among the highest paid clinical nursing personnel in the health service.

The National Health Service (NHS) in Britain is the biggest employer in Europe. It organises and delivers healthcare through a complex and devolved network of agencies and institutions. Citizens are registered with local General Practitioner (GP) surgeries, through which most primary care is provided. Access to other aspects of the system, such as specialist hospital care, is predominantly via GP referral. Primary Health Care Trusts (PCTs), funded by the Department of Health (DH), employ a range of ancillary health workers, including health visitors. Nearly all health visitors are physically located within GP surgeries and their caseloads are usually derived from GP patient lists. However, their line of managerial responsibility is to Primary Health Care Trusts (PCTs), not GPs. Over the past decade, a key policy of the current Labour government has been to bring public services relating to families and children closer together, partly through the 'Sure Start' initiative. At the centre of

this policy is the establishment of Children's Centres (for children under five years old), which aim to provide a 'one stop shop' of social and health care services for local communities. Children's Centres are the responsibility of the Department for Children, Schools and Families (DCSF). Initially located in deprived neighbourhoods, the plan is to have a Children's Centre in every community by 2010. As will be seen, GPs, PCTs and Children's Centres all shaped the history of 'the community of practice'.

The potential professional activities of health visitors are broad, multiple and fluid. Unlike the overwhelming majority of health professionals in the NHS, health visitors focus on the promotion of health rather than the treatment of sickness. They work with the 'well' population, providing advice that aims to promote health, diminish risks and prevent disease. They adopt a holistic, psycho-social model of health. Hence, the professional activities of health visitors may cover all aspects of physical, mental, emotional and social well being. Their remit includes not only the needs of individuals and families but also those of whole populations, such as communities and cities (Cowley and Frost 2006). Frequently, health visitors provide links to other services, drawing on their extensive knowledge of, and networks with, other statutory and voluntary agencies.

Health visiting is a universal service and potentially draws its clients from all age groups. However, in the time and place of our research, as in most of the NHS, the focus was heavily on mothers and children under school age (0-5 yrs). Indeed, as part of their public health functions, health visitors play a major role in child protection (Taylor and Tilley 1989). In this capacity they are not only sources of advice and support – 'mother's helper' (Davies 1988) – but are also of surveillance and discipline. One of our health visitor respondents remarked: 'we are the health police'. (cf., Abbott and Sapsford 1990; Bloor and McIntosh 1990; Dingwall and Robinson 1990; Heritage and Lindstrom 1998; Peckover 2002).

The education and training of health visitors has, from its outset, been grounded in rigorous theoretical knowledge as well as practical application. (Symonds 1991: 257). It is widely regarded as among the most demanding offered to nursing personnel. In addition to placements with practicing health visitors, students

encounter conceptual and empirical aspects of medical science, public health, social sciences and psychology. Graduates of the course are expected to develop an analytical, reflexive and evidence-based attitude towards their practice. This professional training was regarded by many of our respondents as basis of their professional identity.

‘We’ve got this history and this training that encourages us to be independent practitioners’ (Senior HV – Children’s Centre A).

‘I think there’s something about that education that enables you to look at things much, much more broadly than perhaps you have in the past’ (Acting Head of Children’s Centre A and a former health visitor).

Whilst the initial training is highly valued, it is after qualification, through the routine day-to-day practice of visiting mothers and children in their homes, that health visitors learn about the complexities and challenges of their profession:

‘The knock on the front door...that’s hard, really hard ... knocking on someone’s door and expecting them to let you in, that’s actually a bit odd and scary’ (Health Visitor participant in focus group).

Functions

Health visitors have a statutory requirement to visit, usually at home, all babies shortly after birth. They are also expected to carry out up to four further home visits during the pre-school years, although in practice the extent of those reflects availability of time and resources, including PCT funding. As a result, health visitors spend a substantial amount of time on their own, travelling and visiting families:

‘I know people have remarked that, those who’ve not worked on the community before, how difficult it can be and how challenging it can be to work out there on your own, in the community, compared with being a team on a ward. ... Going into people’s homes is completely different to them coming into a hospital environment, for example, or a GP surgery. Because you are just a visitor ... we have no right of entry’ (Senior HV, Children’s Centre A).

‘You are working on your own. You are quite autonomous and at the end of the day the bricks fall on your head’ (Newly Qualified HV).

Home visiting and community outreach are, then, critical aspects of the work of health visitors. In these encounters, they check and monitor the development of the child, identifying any service interventions that might be required, and offer advice constructed round the concept of 'parenting' (Malone 2000). Parents may initiate additional contacts - by phone, home visit or surgery visit - to discuss issues of concern. Mothers and babies also may attend clinics run by health visitors, and/or by health visitors in conjunction with GPs. At birth, babies are issued with a book (known by our respondents as 'the Red Book') which records key health service contacts, including those with health visitors. Among the information recorded in the Red Book are the immunization history of the child and its weight at various stages in its early years. As will be seen, the responsibility of health visitors for these two items was a matter of contention in 'the community of practice'.

In contrast to these specific tasks, there is an enormous range of activities and responsibilities can potentially be seen as central to health visitors' mission. The DoH's (2007) recent report sought to define the scope of health visitors' functions:

- Public health and nursing
- Working with the whole family
- Early intervention and prevention
- Knowing the community and being local
- Proactive in promoting health and preventing ill health
- Progressive universalism
- Safeguarding children
- Working across organisational boundaries
- Team work and partnership
- Provision of health protection services
- Home visiting

The priorities of health visitors were identified as the hugely ambitious tasks of:

- Preventing social exclusion in children and families
- Reducing health and social inequalities

- Tackling key public health priorities (eg obesity, smoking, alcohol, drugs, accidents)
- Promoting infant, child and family mental health
- Supporting better parenting

Such open-ended and challenging roles leave scope for variation between health visiting teams in their daily practices and the inevitability of selecting among a vast range of possible tasks. Thus, a gap opens up between the busy schedule of visits, clinics and development checks that must be done and the bewildering array of interventions that could be regarded as professionally legitimate

Visibility and Status

Another persistent problem is the relative invisibility of the outcomes of health visitors' professional activities. Some hard data may be collected: for example, numbers of mothers breast feeding. However, many valued outcomes are difficult, if not impossible, to quantify because they concern crises that have been avoided; for example, the prevention of post-natal depression, violence in the family or abuse of children. Many outcomes are long term, taking generations to become evident. Many are difficult to attribute to one particular source or intervention. In these circumstances, there may be an understandable temptation for health visitors to focus on measurable short-term activities, which have public and clinical recognition (such as weighing babies), rather than 'big picture' long term strategic work.

The connection of health visiting with nursing intensifies these dilemmas. Health visitors are often called upon to deliver services that other nurses in the community could and can do; for example, immunizations or routine secondary developmental checks. However, community nurses are not able to undertake the broader public health remit of health visitors. It is tempting for health visitors to be drawn into these more routine duties. They justify their position within the hierarchy of the GP surgery and help them feel more acceptable to colleagues who are predominantly engaged in acute medical services. Research suggests that some health visitors respond to (real and perceived) threats to their profession by clinging to 'entrenched routines of dubious value', while newly qualified practitioners express

‘frustration at their inability to put recently acquired public health skills into practice’. (Brocklehurst 2004b: 216) The result is that the population-based, preventative and public health roles, for which health visitors are trained, are jeopardised. Health visitors become an expensive source of services that can be done by less qualified staff.

The uncertainties surrounding health visiting are further exacerbated by an absence of a strong professional body solely representing health visitors that is able to speak truth to power at the highest levels of government and NHS administration. It is striking that of the 34 members of the committee recently charged with reviewing the role of the profession, only one was a working health visitor (Department of Health 2007).

Between 1996 and 2004 numbers of health visitors in employment remained static at a time when other nursing and midwifery occupations increased in size. In 2006 numbers declined by approximately 10 per cent and those in training fell by 40 percent. Work loads in some health visitor teams soared (Campbell 2007). There is a widespread perception that PCTs have sought to reduce the number of relatively expensive health visitor posts and to substitute lower paid and less qualified staff for their routine roles. There is a fear that in a future era of commissioned services, purchasers will not wish to invest in the long-term and unquantifiable benefits of public health outreach work.

THE HISTORY OF A SELF-STYLED ‘COMMUNITY OF PRACTICE’

Inevitably a brief narrative has to simplify what were often complex and multi-layered events and processes. Moreover, there is a danger of making unfolding events seem like a smooth series of challenges and responses, whereas in reality there was often confusion and uncertainty, rumours and false starts. Having said this, for ease of comprehension, the history of ‘the community of practice’ can be characterised as a period of slow initial development and growth, followed by a series of challenges and obstacles.

Health visitors in MidCity were under the managerial control of the PCT but nearly all were physically located in the premises of GPs. One or two had been seconded for limited periods to Children's Centre A. Those who were to form 'the community of practice' operated from premises within four GP surgeries. Each surgery contained health visiting teams comprising two or three health visitors and one or two Nursery Nurses and/or Community Nurses. One team also included a part-time administrative assistant. The four GP surgeries were located close to one another in a neighbourhood containing large numbers of disadvantaged families resident in social housing. As far as the PCT was concerned, these four teams were part of a larger organizational unit that comprised health visitors located in seven GP surgeries, stretched out along one of the main arterial routes into the town from inner city to leafy suburbs.

The New Way of Working

Although each of the four teams had experimented individually with innovative ways of working, in the second half of 2005 they began to collaborate in developing a distinctive collective professional vision and, at the same time, began to refer to themselves as 'the community of practice'. They sought to transform their current way of working, which they believed limited their professional identity, joint learning and shared expertise. This shift was led by three experienced health visitors who brought to bear wide ranging, separate but overlapping expansive learning territories in reassessing and reinterpreting their professional mission. They had a clear idea of how they hoped 'the community of practice' would evolve. Nevertheless, they were keen that new ways of working would be the product of consensus and commitment generated from below, rather than instructions imposed from above. Consequently, 'the community of practice' emerged slowly, gradually building momentum, self-confidence and self-awareness.

During the course of the first year of its existence, 'the community of practice' introduced and developed the following ways of working:

1. A collaborative division of labour across the four surgeries, facilitating: (i) the creation of mixed-skills teams; (ii) more flexible working

patterns (e.g., cover for absence); (iii) specialised contributions from team members with particular skills; (iv) sustained innovations in services; and (v) elimination of duplication of services.

2. Learning by sharing of expertise across and within teams.
3. Corporate case loads, in which members undertook visits and other tasks when they were available, rather than only serving their own personal clients.
4. Enhanced professional roles for all categories of team members, including senior members, who concentrated on non-routine cases and innovative tasks, and less-qualified members (such as, Nursery Nurses), who were given scope to undertake a wider range of roles.
5. Locality working, focusing on residents within local inner city estates, rather than the more scattered and fragmented geographical boundaries of the patient lists of the GP practices in which they were located.
6. Shared baby and toddler health groups, and development clinics, serving the local community, in which junior team members played a major role in devising innovative pedagogies.
7. A collective sense of professional identity across the four teams.
8. Enhanced enthusiasm and confidence in team members, reflected in formulation by team members themselves of plans for further initiatives.

These ideas are not entirely new and to be found in the professional health visiting literature (see, *inter alia*, Gastrill 1994; Jackson 1994; Ferguson 1996; Houston and Clifton 2001). Nevertheless they were certainly innovative within the context of MidCity. Indeed, locality working and corporate case loads entailed a conception of the client that many other health visitors were reluctant to adopt:

‘So it’s not so much about saying, as it used to be, ‘this is my little caseload attached to this little practice and it’s my bubble’. It’s about saying, the population actually. It’s not about *my* client, it’s more about *our* clients. The population are *all* of ours, and therefore all the populations’ needs are to be met ... there’s much more collective thinking about locality population needs’ (Front-Line Operational Manager PCT – respondent’s emphasis).

Furthermore, within the ‘community of practice’ an egalitarian and informal ethos was deliberately fostered:

‘There’s definitely no, sort of, ‘who’s better than who?’. We’re all, sort of, on the same level. Obviously, I look up to [names two old timers]’ (Community Nurse) .

‘I don’t think that she’s inferior to me and I’m superior to her. I know I’ve got much, much more experience. And I’m trained and qualified. But that doesn’t mean I see myself in a position of being the boss ... Everybody has the thing what they bring to offer to the team. ... It’s a skill mix, not a rank mix’ (Senior health visitor).

Our interviews suggest that these developments were warmly welcomed by PCT management, at all levels. As long as proposals were ‘evidence-based’ (as several managers commented), these innovations were seen as positive. In part, they were welcomed because they promised cost-savings. However, more generally, management expressed satisfaction that a group of health workers were taking the initiative in shaping their own professional destinies, rather than waiting passively for instructions:

‘We’re not in a world where you can sit back and wait to be told. The leadership comes from your selves. It comes from a professional group ... Don’t sit back waiting for somebody to tell you what to do’ (HR Manager PCT).

Compared to many other public sector workers, health visitors in MidCity had enjoyed relatively high levels of autonomy and discretion in setting and prioritising job tasks. Managerial regimes had adopted a light touch. There was little formal performance assessment. Annual appraisals took the form of facilitating learning and professional development, rather than ranking achievements. Established PCT management strategies, therefore, afforded ‘the community of practice’ the space in which to develop their ideas.

‘We don’t see them very much. I think we are quite capable of self managing thank you very much. And they are there if we need them, if we get stuck ... but I think that’s our training. That searching out needs and saying: ‘what we can do about it and what can we put in?’ ... We perhaps tell managers what we are doing rather than saying: ‘is it ok?’ (Senior health visitor).

However, as the scope and ambition of ‘the community of practice’ became more apparent, opposition began to be expressed in other quarters; in particular, by some GPs and some health visitors located in surgeries outside ‘the community of practice’. Their disquiet became increasingly apparent in the Spring of 2006.

The Reaction of General Practitioners

The opposition of GPs was not uniform across the four surgeries. Some were comfortable with health visitors developing their role as they saw fit; some were even sympathetic. However, there were several issues that concerned GPs and in one of the four practices these became the subject of bitter conflict. Although GPs did not have formal managerial authority over health visitors, the physical location of health visitor teams within surgeries meant that some GPs had come to feel that they had customary rights over their professional activities. Corporate working, locality working and shared work loads were perceived as breaking the link between GPs and ‘their’ health visitors. Patients might encounter members of health visiting teams from outside their immediate surgery. Moreover, GPs charged the PCT relatively low rents for the premises occupied by health visitor teams (some of which, it has to be said, were woefully basic). In return, GPs expected health visitors to take on a major role in running immunization clinics. GPs have tough government targets with respect to immunizations and the income of their practices reflects achievement of these:

‘GPs became proprietary about anything that happened within their four walls. Because ‘this is our business model’, basically. So we found ourselves, sort of, grafted on to a business model when we were a public health model really ..’ (Senior health visitor).

Some GPs also expected health visitors to participate, in a subservient role, in the conduct of clinics where babies received six week and eight month medical checks (as distinct from the development checks undertaken by health visitor teams themselves). The more traditional GPs expected health visitors to be present in a ‘hand maiden’ role – taking the baby from mother, undressing it, weighing it and conveying a case history. Furthermore, health visitors were expected by many GPs (and mothers) to maintain a regime of regular weighing of babies at home and in clinics, with results recorded in the ‘Red Book’.

Some health visitors in MidCity had been willing to collaborate in this ‘theatre of deference’. However, the new way of working developed by the ‘community of practice’ cut across all these expectations by GPs. The members of the ‘community of practice’ had a keen sense of their professional identity and professional autonomy. They did not see themselves as supports or handmaidens of the GP. They envisaged themselves as engaged in a different professional task, albeit one which was closely related to the work of doctors. These tensions were particularly acute in one of the four surgeries.

‘There was a very paternalistic relationship between the GPs and everybody else. ... the GPs expected that we would do as they said ... their expectation was that we would be doing things that would support them getting payments. ... it means that the mothers don’t see you as an independent practitioner. The mothers see you as being a sort of associate of the GP’ (Senior health visitor).

‘For me the status that you get being based in a doctor’s surgery isn’t that positive. It’s more about being seen as the doctor’s assistant and I have no problem with giving that role up [laughs], that status. Yeah, I would rather be seen as one of a group of professionals working together in an equal way. ... There’s always been this bit of friction between how health visitors see themselves and how GPs see them’ (Health visitor seconded to Children’s Centre A).

As a result, the ‘community of practice’ collectively decided to stop carrying out the routine tasks expected by GPs, in order to free up time to develop different types of services. In particular, health visitors were adamant that weighing babies was not part of their professional role and a gross misuse of highly-trained and highly-paid staff. They further argued that extensive weighing was of no value in most cases and that babies in need of special care should be identified in other ways. They also felt it set up misleading and potentially damaging expectations among mothers. In this, ‘the community of practice’ was supported by the PCT.

‘If you’ve got a perfectly healthy baby, the baby is feeding well, the baby is thriving, there’s absolutely no reason developmentally why you should be concerned about the baby, then I do not see the need to be constantly weighing babies’ (Front Line Operational Manager PCT).

When a long-established, compliant health visitor was replaced by one of the leading advocates of the new way of working, GPs in the most traditional of the four

surgeries mounted vehement resistance to these new arrangements. In a series of increasingly acrimonious exchanges and meetings, the GPs tried to make the PCT remove the new health visitor, but the PCT held firm:

‘... deep, deep hostility towards us from everybody, from everybody ... the first few months was absolutely terrible ... absolutely hell... often to be found sobbing, together and separately. And if it hadn’t been for the support of my colleagues ...’ (Senior health visitor).

Eventually, after many months, most of the recalcitrant GPs were won over. They even began to recognize that the new way of working brought them benefits; for example, health visitors taking an enhanced role in managing post-natal depression relieved some of the burden from their shoulders. The ‘community of practice’ had persisted, not least as a result of support from PCT managers.

The Reaction of Health Visitors outside the ‘Community of Practice’

Although the challenge posed to ‘the community of practice’ by GP resistance was, gradually diffused, resistance by fellow health visitors outside ‘the community of practice’ was more difficult to overcome. Indeed, this remained throughout the research period.

Locality working required health visitors to focus their attention on the needs of mothers and babies within the deprived estates that constituted the immediate geographical surroundings of the four surgeries. However, the geographical boundaries of the patient-lists of the GP surgeries did not match this focus. Not all patients registered with the four GP surgeries were resident in the immediate neighbourhood. Some lived several miles away, on the other side of busy traffic systems. Some of the mothers and babies living in the immediate locality were not registered with one or other of the four surgeries. Locality working meant that health visitor teams found themselves increasingly encountering families that were not registered with the four surgeries. At the same time they felt increasingly irked at having to make long journeys to mothers and babies long distances away.

It seemed to the ‘community of practice’ that the obvious solution was to reach an understanding with health visitor teams elsewhere in the city. It was proposed that the ‘community of practice’ would look after all mothers and babies in the immediate locality, irrespective of their GP registration. Similarly, health visitors in other practices would take on board those patients from the four surgeries living in their immediate vicinity. However, this met with hostility from health visitors elsewhere in MidCity. At the root of their objection was a desire to protect their personal case loads:

‘There’s also a very proprietorial nature, especially running a case load, that these are ‘my families’. That again is a nursing thing: these are my patients, my staff, my families. And I don’t want anybody else looking after my families’ (Senior health visitor).

In addition, they were also unhappy with some aspects of this new way of working introduced by the ‘community of practice’. Entrusting less qualified staff with routine aspects of the work of health visitor teams was also seen as threatening by those health visitors who feared that these developments heralded their deskilling, dilution of their occupational mandate and invasion into their professional territory:

‘People feel it’s actually deskilling health visitors if you delegate some of your work to other professionals’ (Senior health visitor).

‘A lot of my health visiting colleagues aren’t happy about handing over their skills. They’d rather not do it at all than see somebody else do it’ (Senior health visitor).

‘There has been in some quarters, not all quarters, but in some quarters an element of threat with respect to territorialism, if I can put it that way’ (Front Line Operational Manager PCT).

Those health visitors who resisted the new ways of working pioneered by the ‘community of practice’ sought to maintain their position within a professional hierarchy:

‘A lot of health visitors have this sort of hierarchical manner in their work and treat people such as myself or the nursery nurse as sort of like the dog’s body’ (Community Nurse).

They resisted change were characterised by members of ‘the community of practice’, and some PCT managers, as sheltering in their ‘comfort zone’:

‘Some people obviously are not comfortable moving out of their comfort zone ... And I think there’s been a resistance from some staff about letting go’ (Senior health visitor).

‘If you’re in a nice surgery with a nice middle class clientele, it’s quite a nice cushy job actually, thank you very much. £25,000 to £30,000 a year, it’s lovely. They don’t want to change ...’ (Community Nurse).

Although some new births were delegated by ‘the community of practice’ to health visiting teams elsewhere in the city, there was no reciprocation. During the course of our research, not a single baby was referred to the care of ‘the community of practice’. The situation was exacerbated by mixed messages from the PCT as some managers endorsed the proposal, and others countermanded it.

The Impact of Children’s Centres

Opposition from GPs and fellow health visitors tested the confidence of the ‘community of practice’. However, further challenges were about to unfold. In March 2006, members of ‘the community of practice’ discovered that the PCT had negotiated (without consultation) and signed a Service Level Agreement (SLA) with Children’s Centre A in MidCity. The SLA committed members of ‘the community of practice’ to substantial hours of work, each week, within the Centre. Moreover, they only discovered its existence when, at a meeting three weeks before it was due to come into effect, they were asked by Centre staff how they proposed to fit in with the existing programme. The members of ‘the community of practice’ felt angry and betrayed by this development.

Ironically, few if any of the members of ‘the community of practice’ were opposed to Children’s Centres in principle, and a number suggested that Children’s Centres could be the salvation of health visiting. Several aspects of the work of Children’s Centres chimed well with their professional vision. Children’s Centres were engaged in the promotion of healthy lives and the education of parents. They adopted locality working, supported imaginative new services (such as baby massage and yoga for mothers), and incorporated a wide range of other professionals with

whom health visitors were already involved. Children's Centres, at least potentially, offered the opportunity to occupy better quality accommodation, form larger groups of health visitors in daily contact, and escape from the clutches of GP surgeries. Furthermore, Children's Centres were relatively well funded and were clearly favoured by government. Some members of 'the community of practice' also recognised that health visitors themselves had a great deal to offer Children's Centres; including, for example, their long-established reach into communities and their professional access to all mothers and pre-school children. There were some anxieties about Children's Centres among members of 'the community of practice'. They were concerned to ensure that health visitors based in Centres would be able to maintain their outreach, home visiting role. They feared that educational issues rather than health agendas might have priority. Nevertheless, the objections were not to Children's Centres in general, nor to Centre A in particular. Rather, it was to the manner in which the SLA had come into existence and its implications for the new way of working:

'That was not because we didn't want to work with the Unit. It was the way it was imposed. Essentially management agreed things without consultation. There were people within the PCT who think their role is to tell the health visiting service what they should be doing. And that's not always acceptable' (Senior health visitor).

'So we were just informed ... that was the objection. There was no consultation' (Senior health visitor).

'The community of practice' feared the hours they were required to divert to Children's Centre A would jeopardise the continuation of some of the imaginative new services they had developed:

'These ideas are fantastic, aren't they, but you can't run them without people. And if you are taking people out of existing services into these Centres, they are not doing what they were before' (Senior health visitor).

The 'community of practice' also felt that its expertise in identifying needs and appropriate services had been sidelined. It had been treated as a source of service delivery but not service design. The work health visitors were expected to do in Centre A would, they believed, duplicate, marginalize or undermine programmes they

already had in place. Finally, it was argued that drafting members of ‘the community of practice’ into a Children’s Centre on a part-time basis cut across organizational frameworks, lines of responsibility and geographical boundaries. This was a view shared by Children’s Centre management.

Protracted and sometimes difficult negotiations ensued over several months, but in *the* end, a compromise gradually emerged. A senior health visitor was appointed by the PCT to the relevant liaison committee, thereby bringing ‘the community of practice’ into the communication and negotiation loop. Eventually, ‘the community of practice’ supplied some hours of work to Children’s Centre A, but not to the full extent of the original SLA and on its own terms. Other health visitors, from outside ‘the community of practice’, were brought in by the PCT to cover some of the work. Eventually, in Spring 2007, the SLA was replaced (again without consultation) by a ‘partnership’, which appeared to provide a much looser and less prescriptive relationship between ‘the community of practice’ and the Children’s Centre.

While negotiations were continuing with Children’s Centre A, ‘the community of practice’ sought to develop an outflanking strategy. A programme of Children’s Centres was being rolled out in MidCity during the Summer of 2006. Leading health visitors within ‘the community of practice’ made contact with the Director of Children’s Centre B, which was soon to be launched within the immediate vicinity of the four surgeries. Centre B had fewer resources than Centre A, but the Director was looking for ideas about how to make it a success. Becoming involved at the early planning stage enabled ‘the community of practice’ to shape the scope and format of services provided through the new Centre. Thus, ‘the community of practice’ was willing to cooperate with Children’s Centres when the terms of the exchange respected their professional expertise and autonomy. It was a measure of their distrust of the PCT, however, that ‘the community of practice’ kept negotiations with Children’s Centre B secret for as long as possible. Relationships with management had become strained.

‘I think we were now seen as the difficult bunch’ (Senior health visitor).

Erosion of the 'community of practice' from within

Struggles with GPs, the PCT, Children's Centres and fellow health visitors exacted a toll on the enthusiasm and energies of members of 'the community of practice'. A Community Nurse commented:

'You lose the morale. And I've picked up there's some really, really low morale amongst the health visitors'.

These pressures were augmented, however, by a longer term and more insidious drain on their confidence. Turnover of personnel in 'the community of practice' gradually diluted the commitment of members to the new way of working. Several processes were at work here. Some of the less qualified staff became so enthused by the new way of working that they decided to retrain as health visitors. Some of the senior members retired. Others, partly on the strength of their experiences, went on to more senior and responsible jobs elsewhere. Some replacements at team leader and other levels proved to be unfamiliar with, or overtly hostile to, the new way of working. They sought to reinstate the GP-focused, individual case load approach. This caused great stress in the teams concerned and several members went on long-term sick leave.

Management of change, not to mention the reconfiguring of work, is challenging in any organization. However, for the health visitors in 'the community of practice' there were particular difficulties. To fulfil the ambitions of their vision, they needed the consent and commitment of colleagues. Their previous history meant that they had few allies in management who they could call upon to compel compliance. When new health visitors came on the scene and persisted in operating in ways fundamentally at odds with the new way of working, there was little the 'community of practice' could do other than seek to persuade (cf. Fuller *et al.* 2005).

THEORETICAL ANALYSIS

We now turn to an analysis of this case study in terms of three conceptual dimensions: productive systems; work organization; and learning environments.

The horizontal and vertical links of the productive system of health visitors are represented diagrammatically in Figure 1 on page 28 (cf. Bircree *et al.* 1997; Wilkinson 2004). The horizontal axis of Figure 1 represents the sequences or stages of the productive system. On the left hand side of the horizontal axis, health visitors are supplied with clients – mothers and babies - through channels that are clear and unambiguous. New births are referred to health visitors from maternity hospitals and midwives. They are also formally notified of transfers into GP patient lists from overseas or elsewhere in the UK. These sources are precise, prescribed and formally organized. Once in the system, babies are tracked via the ‘Red Book’, GP-managed medical records and through health visitors own filing systems.

As we follow through the horizontal axis of the productive system to the right hand side, we can see that the outputs of health visiting teams are much less certain. They call for skills in creating and maintaining on-going rapport and empathy with mothers, babies and families in many different circumstances, cultures and contexts. Each family has its distinctive strengths and weaknesses that the health visitor is required to identify, assess and address. This work called for reflexivity, emotional labour and engagement of the self. Furthermore in responding to the needs of families, health visitor teams are drawn into multiple relationships with other professionals, within and outside the NHS.

‘Everybody wants a slice of health visiting because they know they can do something for them. So you end up having all the slices together’
(Senior health visitor).

Here, health visitors are often engaged in ‘knotworking’ across the boundaries of professional expertise, knowledge and responsibility (Engeström *et al.* 1999; Engeström 2000).

‘You are kind of like the middle of a wheel sometimes ... you do know what’s out there and you’re able to let other people access it’ (Newly-qualified health visitor).

‘It’s working across boundaries’ (Senior health visitor).

The horizontal axis of health visitors’ productive system, thus, potentially promotes forms of work organization that facilitate expansive learning.

The striking feature of the vertical axis of the productive system of health visitors is the diversity and fragmentation of lines of managerial control and professional responsibility. Three different major lines of managerial control bore down on ‘the community of practice’: GPs, the PCT and Children’s Centres. Furthermore, each was internally divided, adding to complexity and uncertainty. GP surgeries adopted different working practices and attitudes; different PCT managers issued contradictory messages; and different Children’s Centres were relatively autonomous and open to negotiations. Moreover, the PCT and GPs were both funded and organised through the NHS, whereas Children’s Centres were ultimately responsible to the DCSF.

These divisions had both positive and negative implications for ‘the community of practice’. On the one hand, the gaps between different sources of control generated a degree of autonomy and discretion. Opponents in one situation might be recruited as allies in another. On the other hand, ‘the community of practice’ was caught between the conflicting demands of different sources of authority, management and obligation. They tried to renegotiate their relationships with all these, while at the same time asserting their professional independence from each. This proved to be a difficult and debilitating task. Furthermore, fractured lines of control within the vertical axis of the productive system positioned ‘the community of practice’ across an array of different geographical areas, organizational units and professional missions. The PCT, Children’s Centres and GPs all had their own notions of how and where the health visitors were expected to operate. As a result of its position in the vertical axis of the productive system, ‘the community of practice’ faced uncertainty, changes of fortune and unanticipated pressures.

In an uncertain and shifting situation, some health visitors outside ‘the community of practice’ sought to maintain traditional ways of working that appeared to offer a secure (albeit subservient) niche within GP surgeries. This approach to surviving the vicissitudes of the vertical axis of the productive system left them relatively isolated from one another, defending their personal case loads. However, it did provide them with a source of identification.

One of the main aims of the senior members of ‘the community of practice’ was to generate and maintain a sense of *collective* identity and solidarity among health visitors located in the four surgeries. They saw this as critical to the project and a source of the dynamism that would keep it intact. However, they did not have the managerial authority to compel colleagues to adopt new ways of working or sustain group identity. They relied upon consent and persuasion. When they encountered incomers to ‘the community of practice’ who refused to identify with their project, there was little they could do to prevent the network unravelling (cf. Callon 1986; Law 1986).

The combined effects of the vertical and horizontal axes of the productive system of health visitors in MidCity were paradoxical. Some aspects promoted, or at least facilitated, the emergence of new ways of working by the ‘community of practice’; others undermined or blocked it. The potential for expansive learning, inherent in the diverse and multiples tasks generated within the horizontal axis of the productive system, was smothered by forces created by the fractures and fissures of the vertical axis of the productive system. The result was a pattern of uncertainty and indeterminacy; raised hopes followed by dashed confidence. Ultimately, ‘the community of practice’ could not overcome the systemic problems that have beset the profession of health visiting for many years.

CONCLUSION

This paper has examined attempts by a group of professionals in the English health service to reconfigure their work organisation, in order to expand their opportunities to learn and collaborate more effectively. Our research suggests that the conditions for the success of their project were:

- Trust in the judgement and integrity of long-standing senior colleagues, who were prepared to undertake stressful leadership roles;
- Consensus about, and confidence in, a new way of working;
- A group focus that transcended the geographical, social and personal isolation created by dispersal across GP surgeries;
- A safe and secure learning environment for the steady growth of a new way of working that reflected the professional interests of participants;
- The exercise of a sufficient level of professional discretion and autonomy.

However, these conditions were not sustained. The autonomy and discretion of ‘the community of practice’ was challenged from above by a variety of sources of control. Fellow health visitors were unwilling to collaborate with their project. As a result, the community of practice remained localised and vulnerable to disruption.

An analysis of the layers and inter-relationships of the productive system of health visiting reveals the drivers of, and obstacles to, change. Fractures in the productive system afforded sufficient discretion for an enterprising group of health visitors to seize the initiative and, without prompting from management, begin to develop their own innovative way of working. However, the productive system also constrained or denied their autonomy and eroded their confidence at key moments in the development of ‘the community of practice’. Members maintained a semblance of their vision, but their cynicism and distrust of management increased. They could not find an organizational context that they could rely on to respect the kind of professional discretion and self-directed expansive learning to which they aspired. The ‘community of practice’ was unable to roll out its vision across MidCity, and beyond.

‘The service is in disarray and it’s across the board. The health visiting service in the country is confused and has no vision, no direction, and doesn’t really know what it’s about. In which case, why should we expect anybody else to know what we’re about then?’ (Senior health visitor).

‘The key is within the profession. The key is: what is the vision for this profession? And I’m not sure I’ve heard it yet’ (HR Manager PCT).

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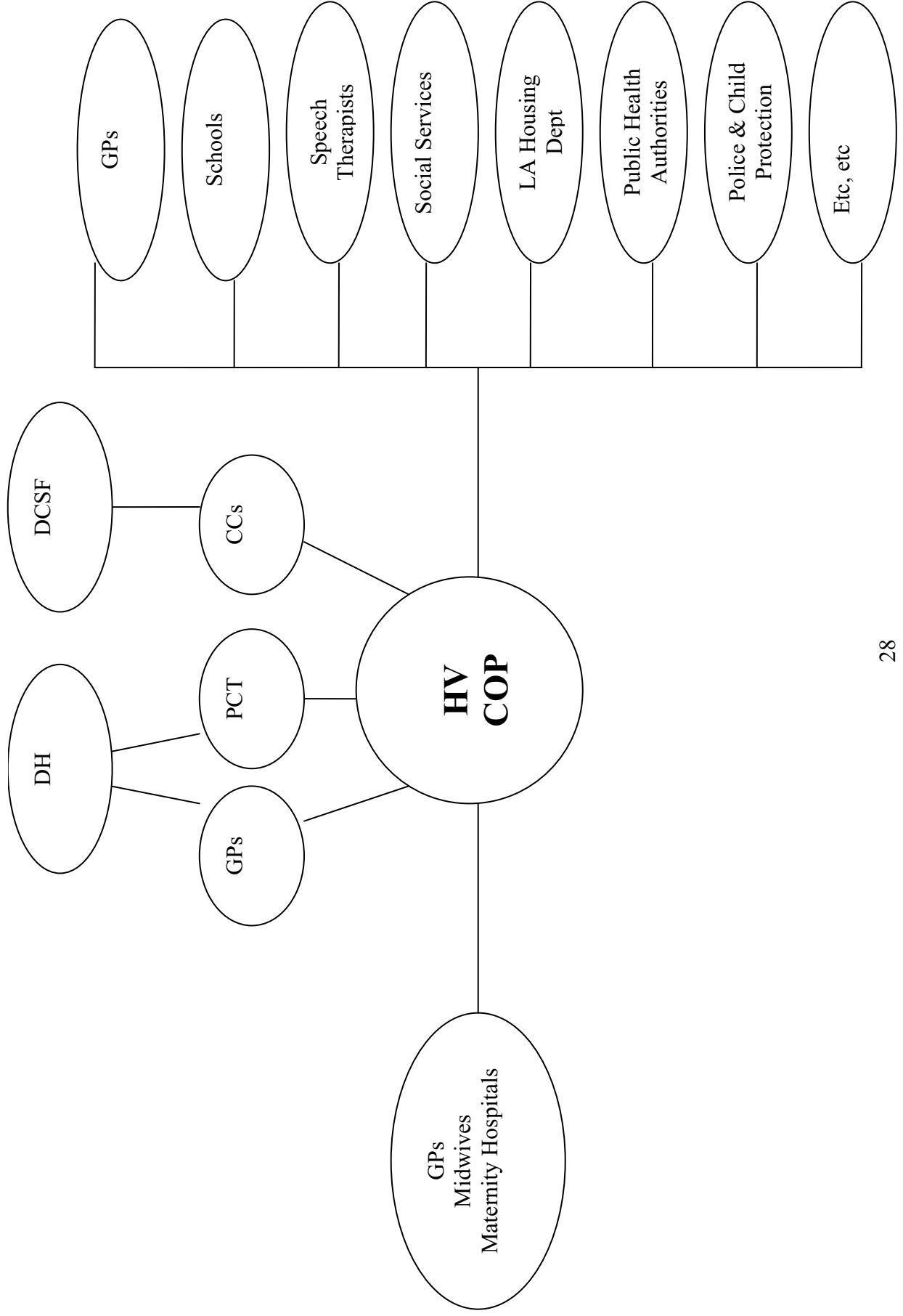
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REFERENCES

- Abbott, P. and Sapsford, R. (1990) 'Health visiting: policing the family' in Abbott, P. and Wallace, C. (eds) *The Sociology of Caring Professions*, Basingstoke: The Falmer Press.
- Bloor, M. and McIntosh, J. (1990) 'Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting', in Burley, S. and McKegany, N. (eds) *Readings in Medical Sociology*, London: Routledge.
- Billingham, K., Morrell, J. and Billingham, C. (1996) 'Professional update: reflections on the history of health visiting', *English Journal of Community Health Nursing* 1 b(7): 386-92
- Birecree, A., Konzelmann, S. and Wilkinson, F. (1997) 'Productive systems, competitive pressures, strategic choices and work organization: an introduction', *International Contributions to Labour Studies* 7: 3-17
- Brocklehurst, N. (2004a) 'The new health visiting: thriving at the edge of chaos', *Community Practitioner*, 77 (4): 135-139
- Brocklehurst, N. (2004b) 'is health visiting "fully engaged" in its own future well-being?', *Community Practitioner*, 77 (6): 214-218
- Callon, M. (1986), 'Some elements of a sociology of translation: domestication of the scallops and fishermen of St Brieuc Bay', in Law J (ed) *Power, Action and Belief: A New Sociology of Knowledge?* London: Routledge & Kegan Paul, pp196-233
- Campbell D (2007) 'Mothers miss a 'friend' as health visitors decline', *The Observer*, Sunday 15th April
- Connolly MP (1980a) 'Health visiting 1850-1900: a review', *Midwife, Health Visitor & Community Nurse* 16 (7): 282-85
- Connolly MP (1980b) 'Health visiting 1900-1910: a review', *Midwife, Health Visitor & Community Nurse* 16 (9): 375-78
- Cowley S (1996) 'Reflecting on the past; preparing for the next century' *Health Visitor* 69 (8): 313-36
- Craig P. and Smith L.N. (1998) 'Health visiting and public health: back to our roots or a new branch?' *Health and Social Care in the Community* 6 (3): 172-180
- Davies C. (1988) 'The health visitor as mother's friend: a woman's place in public health, 1900-1914' *Social History of Medicine* 1: 39-59
- Davis C. (1995) *Gender and the Professional Predicament in Nursing*, Buckingham: Open University Press
- Department of Health (2007) *Facing the Future: A Review of the Role of Health Visitors*, Department of Health: London
- Dingwall R (1977) 'Collectivism, regionalism and feminism: health visiting and English social policy, 1850-1975', *Journal of Social Policy*, 6 (3): 291-315
- Dingwall, R. and Robinson, K. (1990) 'Policing the family? Health visiting and the public surveillance of private behaviour', in Gubrium, J. and Sankar, A. (eds) *The Home Care Experience: Ethnography and Policy*, Newbury Park, CA: Sage
- Engeström, Y. (2000) 'Activity Theory as a framework for analyzing and redesigning work', *Ergonomics*, 43(7): 960-974.
- Engeström, Y., Engeström, R. and Vähäaho, T. (1999) 'When the center does not hold: the importance of knotworking', in Chaiklin, S., Hedegaard, M. and Jensen, U. J. (ed.) *Activity Theory and Social Practice*, Aarhus: Aarhus University Press, 345-374.
- Ferguson, L. (1996) 'Sharing in practice: the corporate caseload', *Health Visitor* 69 (October): 421-423

- Fuller, A. and Unwin, L. (2003) 'Learning as apprentices in the contemporary British workplace: creating and maintaining expansive and restrictive participation', *Journal of Education and Work* 16 (4): 406-427
- Fuller, A. and Unwin, L. (2004), 'Expansive learning environments: integrating organizational and personal development' in Rainbird H, Fuller A and Munro A (eds) *Workplace Learning in Context*, London: Routledge.
- Fuller, A., Hodkinson, H., Hodkinson, P. and Unwin, L. (2005) 'Learning as peripheral participation in communities of practice: a reassessment of key concepts in workplace learning', *British Educational Research Journal*, 31 (1): 49-68.
- Gastrill, P. (1994) 'A team approach to health visiting', *Primary Health Care*, 4: 10-12
- Heritage, J. and Lindstrom, A. (1998) 'Motherhood, medicine and morality: scenes from a medical encounter', *Research on Language and Social Interaction*, 31 (3) and (4): 397-438
- Houston, A.M. and Clifton J. (2001) 'Corporate working in health visiting: a conceptual analysis', *Journal of Advanced Nursing* 34 (3): 356-366
- Hughes, J., Jewson, N. and Unwin, L. (2007) *Communities of Practice: Critical Perspectives* London: Routledge
- Jackson, C. (1994) 'Strelley: teamworking for health', *Health Visitor* 67: 28-29
- Kelsey, A. (2000) 'The making of health visitors: an historical perspective part 1', *International History of Nursing Journal*, 5 (3): 44-50
- Law, J. (1986) 'On the methods of long-distance control: vessels, navigation and the Portuguese route to India', in Law J (ed) *Power, Action and Belief: A New Sociology of Knowledge?* London: Routledge and Kegan Paul
- Lave, J. and Wenger, E. (1991) *Situated Learning*, Cambridge: Cambridge University Press.
- Malone, M. (2000) 'A history of health visiting and parenting in the last 50 years', *International History of Nursing Journal*, 5 (3): 30-43
- Peckover, S. (2002) 'Supporting and policing mothers: an analysis of the disciplinary practices of health visiting' *Journal of Advanced Nursing*, 38: 369-377
- Rowe, A., Hogarth, A., Teager, M., Brocklehurst, N., English, G., Cox, S. and Yates, J. (2003) 'Modernising health visiting and school nursing practice: an account of the PHAAR programme in central Derby', Derby: *University of Sheffield and Central Derby PCT*.
- Symonds, A. (1991) 'Angels and interfering busybodies: the social construction of two occupations', *Sociology of Health & Illness*, 13 (2): 249-264.
- Taylor, S. and Tilley, N. (1989) 'Health visitors and child protection: conflict, contradictions and ethical dilemmas', *Health Visitor*, 62 (9): 273-275.
- Twinn, S. (1993) 'Principles in practice: a re-affirmation', *Health Visitor*, 66 (9): 319-321.
- Wenger, E. (1998) *Communities of Practice: Learning, Meaning and Identity*, Cambridge: Cambridge University Press
- While, A.E. (1987) 'The early history of health visiting: a review of the role of central government', *Child Care Health Development* 13 (2): 27-36
- Wilkinson, F. (2004), 'Productive systems and the structuring role of economic and social theories', *Working Paper No. 225*, ESRC Centre for Business Research, University of Cambridge.

FIGURE 1: The Productive System of Health Visiting



Learning as Work Research Papers

Jewson, N, Unwin, L, Felstead, A, Fuller, A and Kakavelakis, K (2008) ‘‘What is the vision for this profession?’’: learning environments of health visitors in an English city’ *Learning as Work Research Paper No 14*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

Bishop, D, Felstead, A, Fuller, A, Jewson, N, Kakavelakis, K and Unwin, L (2008) ‘Constructing learning: adversarial and collaborative working in the British construction industry’ *Learning as Work Research Paper No 13*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

Fuller, A, Kakavelakis, K, Felstead, A, Jewson, N and Unwin, L (2008) ‘Learning, knowing and controlling “the stock”’: the changing nature of employee discretion in a supermarket chain’ *Learning as Work Research Paper No 12*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

Kakavelakis, K, Felstead, A, Fuller, A, Jewson, N and Unwin, L (2007) ‘‘I am a genuine person’’: sales training and the limits of moulding instrumentality’ *Learning as Work Research Paper No 11*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

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Lee, T, Jewson, N, Bishop, D, Felstead, A, Fuller, A, Kakavelakis, K and Unwin, L (2007) ‘There’s a lot more to it than just cutting hair, you know: managerial controls, work practices and identity narratives among hair stylists’, *Learning as Work Research Paper No 8*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

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Felstead, A, Bishop, D, Fuller, A, Jewson, N, Lee, T and Unwin, L (2006) ‘Moving to the music: learning processes, training and productive systems – the case of exercise to music instruction’, *Learning as Work Research Paper No 6*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

Bishop, D, Felstead, A, Fuller, A, Jewson, N, Lee, T and Unwin, L (2006) ‘Connecting culture and learning in organisations: a review of current themes’, *Learning as Work Research Paper No 5*, Cardiff: Cardiff School of Social Sciences, Cardiff University.

Unwin, L, Felstead, A, Fuller, A, Lee, T, Butler, P and Ashton, D (2005) 'Worlds within worlds: the relationship between context and pedagogy in the workplace', *Learning as Work Research Paper No 4*, Leicester: Centre for Labour Market Studies, University of Leicester.

Felstead, A, Fuller, A, Unwin, L, Ashton, D, Butler, P, Lee, T and Walters, S (2004) 'Applying the survey method to learning at work: a recent UK experiment', *Learning as Work Research Paper No 3*, Leicester: Centre for Labour Market Studies, University of Leicester.

Lee, T, Fuller, A, Ashton, D, Butler, P, Felstead, A, Unwin, L and Walters, S (2004) 'Workplace learning: main themes and perspectives', *Learning as Work Research Paper No 2*, Leicester: Centre for Labour Market Studies, University of Leicester.

Butler, P, Felstead, A, Ashton, D, Fuller, A, Lee, T, Unwin, L and Walters, S (2004) 'High performance management: a literature review', *Learning as Work Research Paper No 1*, Leicester: Centre for Labour Market Studies, University of Leicester.

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