Primary Health Care Research and Development 2007; **8**: 80–90
doi: 10.1017/S1463423607000096

Exploring health visitors' perceptions of the public health nursing role

Shona Cameron School of Health Sciences – Nursing, Corstorphine Campus, Queen Margaret University College, Edinburgh, UK and **Grace Christie** Public Health Practitioner, Alloa Health Centre, Marshill, Alloa, UK

This small exploratory study in one local area in Scotland aimed to identify health visitors' perceptions of public health nursing and the factors that influenced their capacity to adopt a broad public health role in line with current policy direction in Scotland. The literature review focused on the historical and political context of public health nursing and the extent to which health visitors across the UK have managed to shift practice towards a greater emphasis on community focused public health work. This study involved 10 qualitative interviews with practising health visitors, who had at least 2 years' experience and trained prior to September 2001 when the public health nursing course replaced the health visiting course in Scotland. Participants identified a range of barriers to local implementation of the model of public health nursing practice set out in recent national policy. Findings suggested that theoretical perspectives of public health and leadership issues for health visitors perpetuate the dominant clinical agenda in their work setting. Although participants were generally willing to develop wider public health work they identified a number of constraints related to the perceived higher value given to clinical duties. This was reinforced by the low priority given to public health work at all levels within the organization and by primary care team colleagues. The study found participants felt powerless to influence change and were frustrated by unrealistic expectations of their ability to develop their public health nursing role without adequate support and planning infrastructure. Dominant themes that emerged from the investigation reinforce the need for effective leadership and application of social science theory to enable public health nurses to challenge the perceived dominant biomedical approach to public health in primary care.

Key words: health visiting; primary care practice; public health; public health nursing

Received: November 2004; accepted: May 2006

Introduction

In the UK, general practice has developed as a reactive medical service for individuals and their families (Peckham and Exworthy, 2003). For Health visitors (HVs) there is increased emphasis on nursing in teams, through being based in general practitioner (GP) practices, termed GP attachment. The role is now changing from a focus on the health of mothers and children to a broader community public health role. HVs along with other colleagues in primary care are facing the challenge of responding to the public health agenda.

The increased emphasis on public health is as a result of international and national changes. In the international field, the Alma Ata Declaration and its resolve to achieve 'Health for all by the Year 2000' (World Health Organisation, WHO, 1981), later updated in 'Health 21' (WHO, 1998), incorporated principles of equity, community participation, partnership and addressing local health inequalities thus suggesting the promotion of public health through primary care (Cowley, 2002). 'Health for All' is informed by a socio-ecological model of health which recognizes that the common causes of ill health and a sense of well-being

Address for correspondence: Shona Cameron, School of Health Sciences – Nursing, Corstorphine Campus, Queen Margaret University College, Edinburgh, EH12 8TS, UK. Email: scameron@qmuc.ac.uk

is created and lived by people within the settings of their everyday life (Hamer and Ross, 2000).

Health care policy has shifted from an emphasis on secondary care towards primary care, resulting in national policy changes. The various primary care organizations across the four UK nations, were charged with improving population health and narrowing the health gap between the most affluent and the most disadvantaged people (Hunter, 2003a). In Scotland, Local Health Care Co-operatives (LHCCs) were established in response to 'Designed To Care' (Scottish Office, 1997), which set out the main proposals for reorganizing Primary Care. LHCC's consisted of voluntary co-operatives of GP practices serving an average population of 50 000–100 000, with health visiting as a key discipline within GP practice teams. Following evaluation and review of LHCC's, further reorganization in April 2005 established Community Health Partnerships, with the expectation of co-terminosity and closer partnership working between Primary Health Care and Local Authorities (Scottish Executive, SE, 2003d; 2005).

A national review of public health (Department of Health, 1998) highlighted the need for a multidisciplinary public health workforce to address the determinants of health, and suggested HVs are well placed to take a lead role in public health work in primary care. In Scotland 'Nursing for Health' (SE, 2001) defined a distinct public health role for HVs and school nurses, establishing a new discipline of public health nurse (PHN) which combines the two disciplines. Public health practitioner (PHP) posts were also created in each area with a key remit to support the development of the public health function in primary care by working to build skills for effective partnership planning and delivery of public health programmes and projects.

The PHN role requires a radical change from the traditional health visiting role, with its focus on child and maternal health, to a broad community orientated public health approach. This approach can complement and build on a family focused role by identifying and addressing targeted action on common health issues in communities (Craig and Lindsay, 2000). The expectation is that PHNs will play a key role in supporting the primary care contribution to public health action, by strengthening individuals, strengthening communities and reducing structural barriers to health.

However, in this study the traditional nomenclature of HV is used, as the participants were employed as such, and this is the title still in common usage at this time of transition. The use of the term HV/PHN in Scotland demonstrates the shift towards the new identity.

This study aims to explore HVs' perceptions of the new public health nursing role.

Literature review

The term 'public health nurse' was introduced in the 1990s, with very little definition. Craig and Lindsay (2000) found that the bulk of the literature related to public health nursing in North America, which developed through a community-focused health improvement role, rather than the UK GP attachment model. Across the UK, HVs are members of GP practice teams and this arrangement currently continues for HV/PHNs in Scotland. In each area, support is offered by PHPs, but the challenge is for all primary care practitioners to integrate public health practice with their clinical practice. HV/PHNs are an important resource in influencing this change agenda (SE, 2003c).

Historically, while some authors argue that HVs have a tradition of being involved with public health work to varying degrees (Goodwin, 1992; Twinn, 1993; Cowley, 1995), others suggest that HVs' public health activity is concentrated on individual health education and preventative medicine with lower involvement in community-focused public health (Caraher and McNab, 1997; Poulton *et al.*, 2000; Brocklehurst *et al.*, 2003). There are concerns about the capacity to deliver this agenda (Hall and Elliman, 2003, SE, 2003a; 2003b) and possible constraints include the emphasis on GP attachments, the creation of the internal market and a contract culture (Billingham, 1994; Caraher and McNab, 1996; Symonds, 1997; Cowley, 2002). There could be a lack of clarity about the public health component of HVs' work and how it fits with primary care team priorities (Symonds, 1997), with the possible competing clinical and public health priorities identified as a barrier (Billingham and Perkins, 1997; Craig and Lindsay, 2000; Cowley, 2002; Brocklehurst *et al.*, 2003). Caraher and McNab (1996) and Billingham and Perkins (1997) recommended that HVs develop their community-wide public health role and break from the confines of the traditional focus

on screening and surveillance of children and families, and individualized health promotion.

The literature review of Hawksley *et al.* (2003) aimed to uncover the extent to which HVs have developed their public health role. Of 344 examples of public health practice, only a small number related to community empowerment, suggesting that a broader public health approach to health visiting is still at an embryonic stage.

Smith (2004), in focus groups with 27 HVs, highlighted the need for greater connection to public health through local leadership and facilitative management, and clarification of the health visiting role. The evidence for wider public health work was presented by Elliot *et al.* (2001) in their systematic review of the effectiveness of PHN.

Plews *et al.* (2000), investigating practitioner understanding and practice of public health nursing, found that there were various interpretations and a lack of collaborative working to support a move to community focused public health. Jinks *et al.* (2003) presented some limited evidence of a reorientation of practice towards the adoption of models of public health. Carr *et al.* (2003) found a lack of a distinctive model for public health practice in England and Wales, in contrast to the specific model in Scotland.

In view of the expectation of the new PHN role in supporting change in practice towards greater focus on community-wide public health activity, a small exploratory study was planned in one LHCC area in Scotland. The aims are to elicit the views of a purposive sample of HVs about public health, and contributory helping and hindering factors to the implementation of the new model of public health nursing practice.

Methods

Design

An exploratory, descriptive design was used to carry out a focused exploration of the participants' understanding of public health nursing and the factors they considered important to the development of that role. This research study focused on HVs within their natural working environment in Primary Care and aimed to examine their opinions, perceptions and attitudes to the new public health role. The use of a qualitative approach lends itself to more description and use of intuition, which assisted in the production of rich data with detailed description of participants' perceptions.

The researcher, as a PHP and former HV, has a remit to support change towards broader public health activity across the LHCC workforce. This remit and background stimulated an interest in understanding the factors which currently constrain or support HVs' willingness to become involved in community focused public health work.

This can be interpreted as a source of bias, and so was discussed with all participants, and addressed by detailed feedback to participants through member checks, peer review and sharing transcripts with a supervisor.

Limitations of the study are listed in Box 1.

Box 1 Limitations of the study

- This was a small exploratory study related to a specific context, at a time of transition.
- The sample was restricted to HVs who had trained prior to the introduction of the new PHN education programme.
- The sample was self-selecting, and the participants who volunteered may not be representative of the breadth and depth of views of HVs/PHNs.
- The familiarity of the researcher with the context and participants, and vice versa.

Participants

Using the principles of purposive sampling appropriate to exploratory, descriptive studies, currently practising HVs were invited for interview. These HVs met the criteria of 2 years experience and thus trained prior to the introduction of a named public health nursing degree course. The geographical unit of one LHCC was selected. This unit represents a grouping of general practices in one area, responsible to the primary care trust, who are charged with planning and delivering local services. All HVs within this one local area who met the criteria were approached by letter to invite them to participate.

Ten HVs from a sample of 31 volunteered to be interviewed. Later verbal responses from non-respondents indicated their tentative interest, but for this small-scale study the sample of 10 was considered manageable and concurrent analysis also supported that a range of experiences was elicited. However, as the participants were self-selecting, it

Box 2 Topic guide

- The public health component of participants' education.
- Participants' current public health activity.
- Participants' understanding of public health nursing.
- The factors they considered supported their public health work.
- The factors they thought hindered their public health work.
- Any other comments.

could be speculated that the staff who volunteered might not have been fully representative of the widest range of views.

The 10 participating HVs had varying years of experience in practice and were currently working in either rural or urban settings attached to GP teams of different sizes. The range of years since initial training as an HV was between 6 and 28 years. Six participants trained over 15 years ago.

Method

Individual in-depth, semi-structured interviews were chosen as a particularly useful method of finding out about people's perceptions or opinions on specific matters (Pontin, 2000). Both the local research ethics committee and the local research and development department approved the study. A participant information sheet included aims of study, measures to protect confidentiality and a consent form.

After reviewing the literature, a topic guide was created (Box 2) which addressed possible areas of confusion about views of public health and the public health nursing role. The guide was used to gain an overview of current activity of perceived public health work and to capture their understanding of the new PHN role, identifying which factors supported or hindered their involvement in public health work.

All interviews were tape recorded and fully transcribed and all the identified themes and quotations verified with participants.

Data collection

One pilot interview was held, to test the schedule. Ten local HVs were interviewed during July and August 2003.

In qualitative interviewing the researcher is an active participant in the process. The researcher explicitly addressed possible role confusion by emphasizing that the participants' own experiences and opinions were the important element in this study.

Participants were encouraged to describe and explain their understanding of public health nursing and public health work, using their own frames of reference.

Data analysis

The data collected during this study consisted of 'wordy' transcripts and field memos which required systematic sorting and handling to assist data analysis. Sensitivity to the data was facilitated by personally typing all transcripts and repeated listening to the interview tapes (Patton, 2002). Thematic analysis of transcripts was informed by constant comparison method, a systematic tool for developing and refining theoretical categories (Strauss and Corbin, 1991; Coffey and Atkinson, 1996).

The transcripts were analysed line by line to generate concepts. Software to assist analysis was considered but rejected in favour of manual sorting to aid the researcher's own learning. Concepts were coded and used to link segments of narrative to create categories with common properties and the interview topic guide was used to cluster related categories together. Through use of constant comparison nine key categories emerged. Sections of the participants' words were highlighted as potential quotations. After the emergence of the key categories a further literature search was instigated to investigate these in greater detail.

Issues of rigour such as trustworthiness and a decision trail were addressed through the reflexivity of the researcher, who was constantly vigilant, reflecting on field notes and regularly listening to the tapes. The transcripts and coding were shared with her supervisor to assist confirmability. The study's findings and quotations were checked with participants to check their authenticity and credibility.

Results

Analysis organized the wealth of data from the interviews into nine key categories (see Box 3), which are supported by the participants' own words.

Theory practice gap for public health practice

The majority of participants had difficulty recalling the public health component of their health visiting course:

> The training didn't prepare me for practice. The theory only touched on public health. But the format was mostly lectures with little structure and no real teaching.

> We had very little public health, a few lectures, but they were about home and working conditions and given by a consultant in public health. It was very limited and had no resemblance to the public health content that public health nurses get nowadays.

These quotes are from both the most experienced and most recently trained participants and imply that there was little social science theory or practical public health skills training within the course curricula which participants experienced. A review of the content of curricula revealed that these aspects are now included. However, these participants expressed gaps in knowledge.

On completion of training the reality of the type of practice these HVs experienced is closely aligned to the traditional health visiting role with its focus on mothers and children. All participants stated they had limited experience in working with groups other than mothers and families. The lack of opportunity to become involved in wider community focused public health work seemed to be an influencing factor in participants' limited confidence and enthusiasm for the PHN role.

One participant who had 10 years experience working in a variety of HV posts throughout the UK summed up her experience as follows:

> My early experience of health visiting was mainly crisis visiting and coping with a very large 0–5 caseload, with lots of problems and public health was a very small component of the work and only in relation to the core under 5 work. I can't remember doing any groups or development work.

Mindset

The qualitative interviews facilitated participants in expressing their inner feelings about taking on the PHN role. Many indicated the proposed change would require people to move out of their 'comfort zone' and this caused fear of not being adequately skilled or supported to plan and deliver on appropriate public health interventions to wider community groups. The majority seemed willing to embrace the public health role and felt they had many transferable skills, but there were issues around letting go of traditional work:

> I think it's very daunting, because I think however much people are bogged down in their caseloads and however they see their work, like we all do they probably feel quite safe and any suggestion of working differently is threatening. Particularly, if you're taken away from the structure of caseloads.

> … individuals being scared that this is going to happen and they'll be expected to do strange things with strange people. Maybe they feel inadequate to work differently and with partners. Some people don't feel they've got the skills or knowledge.

The interviews explored the factors participants considered supportive and restrictive to the development of their public health nursing role. A number of the key categories illuminate these factors.

Political influence

Seven participants mentioned central government or national policy as key influencing factors in supporting or hindering their public health role. The earlier Conservative government rule of 1979–1997 was highlighted as an era when specific policies inhibited public health work and prioritized clinical and routine surveillance activity in primary care. Participants perceived the New Labour government as supportive of the public health nursing role and alluded to the increasing emphasis on public health work in primary care. There was some concern and uncertainty about the future.

There seemed to be a general feeling that public health work in primary care is politically driven and controlled by specific government targets. Participants recognized that targets dictate allocation of resources and work priorities in primary care. One participant saw this as helpful, while others associated targets with restriction of HVs' public health work:

> We don't know what's going to happen in the next few years because health policy is bound

by the political party in power. A change of government may mean public health is no longer the way forward for health visitors.

When I started health visiting the role was more like a public health nurse role, but from around 1991, when the GP contracting system came in that changed. The GP's didn't want us out there doing community clinics. The targets coming in had to be the main focus. That really limited what health visitors could do.

Integrated GP teams

Participants confirmed that all HVs in this LHCC are required to work within an integrated GP practice team. These teams are made up of doctors, practice nurses, district nurses, administrative staff and one or more HVs. When asked if their team colleagues were supportive of public health work, all the participants indicated that public health is not a priority for their teams. This resulted in some support in principle, but little actual support, and in many cases objections to any activity perceived as outwith the treatment and care of the practice population. Participants implied that GP's prefer to have 'their' HV visible in the clinic and available to deal with patients. These HVs seemed to feel they needed permission from their team to allow time for any public health activity:

Our GPs are not that interested in public health. They'd much rather see us doing clinic-based work. I think they're feeling a bit disgruntled, because they're running a business and paid to do chronic disease management clinics, so that's the aspect of our work that they value most.

GPs like their health visitor to be around to see patients in the clinic whenever problems arise, like headlice or whatever. I think a lot of GPs would like less home visiting and health visitors to be around the surgery more.

Alien culture

Participants agreed that GPs and other community nurses in the teams favoured a medical approach to public health work, and that approaches that are more appropriate in tackling the social determinants of health were usually discarded by the team in favour of advice-giving to patients. Participants suggested their community focused public health work had often been blocked by other priorities agreed by the team so that any public health work was marginalized and not included in the team agenda or discussions. Several participants emphasized the tension this created for HVs working in GP teams:

Different people in the team have different ideas about what health is and what they're there for. Some people think public health is what the public health department do. Health visitors are the only ones who start from a fundamental very different perspective. Everyone else is banging a different drum. It can be very difficult to keep pushing our perspective as worthwhile when nobody sees the results.

Workload pressures

Participants explained that their capacity to undertake public health work was constrained by current workload pressures and competing priorities. The under-five caseload, a range of clinic commitments and child protection work were frequently cited as accepted priority areas of work for these HVs:

It may be difficult for some health visitors to prioritize any public health work. Caseloads and clinics have to take priority, certainly as long as our key responsibilities stay the same. The day to day work of health visitors is the stuff that lands on your desk and public health work has to fit round that.

Lack of resources to support public health nursing emerged as a theme across the 10 interviews. Although lack of resources can be used as a convenient 'catch-all' to resist change, participants reported they are expected to continue with current commitments while also addressing the wider public health remit.

Time to plan and deliver public health, and public health skills training, including knowledge to access funding, and negotiating and influencing skills, were identified as needs by the majority of participants.

Powerlessness

Participants gave various examples of the lack of power of HVs as a discipline:

> Certain professional groups have the power and they're not going to hand it over to anybody else … doctors have money and power. We don't.

> There is no recognition of the expertise of health visitors and we have no access to funds or how they're used … our partners don't see us as important players. They need to recognize at strategic level the contribution public health nurses can make.

Several participants shared that they have experienced a lack of confidence to voice opinions and challenge decisions at Primary Care and partner agency fora. In view of the fact that it may be the more assertive PHNs who volunteered to share their views in this study, this aspect is particularly crucial.

Lack of strategic direction

Participants recognized the need for clear strategic direction for how and why practice needs to change. Several people indicated that they had no clear picture of the strategic direction for public health nursing within the wider NHS organization. This contributed to participants feeling vague and confused about the process of change and how they could positively influence development of their PHN role:

> There needs to be a strategy for what we're trying to achieve and we need an infrastructure, that includes other agencies to begin to take small pieces of work forward, at the minute it seems so *ad hoc* and so huge. Without any structure, without any direction, I don't know how we're going to achieve anything.

Participants felt, given the lack of an agreed vision, that managers and planners had unrealistic expectations of HVs' ability to effect change. They expressed a feeling of being 'rudderless', which prevented their progress towards a new PHN role:

> There's no managers in place and you're left to pick things up yourself and not really sure where you're going with things. It's difficult in such a big organization that you don't know what's going on. You don't get the whole picture.

Support for implementation

Several participants identified three key areas that require support, the appropriate tools and implementation skills. These were, how to set realistic priorities for public health work, negotiation with GPs and planning for partnership work. There was a general feeling that effective leadership and adequate resources would facilitate realistic project planning and delivery of appropriate needs led public health improvement locally:

> People are feeling a bit in the dark at the moment, especially about how to get started, how to get resources, all the processes that need to be gone through and a chance to speak about and share this type of information.

There was a general plea from participants for a support infrastructure to help collective planning and co-ordinated activity for public health work. Several participants suggested this process should be participatory, so HVs could be meaningfully involved in development of public health nursing locally.

Participants identified that HVs themselves require leadership skills so they can effectively deliver on their contribution to the huge and complex public health agenda. Several mentioned that working collectively as teams would support development of public health work:

> I think we need better leadership and co-ordination to pull it all together. We're too busy doing our day-to-day work to do this.

Discussion

Analysis of these nine categories (Box 3) identified three core themes: the dominant clinical agenda, theoretical perspectives, and the need for leadership.

Dominant clinical agenda

The biomedical model informs the way primary care is currently structured and organized. The participants felt their capacity for public health work was reduced, because like all primary care

Box 3 Nine key categories

- Theory practice gap for public health practice
- Mindset
- Political influence
- Integrated GP teams
- Alien culture
- Workload pressures
- Powerlessness
- Lack of strategic direction
- Support for implementation

nurses they were expected to prioritize delivery of services to patients registered with the practice and comply with the accepted team approach to healthcare delivery. Robotham (1999) in her article about the doctor–nurse relationships, suggests that although the patriarchal nature of doctors' relationships to nurses is changing there is still a tendency for nurses to adopt a task orientated role that is directed by doctors. The fundamental issue of whether team colleagues perceived the HV as a primary care nurse or a PHN with a remit for meeting the needs of communities in a more proactive way in line with 'Nursing for Health' (SE, 2001), appeared to underlie the tensions around the reported lack of dedicated resources and support for their public health work. Participants reported an increase in clinical orientation and practice population focus of their workload since moving to integrated GP teams and a sense of powerlessness to effect change in the alien culture with its prevailing medical dominance. Similar barriers due to primary care team working have been highlighted in a range of previous studies, where HVs experienced constraints in developing their broader community focused public health practice (Billingham and Perkins, 1997; Symonds, 1997; Brocklehurst *et al.*, 2003). Wiles and Robison (1994) in a study of the experiences of HVs and nurses in primary care teams in one area of England, identified that the HVs' public health role was weakened by attachment to GP practice teams, which was identified as an 'alien culture' which marginalized their public health role. Kuokkanen and Leino-Kilpi (2000) suggest that a perceived lack of power and support demotivates and disables practitioners. Empowerment is a core component of public health practice, explicit in international public health policy (WHO, 1981), at the root of the fundamental reform of health visiting and the PHN programme in Scotland. Nursing For Health (SE, 2001) specifies the expectation for HVs as a new public health nursing discipline to continue to work within GP practice teams while re-focusing on wider community public health. Implementation of the new model of public health nursing will require a supportive empowerment process, which affords the PHN workforce appropriate support at local level and incorporates significant organizational development investment, to develop more effectively their collective negotiation and influencing skills, to present a convincing argument for re-focusing their practice.

Theoretical perspective

It could be argued that the traditional education of HVs prior to the PHN education programme of 2001 lacked exploration of how to implement public health practice, which draws on social scientific theory. The findings from this study confirm that participants perceived this theory to practice gap. In her analysis of published literature within the last 5 years Haycock-Stuart (2004) highlights the need for theoretical underpinnings of both the Public Health Nursing evidence base and practice to make explicit the knowledge that is informing the design of effective public health work. The use of theory acknowledges intellectual, experiential and emotional preconceptions and enables them to be measured against tested theoretical frameworks of explanation (Jones, 1994). Further inclusion of social science theory in continuing as well as professional PHN education, may support HV/PHN's to present a cogent argument for appropriate public health methods in the predominantly biomedical culture in which they operate.

Health related sociological literature indicates that the health system usually reflects and seldom leads the broader prevailing political agenda (Baggott, 2000; Hunter, 2003b). Now that renewed concern for health improvement focused on tackling inequalities is equally explicit in policy alongside health system efficiency targets, PHN's who are adequately supported and educationally prepared would be in a good position to seize the opportunity to develop public health nursing practice.

This study was limited to HVs educated before the introduction of the PHN programme. In the absence of any published research of the impact of newly trained PHN's, a consensus conference report,

'Developing Public Health Nursing in Scotland' (Scottish Executive Health Department, SEHD, 2004), after nearly 4 years, identified that the new programme is well established, with newly qualified PHN's thinking and seeking to work differently. An American study (Smithbattle *et al.*, 2004) of how their PHN workforce develop public health knowledge and experience after qualification found that inexperienced PHN's enter the field with the theoretical knowledge but great gaps in practical know-how and take considerable time before they can translate formal theory into practical situations. The findings illustrate how novices benefit from experienced colleagues to support their practice development. In Scotland, one way of supporting this collective development for public health theory to practice is to establish PHN teams, possibly with the PHP as a facilitator for the process within local areas.

Leadership

Participants identified lack of strategic leadership which would provide clear direction and inspiration to support change and development of public health nursing locally.

A key element of the vision for public health nursing set out in 'Nursing For Health' (SE, 2001) is the development of effective leadership at all levels, including PHN teams. Managers need to demonstrate strategic support and direction for significant cultural change through communicating that public health is an organizational priority, by identifying PHN capacity and restructuring workloads accordingly (McMurray and Cheater, 2004).

Participants in this study identified a flattened hierarchy within the LHCC affording little contact with managers which led to feelings of isolation from core planning for public health across the wider organization. This resonates with Hyett's (2003) findings that nurse managers are unfamiliar with the daily challenges for HV's in taking forward public health work, and to Smith's (2004) study, which suggested that HVs working in GP teams felt isolated from public health colleagues.

Supportive networks are recognized as integral to the 'Nursing for Health' model for public health nursing (SE, 2001; 2003c). Presently due to the developmental stage of public health nursing there is little evidence of structures in primary care to support the collective empowerment process for HVs. This raises concerns, since they have been challenged with developing a leadership role for public health within a clinically focused team structure that currently does not recognize public health as core work. Locally public health nursing teams have been formed in localities and are being facilitated by the PHP to develop local public health nursing plans linked to strategic planning. The team sessions focus on team building, wider partnership working and reflection on theory and evidence for public health practice.

This study highlighted that local leadership for public health nursing in primary care will be crucial to stimulation of a co-ordinated, planned approach to evidence-based public health work.

Conclusion

The categories identified from this small study require further research to find out if they are common across the wider health visiting population, and whether similar barriers exist to development of their wider public health nursing role.

Recommendations are listed in Box 4, and suggestions for further research are made in Box 5.

It is clear from national policy in Scotland that HVs are expected to adopt the new public health nursing role with support from educational establishments, public health departments, nurse management and primary care.

Recent work demonstrates that little progress has been made UK wide towards a shift in emphasis from individual health promotion towards community empowerment approaches to public health (Hawksley *et al.*, 2003; Jinks *et al.*, 2003). This small qualitative study in one geographical area was not designed to produce conclusive evidence regarding the present experience or future implementation of public health nursing. However, it does identify common themes within the sample population that mirror the UK picture of HVs' slow progress towards implementation of broader public health.

The findings indicate that competing clinical and public health priorities, an alien culture, lack of resources, lack of influence of HV/PHNs to drive change and lack of vision orientated leadership for public health nursing, conspire to impede the shift towards greater emphasis on community orientated public health work.

Box 4 Summary of recommendations

- Local infrastructures are required to support collaborative planning and teambuilding for public health in primary care.
- Effective leadership is required to support a co-ordinated planned approach to evidence-based public health nursing practice.
- Teams require support to develop skills to implement public health work.
- Practitioners would welcome appropriate tools to use in planning, implementing and evaluating public health.

Box 5 Further research

Further research is required in order to:

- Build on this research by use of a larger sample of HVs across a wider geographical area and national contexts, to investigate these findings further.
- Explore how the theoretical underpinnings of public health work are translated into practice.
- Build on the core themes using participatory action research to support PHNs in developing a leadership role for public health in primary care.

If HV/PHNs are to develop a service that works effectively in partnership to deliver public health programmes which tackle inequalities and improve the health of local people, they must be adequately supported and empowered to build corporate public health knowledge and skills. The findings from this study suggest a participatory process that supports team building with HV/PHNs and local partners, and supports project planning for focused areas of public health work, could begin to develop a service that practises true empowerment for workers and the communities they serve.

Acknowledgements

This study was undertaken as a dissertation for the award of the MSc in Primary Care, from Queen Margaret University College, Edinburgh. This could not have been achieved without the help and cooperation of the participating HVs, to whom we owe our thanks.

References

Baggott, R. 2000: *Public health policy and politics*. Houndmills: Macmillan Press Ltd.

Bell, J. 1999: *Doing your research project*. Buckingham: Open University Press.

Billingham, K. 1994: The challenge of practice. *Nursing Times* 90, 43.

Billingham, K. and **Perkins, E.** 1997: A public health approach to nursing in the community. *Nursing Standard* 11, 43–46.

Brocklehurst, N., Heaney, J. and **Pollard, C.** 2003: GP attachment versus geographical working. What's best? *Community Practitioner* 76, 81–82.

Caraher, M. and **McNab, M.** 1996: The public health nursing role: an overview of future trends. *Nursing Standard* 10, 44–48.

Caraher, M. and **McNab, M.** 1997: Using lessons from health visiting's past to inform the public health role. *Health Visitor* 70, 380–84.

Carr, S., Procter, S. and **Davidson, A.** 2003: Models of public health nursing. *Community Practitioner* 76, 96–99.

Coffey, A. and **Atkinson, P.** 1996: *Making sense of qualitative data.* London: Sage.

Cowley, S. 1995: Health-as-process: a health visiting perspective. *Journal of Advanced Nursing* 22, 433–41.

Cowley, S. 2002: *Public health in policy and practice*. Edinburgh: Harcourt.

Craig, P. and **Lindsay, G.** 2000: *Nursing for public health.* Edinburgh: Churchill Livingston.

Department of Health. 1998: *The report of the Committee of Inquiry into the Future Development of Public Health Function.* London: HMSO.

Elliot, L., Crombie, I.K., Irvine, L., Cantrell, J. and **Taylor, J.** 2001: *Nursing for health: the effectiveness of public health nursing: a review of systematic reviews*. Edinburgh: Stationery Office.

Goodwin, S. 1992: Community nursing and the new public health. *Health Visitor* 65, 78–80.

Hall, D. and **Elliman, D.** 2003: *Health for all children*. Oxford: OUP.

Hamer, L. and **Ross, A.** 2000: *Partnerships for health policies, principles and practice, a resource pack*. United Kingdom: Health for All Network.

Hawksley, B., Carnwell, R. and **Callwood, I.** 2003: A literature review of the public health roles of health visitors and school nurses. *British Journal of Community Nursing* 8, 447–53.

Haycock-Stuart, E. 2004: Public health nursing: issues for practice research and policy. *Community Practitioner* 77, 342–45.

Hunter, D. 2003a: *Public health policy*. Oxford: Blackwell.

Hunter, D. 2003b: Public health policy. In Orme, J., Powell, J., Taylor, P., Harrison, T. and Grey, M. editors, *Public health for the 21st century*. Maidenhead: OUP.

Hyett, E. 2003: What blocks health visitors from taking a leadership role? *Journal of Nursing Management* 11, 229–33.

Jinks, A., Smith, M. and **Ashdown-Lambert, J.** 2003: The public health roles of health visitors and school nurses: a survey. *British Journal of Community Nursing* 8, 496–501.

Jones, L.J. 1994: *The social context of health and health work*. Houndmills: Palgrave.

Kuokkanen, L. and **Leino-Kilpi, H.** 2000: Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing* 31, 235–41.

Laws, S., Harper, C. and **Marcus, R.** 2003: *Research for development.* London: Sage.

McMurray, R. and **Cheater, F.** 2004: Vision permission and action: a bottom-up perspective on the management of public health nurses. *Journal of Nursing Management* 12, 43–50.

Patton, M.Q. 2002: *Qualitative research and evaluation methods.* London: Sage.

Peckham, S. and **Exworthy, M.** 2003: *Primary care in the UK*. Basingstoke: Palgrave Macmillan.

Plews, C., Billingham, K. and **Rowe, A.** 2000: Public health nursing: barriers and opportunities. *Nursing Standard* 8, 138–46.

Pontin, D. 2000: Interview. In Cormack, D., editor, *The research process in nursing.* Oxford: Blackwell Science.

Poulton, B., Mason, C., McKenna, H., Lynch, C. and **Keenay, S.** 2000: *The contribution of nurses, midwives and health visitors to the public health agenda.* Belfast: HMSO.

Robotham, M. 1999: What you think of doctors. *Nursing Times* 95, 24–27.

Scottish Executive. 2001: *Nursing for health: a review of the contribution of nurses, midwives and health visitors to improving the public's health.* Edinburgh: Stationery Office.

Scottish Executive. 2003a: *Making it work for Scotland's children: child health support group overview report.* Edinburgh: Stationery Office.

Scottish Executive. 2003b: *Health for all children: guidance on implementation in Scotland. A draft for consultation.* Edinburgh: Stationery Office.

Scottish Executive. 2003c: *Nursing for health two years on*. Edinburgh: Stationery Office.

Scottish Executive. 2003d: *Partnership for care*. Edinburgh: Stationery Office.

Scottish Executive. 2005: *Building a health service fit for the future*. Edinburgh: Stationery Office.

Scottish Executive Health Department. 2004: Developing public health nursing in Scotland. *Unpublished Conference Proceedings of Consensus Conference* held on 16 November, Dunfermline.

Scottish Office Department of Health. 1997: *Designed to care, renewing the NHS in Scotland*. Edinburgh: Stationery Office.

Smith, M. 2004: Health visiting: the public health role. *Journal of Advanced Nursing* 45, 17–25.

Smithbattle, L., Diekemper, M. and **Leander, S.** 2004: Getting your feet wet: becoming a public health nurse part one. *Public Health Nursing* 21, 3–11.

Strauss, A. and **Corbin, J.** 1991: *Basics of qualitative research: grounded theory procedures and techniques.* London: Sage.

Symonds, A. 1997: Ties that bind: problems with GP-attachment. *Health visitor* 70, 53–55.

Twinn, S. 1993: Principles in practice, a re-affirmation. *Health visitor* 66, 319–21.

UKCC. 2001: *Developing standards and competencies for health visiting – consultation document*. London: UKCC.

WHO Regional Office for Europe. 1998: *HEALTH 21 – an introduction to the health for all policy framework for the WHO European region*. Copenhagen: WHO Regional office for Europe.

Wiles, R. and **Robison, J.** 1994: Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. *Journal of Advanced Nursing* 20, 324–30.

World Health Organisation. 1981: Global strategy for health for all by the year 2000. Geneva: WHO.