

Leading change in public health – factors that inhibit and facilitate energizing the process

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Background: Primary health care has recently undergone and is continuing to experience significant change. One issue is the increased emphasis on population health. Public health is at the centre of recent United Kingdom government policy as well as international policy. This paper describes the adoption of a specialist practitioner public health nurse role as a resource for public health practice development. The issues raised by the approach to practice and service development are located within discourses on leadership, modernisation and change in health and social care. The discussion is guided by critical theory approach to facilitate exposure of the factors influencing decisions and consequences of decisions. **Evaluation method:** The evaluation design drew on the theories of change approach which focuses on 'surfacing assumptions' underpinning a change process. Purposive sampling was used to identify a range of stakeholders to the post. Individual interviews were conducted with 11 stakeholders from management, nursing, social work and medical roles. Four focus groups were conducted with health visitors. **Findings:** Thematic analysis identified three issues that relate to a specialist role aimed at public health capacity development; location of the specialist role within existing teams, the routes available to providing public health subject leadership and sharing expert knowledge, potential for conflict or tensions between specialist and other roles. **Conclusions:** Capacity to address the public health agenda is being developed at the same time as the modernisation of leadership. The role and impact of historical organizational structures and approaches to management and leadership must be acknowledged. The research indicated that specialist posts have positive potential in relation to public health practice developments. Key success factors included involving the generalist in the rationale development of such a role, sharing expectations of the impact of all roles and where to locate the specialist role with respect to existing teams and structures.

Key words: capacity development; leadership; modernization; public health; specialist roles

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Introduction

This paper describes the approach developed by one primary care trust (PCT) to the development

of public health capacity in that workforce. The issues raised by this approach to practice and service development are located within discourses on leadership, modernization and change in health and social care. Of particular relevance to the practice development required to actualize the public health agenda is the concept of creativity. Howkins and Thornton (2002) describe this as questioning traditional approaches, rejecting the routine and

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being willing to rethink outside conventional role delineations. The issues described fit very well with the public health challenge. According to Howkins and Thornton (2002: 14) creativity generates 'the force that energises the change process'. Factors that both encourage and stifle the creative endeavour are highlighted in this paper.

Primary health care has recently undergone and is continuing to experience significant change. One issue is the increased emphasis on population health. Public health is at the centre of recent United Kingdom (UK) government policy (Department of Health, 1999a; 1999b; 2000; 2002; 2005) as well as international policy (World Health Organisation, 1998). In UK policy, health visitors (HVs) (registered nurses with additional professional education in primary care and public health) have been identified as having a key role to play in achieving health improvements. Public health has always been part of the HV role, although arguably, at least most recently, at a more individual than at a family or population level. Embracing the public health agenda requires significant public health nursing capacity development. A number of barriers and constraints have been identified to successfully developing public health practice (McMurray and Cheater, 2003; 2004; Hyett, 2003; Smith, 2004). These have focussed around lack of role clarity and the processes of changing practice. A variety of service configurations have resulted in responses to this development challenge. These include the development of public health lead roles, distribution of specific public health responsibilities between a number of roles, development of public health as a facet of community nurse roles (Plews *et al.*, 2000; McConville, 2001).

This paper describes the adoption of a specialist practitioner role as a resource for public health practice development. This raises a wide range of issues, two of which are explored in this paper; first specialist roles in primary care and secondly the application of this model to public health capacity development. There has been a growth in specialist practice roles in primary care and a variety of specialist roles already exist in primary care. Some examples would include diabetes care, palliative care and child protection. However, McKenna *et al.* (2003) describe the generalist to specialist movement in primary care roles in Ireland as bringing the potential for role confusion, conflict and overlap. Specialist roles often stand outside the standard workforce and leadership structures. The place of

the specialist practitioner within nursing teams is often unclear. The adoption of specialist roles is therefore not without challenges and tensions. Secondly, the transferability of the specialist model to public health capacity development is another key issue explored in this paper. A common feature of most specialist roles is that they tend to focus on a discrete health care need. The development of an expert level of knowledge that can serve as a resource for a generic practitioner is therefore possible. This model is not directly transferable to a specialist role in relation to public health capacity building. Individual practitioner's need for, and application of, public health knowledge will be diverse due to the need to respond to the health needs analysis of different populations. Work patterns and workload also have to change as a consequence. This is not the usual sequelae to specialist input. It is more usual for the generalist to be facilitated in their role, rather than be facilitated to redefine their role.

This paper explores these specialist role issues as they manifest in the evaluation of a PCT wide public health nurse (PHN) role developed in a UK setting (Carr, 2003). PCTs provide and commission community health care for designated geographical areas. This single post was set up to take a leading role in public health developments and developing the public health capacity of community nurses, in particular HVs. In this PCT HVs are located in one of three geographical localities. Each locality has at least one generalist clinical nurse leader (CNL). The CNL has a remit to lead practice as well as fulfilling personnel and administrative responsibilities. Herein lies the other key drivers in this discussion, the changing face of management and leadership in nursing and health and social care in general. There is a movement away from the idea of leadership being invested in a single individual (Department of Health, 2002). This involves a shift from transactional and hierarchical leadership approaches to an embracing of transformational and empowering approaches (Howkins and Thornton, 2002).

The discussion of these issues is guided by critical theory approach which:

... aims at an analysis of social processes, delving beneath ostensive and dominant conceptual frames, in order to reveal the underlying practices (Harvey, 1990: p. 4)

The purpose is not to focus on deficiencies or negatives of the situation, but rather to expose the factors influencing decisions and the consequences of decisions. The agendas to increase public health activity, liberate talents and modernize leadership are brought together to expose the challenges, tensions and potential solutions. Others making decisions around specialist role development or public health capacity development may therefore be armed with a menu of potential options and consequences.

Aims of the study

The aim of the research was to evaluate a newly introduced PHN role and the contribution of the role to the development of public health capacity within the PCT. The evaluation activity was concurrent with the role implementation process to inform the development of the role function.

Sample and methodology

This paper explores the perceptions of a range of health and social care stakeholders to the PHN post. It was strongly influenced by the theories of change approach which focuses on ‘surfacing assumptions’ underpinning a change process (Barnes *et al.*, 2001: 1). This fits well with the critical theory paradigm aim of cutting through ‘surface appearances’ (Harvey, 1990: 19). The research process aimed to facilitate participants to surface the assumptions that underpinned their understanding of the change being pursued.

Sampling

By virtue of the nature of the post the PHN worked with a wide range of stakeholders, all of who could have been included in the evaluation. Purposive sampling (Parahoo, 1997) was therefore employed to attempt to ensure stakeholder diversity as well as gaining depth to the evaluation. Details of the sample are provided in Table 1. A limitation of the research was the lack of service user inclusion in the sample. The research budget was influential in this decision.

Table 1 Individual stakeholder interview sample

Individual interview sample	* = 1 interview ** = 2/3 interviews
Post holder	**
PCT manager	**
Public health specialist nurse (strategic level post)	**
Cardiac consultant	*
PCT medical director	**
Senior social worker	*
Social worker	*
SureStart health visitor	**
CNL	**
CNL	*
PCT public health director	**

Individual interviews

Individual tape-recorded interviews were held with the range of stakeholders detailed in Table 1. Depending on their continued involvement over the 3-year period of the evaluation, some stakeholders were interviewed more than once (Table 1).

The interview schedule addressed: definitions of public health, public health needs of the local population, and definitions of the PHN role, role expectations, role successes and disappointments. The schedule was flexible and responsive to the issues relevant to different respondents. Interviews were later transcribed verbatim.

Focus group interviews

Focus group method (Kitzinger, 1995) was chosen to facilitate interaction between participants so that their experiences could be shared and discussed.

Four focus group interviews were held with HVs drawn from across the PCT. Attendance at the focus groups was n3, n8, n9 and n6. The interview schedule addressed: defining the HV contribution to public health, changes in role, facilitators and inhibitors to change, the role of the PHN in these processes, expectations of the PHN role.

Data analysis

The audio tapes were transcribed verbatim. Thematic analysis was performed on all transcripts. Morse and Field (1996) define this approach as searching for and identifying threads or themes

within the data. All three researchers involved in the evaluation undertook analysis of the first round of interview transcripts to enhance confidence in theme development. The research had a function in informing the new PHN role implementation.

The data was therefore analysed to enable aspects of the role that were working well or not working well to be identified. The data was also interrogated to identify expectations, reactions and consequences of the introduction of the PHN role from multiple stakeholder perspectives. This was an ongoing process with each phase informing the subsequent data collection and analysis activity.

Ethical aspects

At the time of the research, Local Research Ethics Committee approval was not required for data collection with NHS staff. Nevertheless, all participants received a project information leaflet detailing the purpose and style of the research. Written consent was obtained at each interview. All participants, with the exception of the PHN, were assured that their contribution would be reported anonymously.

Findings

The analysis identified three themes that relate to the specialist role aimed at public health capacity development. These are:

- Location of the specialist role within existing team structures.
- The routes available to providing public health subject leadership and sharing expert knowledge.
- Potential for conflict or tensions between the specialist and other roles.

Location of the specialist role

This PHN post was located outwith any of the established HV teams, CNL or management structures. Senior nurses involved in developing and managing the post rationalized this decision as aiming to protect the post holder from being drawn into other aspects of practice. Keeping the post separate did ensure that a clear focus on public health could be maintained. However, the

Primary Health Care Research & Development 2007; **8**: 207–215

decision had other ramifications. Not fitting into the recognized framework was one issue:

I don't think we have made any great steps forward – not directly related to the post but because there was not an appropriate infrastructure in place to support it or drive public health. (Medical stakeholder: MS1)

Locating the post outwith existing structures created a clear tension in that this post was about public health capacity building. For this to occur the HVs had to reconfigure their workloads. Public health had to be integrated into their current workload commitments. The 'stand-alone' location of the specialist role impacted on the processes the post holder could use to provide leadership and enable shared expert knowledge to be incorporated into practice:

The PHN has not got the authority to take this forward and is disadvantaged by that. (Senior Nurse: SN1)

For the individual specialist practitioner concerned, there is also the danger of not belonging to any particular professional grouping. This is perhaps particularly pertinent with a developing specialism such as public health nursing when the accompanying structure is in the evolutionary stage. As the PHN post progressed the public health framework in the PCT gradually developed and strengthened. This provided a professional grouping to which the PHN could then be aligned. Professional affiliations and associations are important factors in times of change when practitioners may feel uncertain about their role and future and are looking to understand the change agenda.

Routes to providing leadership

Public health capacity requires an enhanced knowledge base and integration of this knowledge into practice. With respect to knowledge development two activities have to occur. First individual HVs have to be located on a public health knowledge continuum to identify their learning or development needs. Public health practice is multi-dimensional and depending on experience and timing of professional education, different practitioners would have different skill packages.

Secondly the needs of their practice population have to be identified in order to understand the state of the public health and the actions required to achieve health improvement. This happened in two ways in the study setting detailed in Figures 1 and 2.

This required the PHN to work with individual HVs to analyse their practice and development needs. As there was only one specialist practitioner for the PCT, it was not possible for this to happen with every practitioner. Generally this interaction occurred because some HVs sought out the PHN because they had a particular desire to develop their public health role. Another reason was because the HV was in a post with responsibility for a designated population group such as asylum seekers, travellers or homeless people. Another factor determining this seeking out of interaction with the PHN was awareness of the PHN role remit:

I thought it was more of a strategic level as opposed to coming and helping.
(Health Visitor: HV1)

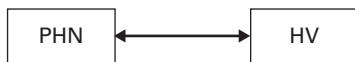


Figure 1 Individual knowledge development approach

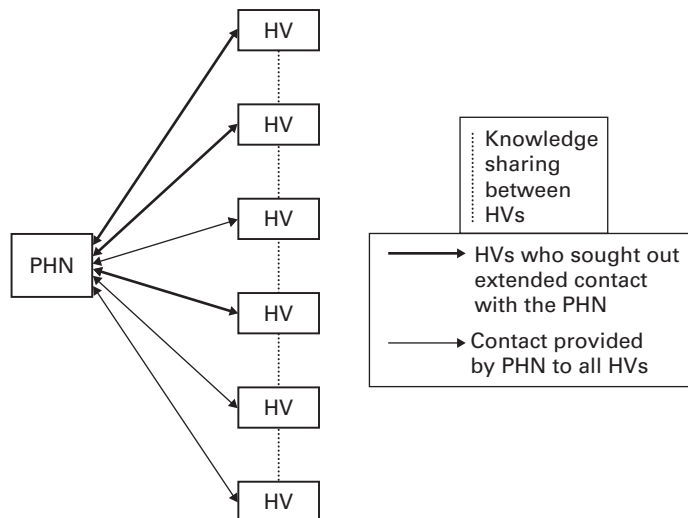


Figure 2 Team knowledge development approach

This may be a result of the PHN role not being part of the recognized and familiar structure and also the fact that one post holder had to limit her potential workload:

As this was a new role, the PHN had to take an incremental approach to working with staff.

(Senior Nurse: SN2)

The consequence of this is that a sub population of HVs received detailed capacity development guidance and support.

Figure 2 presents the concurrent activity of public health knowledge development with all HVs in a locality.

This then could be described as a collective approach to public health knowledge sharing. The HVs did not have to take any initiative to seek this but it was provided by the PHN for every practitioner. Some of the HVs will also have sought out individual discussions with the PHN and a heavy arrow indicates this. The broken line indicates that there was knowledge sharing between HVs.

The next stage in capacity development is the integration of this newly developed knowledge into practice. There were limitations on the role of the PHN in this aspect of practice development in view of the post being positioned outwith the clinical leadership structure in the PCT. In order to put knowledge into practice, the HVs had to negotiate

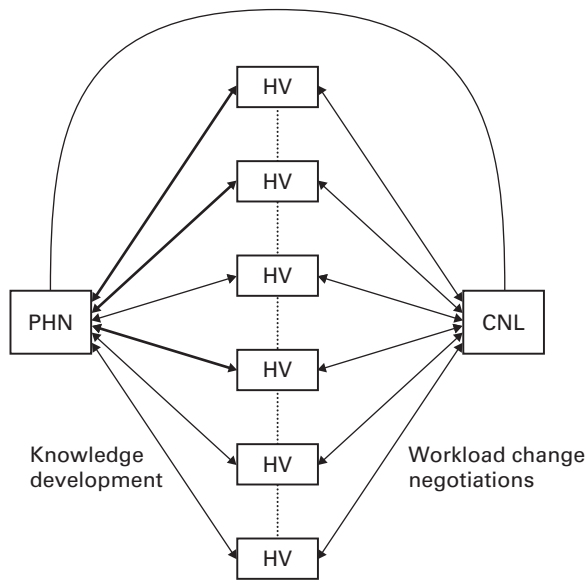


Figure 3 Actions to develop public health capacity

workload modifications with their CNL. Figure 3 illustrates the route to public health capacity development within a locality.

Figures 1, 2 and 3 map the multiple and complex relationships and paths involved in providing leadership in relation to public health capacity development.

Potential for role conflict and tension

Four areas of potential conflict were evident in the data relating to the PHN role. These were:

- The relationship of the specialist role with other roles.
- The balance of public health and other aspects of health visiting practice.
- The establishment of a new post.
- The impact of the specialist role on other roles.

The specialist role had to fit with many roles. Of particular relevance to this discussion is the relationship with HVs and CNLs. The potential for conflict lies in the diversity of leadership requirements for this type of practice development and in clarifying who is providing leadership for what. The complexity of these relationships was detailed in the previous section. The relationship between the

Primary Health Care Research & Development 2007; **8**: 207–215

players was not always clearly understood. The following comment was endorsed by a number of practitioners:

I'm not sure where she [PHN] fits in with everything. (HV2)

Different elements of leadership were invested in each of the roles of specialist practitioner, HV and CNL. The specific contributions of the specialist practitioner were primarily public health knowledge and perhaps at a more secondary level role development facilitation. The CNLs' specific leadership contribution revolves around role development facilitation and workload negotiation. The HVs contribution relates to their embracing the enhanced leadership offered in policies such as 'Liberating the Talents' (Department of Health, 2002). However, the operationalization of these roles was not always clear. The CNLs and other Senior Nurses within the PCT were keen to support diversity in role and capacity development. Concurrently, HVs were calling for role clarification to allow them to know how they could accommodate their developing public health knowledge and responsibilities.

Another potential for conflict was that the PHN was focusing specifically on public health. This can create some tension for those HVs who saw public health as only one aspect of their work. The specialist role was therefore only linking into part of their role and some frustrations could be experienced in that their full workload and commitments were not perceived to be acknowledged:

Public health is part of my role, not all of it. I have other responsibilities and demands on my time. (HV3)

To some practitioners, therefore, the PHN was only seen to be privy to part of their working world.

The PHN role was a new post with the remit of enhancing public health nursing capacity. The fact that a new post had been established to drive the public health agenda forward created some tension for some HVs:

we have to modernize, we have to take on public health – what do they think we have been doing. I get really frustrated sometimes – it makes you feel so undervalued – that

what you are doing now is out of date, not much use. (HV4)

These frustrations were not directed at the PHN post holder, but the decision by PCT managers to establish the post.

Another challenge is the working through of the implications of the specialist role for the generalist practitioner. This requires a process of clarifying what each expects from the other. Three potential models of practice were voiced. Clarification of which of these potential routes was favoured was not made sufficiently evident by the CNLs or other senior staff. HVs queried the specialist model that was perceived to have the potential to separate public health practice from health visiting.

One of the fears is that the PHN takes all the development and public health nursing as a separate entity. (HV5)

Another option articulated was that of the expanded model where public health competencies of generic HVs are developed:

I see a general shift in public health capacity, by this time next year both the PHN and the HVs will have moved on. (SN1)

The third option was the combined model where public health competencies of all practitioners were developed alongside specialist leadership and support from the PHN:

we could always do with someone to come and do some development work – we don't have time to do a lot of the ground work, having the PHN to come in and help establish something or do some information gathering would be good and then we could carry on with things. (HV2)

Discussion

Leadership is an essential component of the modernization and improvement agendas for health and social care. This paper set out to explore the modernisation and leadership discourses impacting on one PCTs approach to developing public health capacity and factors that inhibit and facilitate

energizing the necessary change processes. The research results reveal a number of important messages.

Acknowledging the contextual complexity in primary care is essential. Capacity to address the public health agenda is being developed at the same time as the modernisation of leadership. The role and impact of historical organizational structures need to be highlighted. Laurent (2000) identifies the struggle nursing has experienced distinguishing management and leadership. Historically nursing has relied heavily on the former, particularly in the role titles of senior practitioners. However, Ewens (2002) describes the NHS as being in transition from a hierarchical to a participatory culture. Changes in leadership are occurring across health and social care organizations. These can be summarized as a movement from individual to collective leadership approaches and to an empowerment model where leadership is part of many roles. Success requires simultaneous challenging of what Daiski (2004) describes as nurses disempowering behaviours.

Reference to leadership capacity development in nursing generally sheds light on some of the inherent complexities. A central part of the preparation for nurses has been the Leading Empowered Organizations (LEO) training. Duffin (2001) reports on a range of experiences of the LEO programme. Some attendees showed almost immediate application of leadership development in their communication and negotiation practice. However on a less positive note, some staff were not able to put the leadership education into practice and frustration developed. A mismatch between expectation raising and the opportunity to operationalize in the organization structure is therefore a key message. Capacity development whether it is in relation to leadership or public health needs to be located in a receptive organization context so that development energy is used efficiently and not frustrated.

The capacity development and leadership model in the PCT where this evaluative research was conducted appeared to have the appropriate components for success. Leadership was not confined to one individual, but devolved to a variety of roles. A number of domains of influence were acknowledged such as public health knowledge and workload negotiation (Antrobus and Kitson, 1999). HVs were offered the opportunity to creatively develop their roles as public health capacity increased within the PCT.

Primary Health Care Research & Development 2007; 8: 207–215

However, as the research results identified, the change process was not a totally smooth course. Analysis of the multiple components of the change process offers some potential explanations. Several changes needed to be occurring at the same time, public health knowledge development, collaborative rather than individual models of health visiting practice and supportive development of self-leadership to develop practice in an environment where change is negotiated rather than sanctioned. All of these changes were in process, but not occurring at the same rate. A parallel track of all aspects of change would be the ideal, although potentially not always feasible. However, the important messages to be shared relate to the change model adopted and the organizational context in which it is located. Perhaps a key issue is one highlighted by Kitson (2004: 211) in her comment that 'leadership is a process of drawing out rather than putting in.' In the change process described in this paper the PHN specialist practitioner role was intended to 'put in' additional public health impetus. An important and perhaps not so well acknowledged issue is the need for HVs' ability and power to initiate and determine change to be more clearly legitimized. This would include a clear acknowledgement of their domain of influence in leading public health developments and communication channels and processes that do not sap energy and enthusiasm but allow creativity to flourish. This is not a unilateral task. Rather it is a challenge posed both to HVs and to specialist practitioners and other clinical leaders with whom they must tackle the public health agenda.

Conclusion

This research has indicated that specialist posts have positive potential in relation to public health practice development. Involving the generalist practitioner who will work with the specialist in the planning of the development makes for a smoother process. Sharing the rationale for the post and the impact expectations for the service and the individual practitioners involved is also key to successful implementation.

Based on the learning from this evaluation it is possible to provide recommendations for Primary Care Organizations that may facilitate public health leadership activity (see Table 2).

Primary Health Care Research & Development 2007; **8**: 207–215

Table 2 Lessons from the evaluation

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- Ensure that development rationale and expectations are shared with all relevant members of the organization. This may help to ensure organization support and to reduce potential change generated anxiety and suspicion.
 - Leadership or development roles should not be isolated out with organization structures.
 - Careful consideration must be given to the location of a specialist post within established teams and leadership and management structures.
 - People in leadership and development roles need to derive support and energy from other leaders and developers and therefore should be able to access this type of network.
 - Although the individual may be leading a new development, this must be done cognizant of organization history and cultures.
 - The potential success of individual leadership or development roles will be challenges unless the organization is receptive and prepared for change.
 - Recognize that management is a facet of leadership and attempting to divorce the two activities into exclusive roles may create difficulties.
 - Be prepared to think outside conventional role formats.
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