Royal College of Nursing

Shaping nursing since 1916

Nurses 4 Public Health

Promote, Prevent and Protect

The Value and Contribution of Nursing to Public Health in the UK: Final report

January 2016

Contents

Project Team 3
Acknowledgements 3
Executive Summary 4
Background 5
Project Phases and Design 6
Aims and Objectives 6
Phase 1 – Case Study Examples 7
Summary of Case Studies – national spread 8
Phase 2 – Survey 9
Survey Design 9
Survey Findings 12
Strengths and Limitations of the Survey 16
Phase 3 – Interviews 17
Method 17
Themes from the Interviews 20
Discussion 27
Key Messages and Recommendations 28
References 30
Appendices 31
Appendix 1: Reference Group membership 31
Appendix 2: Case Study Template 32
Appendix 3: Case Study Scoring Criteria 34
Appendix 4: Interview Topic Guide 35

Project Team

Lead:

Helen Donovan
Professional Lead for Public Health Nursing, Royal College of Nursing

Project Consultant and Lead Author:

Nigel Davies
Independent Project Consultant and Professor of Healthcare Leadership and Workforce Development, University of Bedfordshire

Acknowledgements

The team gratefully acknowledge the support, endorsement, feedback, constructive comments and suggestions made by the following individuals and groups during the course of the project:

1) The Project Reference Group. The membership is listed in Appendix 1
2) The RCN country and regional directors
3) The Nursing Policy and Practice Committee
4) The Standards, Knowledge and Information Services (SKIS) team at the RCN
5) The respondents to the survey and the interview participants.

This reports provides a detailed account of the project. For a “quick-read” overview please see the sections and pages highlighted by a blue side panel.

Executive Summary

During 2015 the RCN has been leading work to assess the impact and contribution that nurses make to public health (PH). Government policies in all four countries across the UK point to the importance of improving public health to help address increasing population demands and financial pressures. The Royal College of Nursing believes nurses are well placed to pick up this mantle; however, we questioned whether others shared our views, particularly those outside the nursing profession.

The project has had three parts:

1) The first strand of the project has been to draw together case studies to showcase the diversity of nursing's contribution to public health. Examples include work where nurses target specific client groups or conditions as well as other initiatives to improve health and wellbeing across the lifespan.

2) We undertook a web-based survey specifically asking commissioners and designers of public health services their views. We received 219 responses. Commissioners told us that the skills they look for in nurses include local knowledge, project and research skills, communication skills and behavioural characteristics such as compassion and motivation. Challenges to using nurses when designing services include lack of resources, lack of training amongst some nurses, and lack of knowledge amongst some commissioners of where nurses could contribute.

3) We followed up the survey with in-depth interviews with a sample of the survey respondents. They told us that nurses are well placed to give public health messages and are often seen as more approachable than some other health care practitioners. They reiterated that local knowledge is important but expressed fears that organisational restructuring may move nurses' bases away from the communities they are working with.

Background

Improving public health is at the forefront of all of the UK governments' policies for health and social care (NHS England 2014, NHS Scotland 2012, Scottish Government 2015, Public Health Agency, NI 2015 and Public Health Wales 2015). Health services currently face the unprecedented challenges of both an increasing population and financial austerity. Combining the impact on health services that increasing numbers of people, many living with long-term conditions, are having with limited resources available for health has led to greater emphasis on how best people can be helped to not just live longer but to stay healthy.

At an individual level, the emphasis is on *making every contact count* (Bennett 2012) using all opportunities to provide accurate and up-to-date advice so that people are supported to make good lifestyle choices. At a community level, nurses need to understand who is in the population and support those who are often 'hidden' to access health care. Indeed providing services for all, for example through a universal health visiting service, can create opportunities for patients or service users which they would otherwise remain unaware of or unwilling to engage in (Cowley et al 2015). At a wider population level there is increasingly scope for nurses to work with colleagues in wider health, social care and education systems to consider the inter-relationship between health and other services. Indeed the range of activities which can come under the umbrella of public health is wide and has been described and mapped to domains by the Faculty of Public Health (Faculty of Public Health 2015).

Nurses are often ideally suited and uniquely placed to respond to public health challenges as they understand the particular risks of individuals but also know the population and the communities they work in (Donovan 2015). Traditionally public health nurses have been seen as those in specialist community roles such as health visitors, school nurses and occupational health nurses and in some cases specialist practitioners. However, with the challenges outlined and the need to improve the public's health there is an increasing need now for all nurses to become agents of public health and promote health as part of their clinical practice (While 2014). Indeed recent work, and consultation, by Public Health England to develop a PH skills and knowledge framework (Public Health England 2015) emphasises the art and science of public health which may be particularly relevant for nurses.

Project Phases and Design

During 2015 the RCN has undertaken a project to assess the value and contribution that nurses make to public health across the United Kingdom.

Aims and Objectives

The overall project aimed to explore the perceived value of nursing in public health.

We sought to better understand:

- the role of nursing and midwifery staff in public health
- how nursing roles are valued
- what and where the gaps are in nursing knowledge and education in relation to public health
- and how do nurses and other public health practitioners consider these gaps should be addressed?

The project has been undertaken in three parts:

1) compilation of case studies to showcase the diversity of nurses public health work

2) a web-based survey specifically targeting commissioners, service planners and designers of public health services for their views about the value of public health nursing

3) in-depth interviews with a sample of the survey respondents and other stakeholders.

Phase 1 – Case Study Examples

Case studies have been compiled from our knowledge of good practice across the UK together with a review and update of those featured in the RCN's publication *Going Upstream* (RCN 2012) and new case studies identified by key stakeholders and the RCN's networks across the UK. Furthermore, a search was also undertaken of the relevant professional press to identify innovation in practice.

A template was devised to collection information about potential case studies (see Appendix 2). This information was followed up by the project team and a scoring system used in order to select those case studies that have been included. The criteria included the description of the innovation or project, the nursing contribution, the outcomes and impact. The scoring scheme is shown in Appendix 3.

The case studies will be showcased on the RCN website from February 2016 with presentation materials which include audio recordings with practitioners and service users to complement the written narratives.

See: http://publichealth.testrcnlearning.org.uk/

Summary of Case Studies – national spread

The list below shows the national spread of the case studies. Many of the examples selected showcase public health initiatives which are available in other parts of the country.

- "Weigh-to-Go" – weight loss in 15-18 year olds – Scotland
- Breathing Space Clinic for people with Chronic Obstructive Airways Disease (COPD) – London
- Weight loss advice for parents of overweight 11-year-olds – Northern Ireland
- Self-Management: health literacy and "teach back" – Scotland
- Healthcare for Homeless Adults – East Midlands
- Star Babies – enhancing mental health and parent infant relationships – Northern Ireland
- Alcohol reduction campaign targeted at parents and children – North West
- School nursing app for teenagers – London
- Smoking cessation outreach for hard to reach groups – West Midlands
- Utilising an out-patient department as a Health Promotion Hub for patients and staff in a rural community – Wales
- Cross City approach to TB Contract Tracing – London
- Vitamin D campaign for expectant and breast feeding mums – South East
- Travel Health – nurse-led clinics, training and expedition preparation – South West and London
- HIV - Brighton
- Sexual Health – Yorkshire
- Outbreak Management, Health Protection PHE
- PH Nursing – Yorkshire
- Sexual Health for Homeless People – Bradford

Phase 2 – Survey

A national web-based survey of public health practitioners and commissioners of public health services was conducted in May 2015. A full report of this phase was completed by the RCN's Standards, Knowledge and Information Services (SKIS) team and is available upon request from the RCN Lead for Public Health. A PowerPoint slide pack with a summary of the findings is available on the Public Health Forum pages of the RCN website.

Survey Design

The survey was limited to 23 questions to ensure ease of responding and a good response rate. The majority of the survey consisted of closed questions to ensure a common understanding of what was being asked and facilitate analysis within the given time and resources. Three questions (excluding questions with an 'other' option) were open ended. An online web tool (Smart Survey™) was used for ease of questionnaire distribution and to enable speed and accuracy of analysis. Respondents were asked to provide answers based on their knowledge of practice which although being based on a retrospective assessment and not limited to a particular point in time did ensure experience-based responses were received. The survey was administered during May 2015 with a one-month timeline for respondents to complete the survey. Generic follow-up emails at the beginning of weeks two and three were sent to help increase response rate. The survey was accompanied by a covering letter from the Royal College of Nursing Professional Lead for Public Health that included details of the project.

The first five questions of the survey elicited demographic data and the standpoint of the respondent, for example, whether they answered from the point of view of their organisation or individual opinion, and whether the respondent was involved in commissioning or designing public health services. The next questions used a Likert scale to gain respondents' opinions of:

- the frequency of nurses actual involvement in public health services
- how much involvement respondents thought nurses *should* have
- the reasons respondents employed nurses in public health services
- the skills nurses bring to this involvement
- the quality of the nursing contribution
- whether respondents were satisfied with the skills, knowledge and experience of nurses.

These questions were divided into three areas (see Table 1) reflecting the elements constituting public health (Faculty of Public Health 2015) with the additional of commissioning.

Table 1: Elements of public health included in the survey

Health Improvement	Improving services	Health Protection
Inequalities Education Housing Employment Family/community Lifestyles Surveillance and monitoring of specific diseases and risk factors	Clinical effectiveness Efficiency Service planning Audit and evaluation Clinical governance Equity Commissioning	Infectious diseases Chemicals and poisons Radiation Emergency response Environmental health hazards

Adapted from the Faculty of Public Health definitions (Faculty of Public Health 2015) with additional element of 'Commissioning'.

The three open-ended questions asked respondents to rank the top three challenges to commissioning care with public health interventions, the top three skills respondents look for when designing public health services with nursing teams, and the extent to which respondents felt patient or care pathways included specific indicators for public health. These questions enabled barriers and skills to be highlighted together with current pressing concerns for further exploration.

Pilot

A short pilot phase was conducted to test the survey questions. Two interviews were conducted with a director of public health and a director of quality. Feedback on the draft questionnaire was also obtained from the project reference group. The interviews resulted in minor changes and refinements to the survey questions.

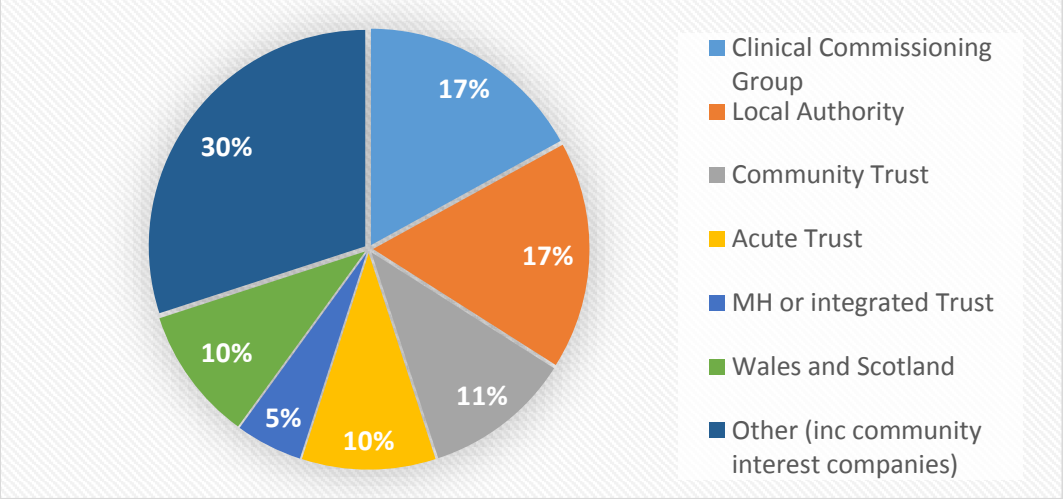
Survey sample, distribution and response rate

Commissioners of PH services or those setting up service specifications were specifically targeted. A snowball sampling method was used to reach networks and suggested contacts based on the inclusion criteria. The survey invitation was sent to a large yet targeted population using the RCN database (for example, members in the public health forum and nurses in management and leadership roles), a specific list identified by the authors and from reference to relevant UK websites such as the Royal Society for Public Health, and, with cooperation from NHS England, by

advertising the link to the survey in the NHS England weekly Clinical Commissioning Group (CCG) bulletin. This helped reduce the risk of missing out potentially relevant respondents.

Over 400 people responded with 219 completed responses from across the UK included in the analysis from the targeted group providing a snap-shot of their views and perceptions. The remainder were filtered out at the first questions because they were not directly involved with commissioning or designing services. The breakdown of respondents is given in Figure 1.

Figure 1 – Responses by country or organisation

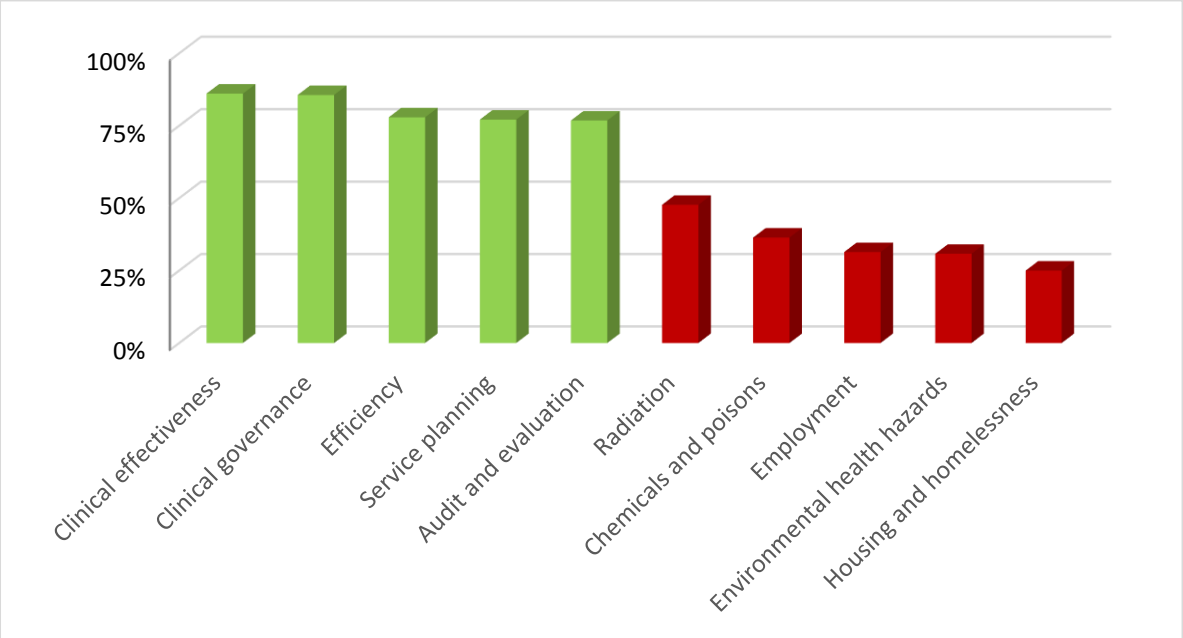


Survey Findings

Nursing involvement

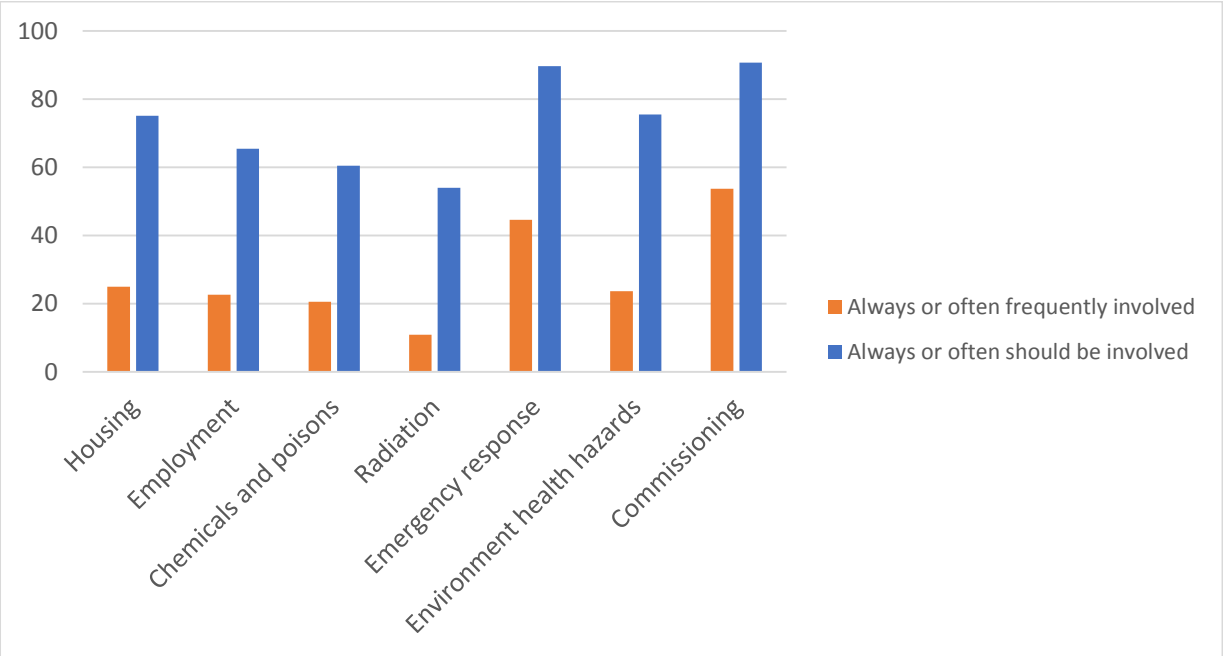
The top five areas nursing is most frequently involved in are all associated with the Faculty of PH domain (Faculty of Public Health 2015) “Improving Services”, whereas the five areas in which nursing is rarely involved are in health protection or in health improvement (see Figure 2).

Figure 2: Top 5 and Bottom 5 areas of nursing involvement in PH



In all areas respondents believed nursing should be involved in public health more than it currently is. There were notable differences (i.e. more than forty percentage points difference) between actual and desired involvement in six areas. The ‘commissioning’ category also had a slightly smaller but still sizable difference (see Figure 3).

Figure 3: Difference between frequency of current and desired nursing involvement in public health (PH)

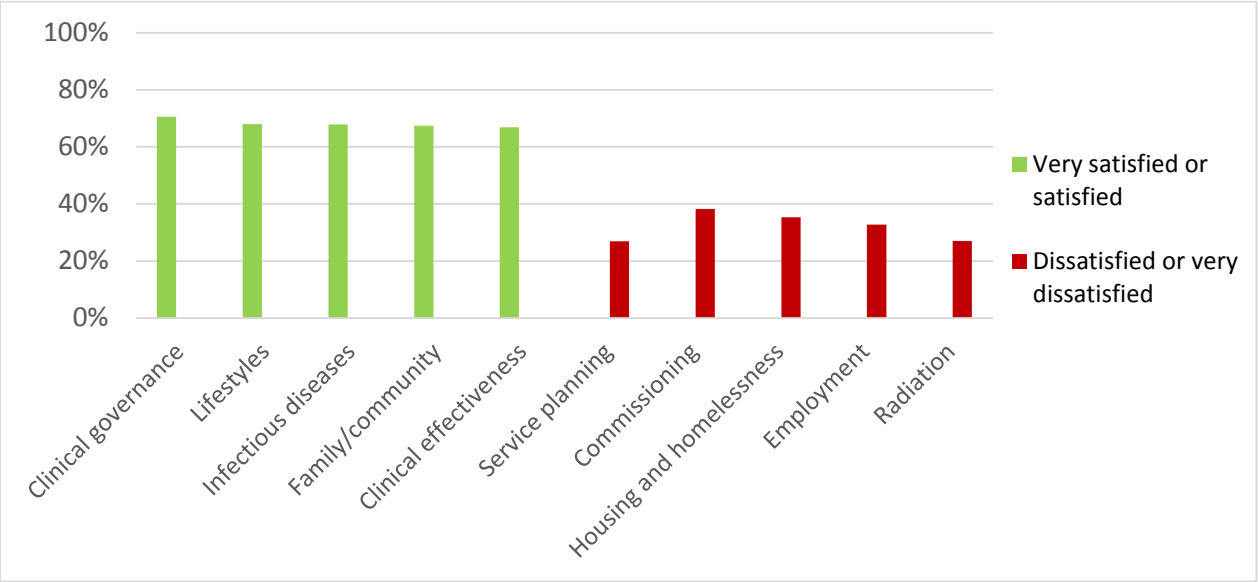


The perceived quality of the nursing contribution could be seen across all domains, with respondents still believing nursing should be involved in those areas rated low. In all areas a higher number of respondents believed that nursing should be involved compared to the satisfaction with nursing contribution.

Skills and knowledge

With regard to skills and knowledge, the top five satisfaction areas contained items from all three public health domains (see Figure 4). However, more than a third of respondents were dissatisfied in the areas of commissioning, housing and homelessness, and employment; and in service planning there was a mixed picture of satisfaction.

Figure 4: Satisfaction that nurses have required skills, knowledge and experience - top 5 and bottom 5 areas

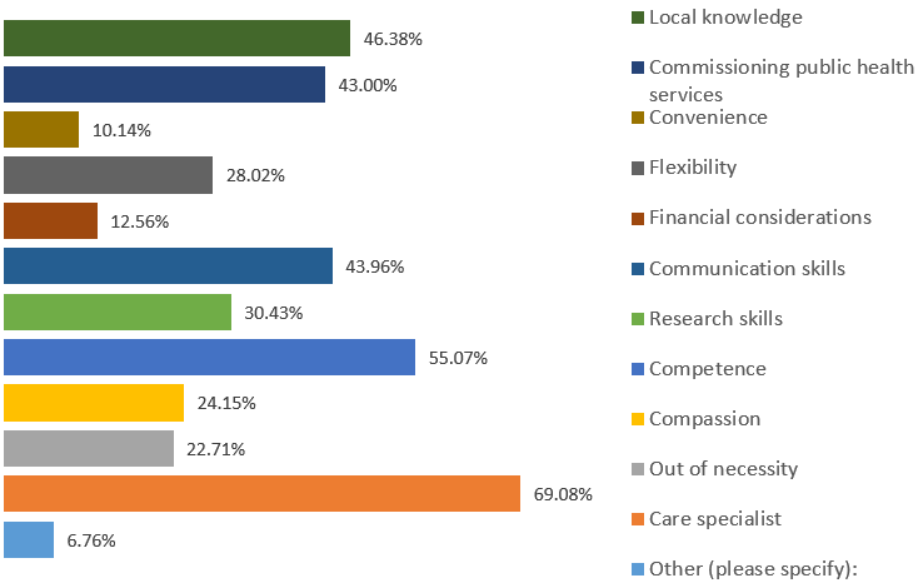


When asked what skills they looked for when designing services, four types of personal qualities and competence came out strongly:

- local knowledge
- project and research management skills
- communication skills
- behavioural characteristics (for example, care, compassion, determination, motivation, commitment).

The main reasons respondents gave for utilising nursing in public health services were because nurses were seen as care specialists, because of their competence and communication skills, and local knowledge relevant to commissioning public health services (see Figure 5).

Figure 5: Reasons identified to employ nurses in public health



Challenges

The top three challenges to commissioning care and the nursing contribution were derived from the open-ended questions. These included lack of resources, issues of knowledge, training and skills and problems with commissioning. (The sub-themes to these categories are shown in Table 2.)

Table 2: Challenges to utilising nursing in public health services

Lack of resources	Issues with knowledge, training and skills	Problems with commissioning
Current capacity	Depth of knowledge required	Shortage of professionals, particularly nurses, in commissioning;
Funding and costs	Challenges with nurse education	Lack of understanding by commissioners of specialist roles
	Lack of skilled staff	Effective commissioning in a changing commissioner and provider landscape

Strengths and Limitations of the Survey

Overall, the survey appears to have raised a number of interesting points that can guide thinking in relation to the value of public health nursing project and support decision making. By targeting a narrow and defined population, including those within the nursing profession and from other professional groups. The survey has been able to highlight specific areas for discussion, which may not have materialised from elsewhere. This survey provides a baseline snap-shot which could potentially be revisited at later stages to give trends over time.

One of the strengths of this survey was the balance between closed questions, which guided respondents to answer on specified issues, and open questions which allowed respondents to answer freely on key topics. This balance resulted in interesting comparisons.

The quantitative analysis focused on descriptive statistics with tests for statistical significance and confidence intervals not undertaken, so it is not possible to ascertain the statistical generalisability of the results. This was appropriate for the data and the purpose of the project, and the usefulness of any further analysis is not guaranteed, with results expected to be comparable.

The survey attempted to be as specific as possible in defining the study population and targeting those with commissioning and service design roles. To that end it used a definition of the ‘relevant participant’ that may not have been understood in the same way by all likely respondents who received an invitation to participate. It may be the case, therefore, that respondents completed the filtering questions in such a way that they were identified as non-relevant and thus excluded from progressing with the survey.

Phase 3 – Interviews

The third phase of the project consisted of in-depth interviews with a purposive sample of public health nurses, commissioners and key stakeholders in the National Health Service, local authorities and government. The quantitative findings from the survey were used to inform this qualitative phase.

Method

Interviews were conducted by telephone, at the convenience of the participants. Contact was established through email. All interviews were recorded and transcribed. Anonymity was maintained in the transcripts. Ethical considerations including consent, confidentiality, anonymity and the right not to answer or withdraw at any time were discussed with participants.

The use of telephone interviews was seen as the best approach as it easily allowed the inclusion of participants from the four UK countries and enabled fairly unobtrusive access to busy senior managers and executives (Harris et al 2008). Indeed, its use has been found to be beneficial in circumstances where easy rapport can be gained with participants who do not feel judged or inhibited (Ward et al 2015).

Interview framework

The interviews sought to gain views from two overall perspectives:

- A SWOT (strengths, weaknesses, opportunities and threats) analysis approach to potentially identify the talents, skills and abilities that nurses have related to public health and help to reveal opportunities which they can take advantage of. Questions and prompts that built on the survey responses were included to gain further insight into what distinguishes the contribution of nurses from other health professionals.
- The Political, Economic, Socio-Cultural, Technological, Legal and Environmental (PESTEL) influences on public health nursing were also explored to gain a greater understanding of external or strategic factors that might influence nurses' roles in public health service provision.

The topic guide including probes is included in Appendix 4.

The rationale for this approach was that it was believed it would enable:

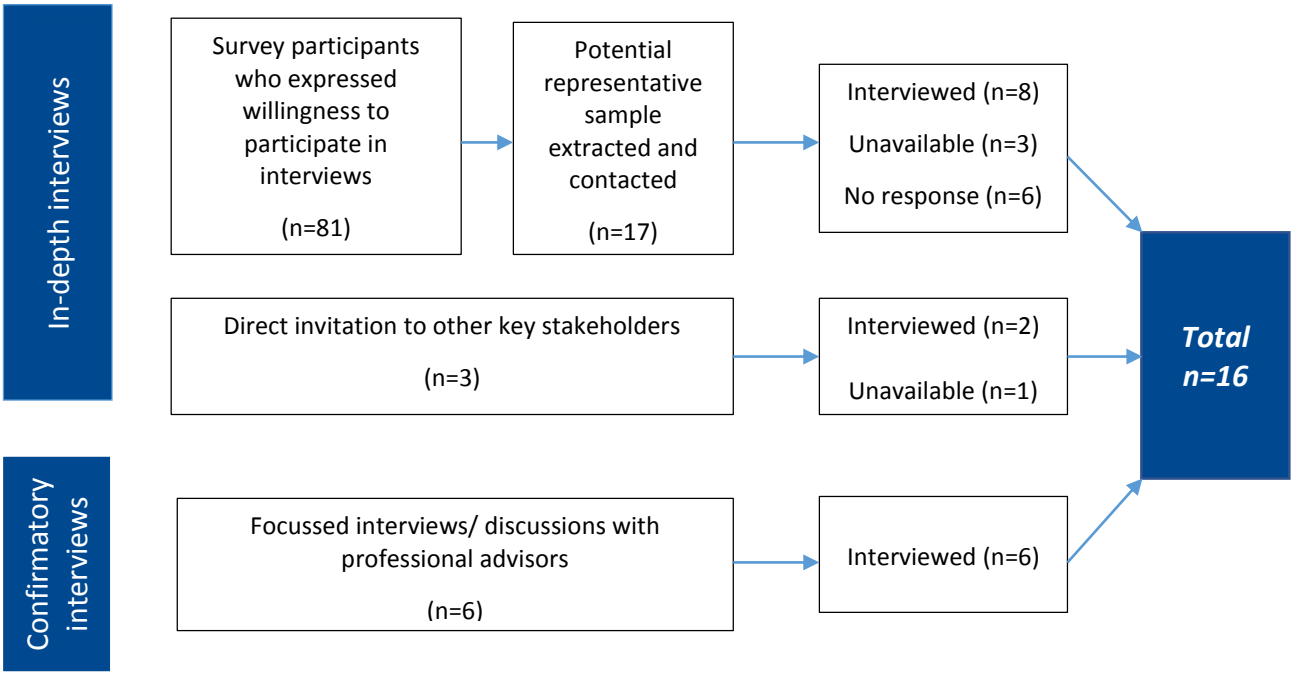
- multi-professional and health system opportunities to be identified thus giving advanced warning of possible significant threats

- to reveal the direction of change within public health in the context of wider health service reform, change and reorganisation to help shape recommendations so nurses in public health are able to work with change rather than against it
- to help set direction so nurses do not embark on public health initiatives that are likely to fail for reasons beyond their control
- to ensure recommendations and direction are not unduly influenced by unconscious assumptions based on traditional approaches to care helping the development of an objective view of the public health landscape.

Sampling Framework for the interviews

The sampling approach used in this phase of the project is shown in Figure 6 below.

Figure 6: Interview sampling approach



This method used a purposive sampling approach (Patton, 1990) with maximum variation sampling to ensure the inclusion of participants representing different backgrounds. Participants were selected from survey respondents who stated they would be willing to be interviewed for the second phase of the project together with national stakeholders who had identified an interest in the study but had not completed the survey. The interviewees were identified based on a selection matrix (Silverman (2004) to gain divergent participants based on job role, clinical specialty or interest and geographical location across the UK and thus attempt to increase the

generalisability of findings. In adopting this methodology an informed pragmatic approach to sample size was taken (Sandelowski, 1995) with a plan to recruit 15 participants.

Initial contact was made by email with 17 potential interviewees drawn from respondents to the earlier survey who had expressed a willingness to participate. Eight people agreed to be interviewed; three people stated they were currently unavailable but expressed willingness to potentially participate at a later date and six did not respond to the request. Following the initial analysis of the interviews, targeted recruitment was undertaken with two people to ensure all cells in the selection matrix were filled to make sure the sample was as representative as possible. A total of ten in-depth interviews were therefore undertaken (See Table 3). These interviews were supplemented with a further six shorter focussed interviews with RCN professional leads and advisors to further illuminate and validate the emerging themes.

Table 3: Characteristics of interviewees (frequencies)

Gender	Age	Ethnicity *	Profession	Job Title *	Interview Time
Female (n=8) Male (n=2)	46-55 years (n=7) 56-65 years (n=3)	Black (n=2) White (n=8)	Nurse (n=7) Health Service Manager (n=1) Other (n=2)	Practitioner (n=2) Manager (n=6) Director (n=2)	Mean: 26 minutes (Range 17-34 mins)

* In order to help preserve the anonymity of the participants ethnicity and job title are reported based for ethnicity on principal ethnic grouping rather than specific subgroups, and for job title on main role descriptor, as more specific categorisation in this small number of participants could lead to identification.

Data analysis

All interviews were audio-recorded digitally, transcribed and then thematic content analysis undertaken. Cases comprising each interview were created and a framework approach (Ritchie and Spencer 1994) taken to manage data. Framework analysis provides systematic analysis stages which are clearly defined, transparent and easily accessible to others which was important in this study undertaken collaboratively by the RCN and an independent researcher.

A predominately deductive approach was taken with themes derived from the findings of the survey and current public health policy and literature (Public Health England 2015, Schaffer et al 2015). We also looked inductively for other themes

grounded in the data. The data from the first four interviews was initially analysed before the subsequent interviews were undertaken facilitating comparisons between cases and across themes with cross-referencing and re-assessment as advocated by (Rivas 2012). Emerging themes form the interviews were shared with the advisory group.

Themes from the Interviews

The following themes emerged from the interviews and are discussed further with verbatim quotes below:

- nurses are able to give public health messages within a holistic care context
- local knowledge equips nurses to better provide public health
- concerns and opportunities arising from change and transformation
- invisibility of some aspects of public health nursing
- diminishing leadership.

1) Nurses are able to give public health messages within a holistic care context

A key strength identified by respondents was that nurses are able to provide public health as part of other care activities in a holistic manner as nurses have a whole-person broad understanding of needs. Comments were made that PH messages can be:

> *"just dropped in the conversation … [as] part of everyday conversations". (Interview 1).*

> *"A broad holistic understanding of their needs and background" (Interview 5)*

> *"Nurses make it more real for people. They are able to unpick what is said at a higher level. Nurses break down things into small steps."* (Interview 6)

Examples of specific services were given to support these comments. For example, in relation to diabetes it was noted that:

> *" … because there are so many comorbidities that go with diabetes that actually can be improved with, you know, improved nutrition, improved exercise, … improved hygiene, you know, for things like peripheral neuropathy in toes, all of those very small things add up to a better outcome." (Interview 1)*

In relation to a community hospital at home team and long-term conditions:

> *"We have a community hospice at home team … through their involvement they promote self-care independence and self-management of people with long term conditions … it overlaps into relatives and carers"* (Interview 5).

It was also noted that holistic care included provision of public health advice and care for carers and relatives with nurses being able to assess carers needs formally and direct to other services as necessary.

The ability to give this holistic care was related to nurses' ability to be agile and adaptable, and that this is facilitated by expert assessment skills:

> *"they have assessment skills, real grounded assessment skills which can actually look at what the need is first and also work with the patient and what they think they can achieve in the short term and what they can achieve in the longer term, empowering people."*

This theme has implications for those commissioning services and for providers managing capacity. The theme is also relevant to education providers and policy makers.

2) Local knowledge equips nurses to better provide public health

Local knowledge was identified as being important in relation to detailed understanding of the local community and in relation to clients and service users being able to approach nurses. The situation is often diverse and relationship based and differs depending on the stability of the service provision and accessibility of data available about local populations. Concerns were expressed that if nurses have bases distant from the communities they are caring for this is not just inefficient in terms of travel time but distances patients and clients from professionals.

Examples given to support these points included:

- Disparity in school nurses provision especially in relation to poorer or non-existent school nurse provision in independent schools. This is an interesting inequity example, possibly due to the locality of the interviewee, from an affluent part of southern England, where inequity for those traditionally seen as better-off being picked up, but provides an example of nurses concern for PH across communities.

- Another concern related to local knowledge was the potential for fragmentation especially when services were organised functionally rather than around the client group or patient.

  "Basing people in large hubs with hot desking … for delivering a service to local communities it isn't so beneficial ... it just doesn't feel local enough, it doesn't feel sensible. I've got a team based in a health centre which is now seven miles … [from] the population they work with, along a road that seven miles can take you 25 minutes that's a long time … They're not there, or visible."

- PH nurses' local knowledge of the impact of social-cultural changes was highlighted in relation to changing attitudes and behaviours amongst people with intellectual disabilities:

  "Supporting families who have learning difficulties, … such as Down's Syndrome, you didn't expect them to be having families, they are."

- Equally, the invisible nature of some vulnerable client groups was given as an example of where local knowledge is important.

  " … 42% of the new births are to families who have English as a second language and they are white European, but of course come from a different culture, [and] don't have the language. They're not visible. …. when you walk down the street in that town you'd think, oh this is a white area, but actually …"

3) Concerns and opportunities arising from change and transformation

Concerns were expressed about current and anticipated organisational changes where responsibility for public health services in England has or will pass from the NHS to local authorities. There was a fear that the complexity of roles would not be fully understood and that specialist public health nurses are expensive to train. Recollection of previous NHS change meant there was a great deal of scepticism with health visitors being seen as an easy options for cuts compared to the acute sector.

"They're about to see a very large budget, …I think there's a belief that other people can deliver the same service that health visitors

> *and school nurses do without needing to have the expensive training."*

> *"…we already know that our colleagues in children and family centres who are meant to be working with vulnerable families do not get the supervision…"*

Fears were expressed here that Local Authorities would have different perspectives to traditional NHS priorities. However, it was also acknowledged that regardless of which umbrella the services were managed under cuts would be needed (given current public sector pressures) but there was a sense that the ability to influence where these cuts would be made had been lost and that inappropriate cuts would be made because prioritises would not be based on health and wellbeing.

> *"They [Local Authorities] have different priorities because they've got a wider range of ages etc. etc... that they have to deal with and services .. children and young people ... [they] may need to make more bigger cuts than we would in the NHS"*

Health visiting was seen as having been protected recently from austerity cuts because of the specific prime ministerial target to increase the numbers of health visitors (HVs). However, the effect on other teams was recognised:

> *"We lost our sexual health service, and … I know a neighbouring organisation lost their school nurse service … the provider for health visiting and school nursing is Virgin and when you read their job description … there are real changes."*

Concerns were expressed about continuing focus on acute sector both in terms of resources and public perceptions of nurses as acute based. Fears about fragmentation also included one interviewee commenting on operational issues with technology – both because of NHS resourcing but also interaction and fragmentation with education services.

> *"Our [school nursing] team's encrypted safe links with all our teaching packs won't work"*

One respondent suggested that:

> *"Health visitors and school nurses will have to become a more flexible resource working with other professionals in other ways …*

> *they will be contributing to broader teams... health education in schools .."*

This was countered by other comments that health visitors want and were trained for a broader public health role but are restrained by a commissioning agenda which focusses their work on young children, and where the impact of their service is only evaluated in terms of easily measured short-term goals (such as vaccination uptake) and that longer-term impacts (for example reducing childhood obesity) remain hidden.

One interviewee stated that nurses should be aware that:

> *"... change is coming, and they will probably get most benefit from the change by embracing it and looking for opportunities to use their skills more widely rather than hunkering down to do what... there's always the risk that the more specialist you become, you know you're clinging to your shrinking iceberg rather than looking to fly off..."*

Although some of the comments made reflected immediate and current tensions and are unlikely to be enduring, this theme emphasises that three years after the reorganisation in the English NHS following the 2012 Health and Social Care Act tensions remain in the system about on-going system changes and fragmentation. Respondents from other parts of the UK, as well as England, also reported similar concerns about navigating around changing systems. However, these concerns are also countered by the opportunities the changes may bring to improve health and wellbeing.

4) Invisibility of some aspects of public health nursing

The invisibility of some aspects of public health nursing was commented on, together with expressions about the identity of certain sectors (such as health visiting).

> *"One of the benefits of nursing is the comprehensive set of skills to deliver different aspects of care, but I suppose that also causes, perhaps, problems in that, it [public health advice] is more covert when they are having conversations."* (Interview 5)

One interviewee commented that the public see nursing as 'care giving' and that is not a natural connection to nursing as public health. An example was given of a nurse who facilitates a carers group with a focus on self-management but where it is

perceived that the carers see this as part of the long-term conditions service and not as public health.

Another interviewee noted that the public do not seem recognise nurses as giving public health advice. This interviewee felt that the public's perception is that it is generally doctors and or politicians who are seen giving advice and health promotion media messages, rather than nurses, which perpetuates the belief that nurses are not involved in public health

> *"I don't think the public recognise nurses [role in public health] so much today as they used to … what we see in the public eye is our doctors that work in public health or administrators, politicians, we don't see nurses much."*

Another interviewee also noted that nurses' role in public health needs to be visible not just to the public but also to nurses themselves. Nurses tend to concentrate on "giving care" and value their role and that of colleagues based on what is seen:

> *"we need to see outcomes in order to engage with the public health agenda – outcomes and trends over time will help us understand [what is] better care".*

In a separate interview it was noted that nurses do have the skills to provide public health and can adapt their existing knowledge and fall into new roles quickly:

> *"I've come across nurses that just have a general feeling, and are able to fall into role quickly …* [meaning probed] *…they have assessment skills, real grounded assessment skills which can actually look at what the need is first and also work with the patient and what they think they can achieve, empowering people".*

Again that nurses feel these aspects of their work is invisible was reflected by this interviewee:

> *"There are things that people can see we can do, we can give an injection or a flu vaccine, a pneumococcal vaccine, that's seen ... its written down but the soft things like you know ... advising someone about their drinking habits, maybe, what they could possibility do to cut down ... you don't actually see that."*

> *"We've got to stop calling ourselves health visitors and school nursing, … I think we really have to emphasise the specialist community public health nurse, … health visitor sounds a bit fluffy."*

However, this is in contrast to later in the interview where this interviewee stated specifically that she believed the loss of 'health visiting' from the nursing regulators title (i.e. the move from the United Kingdom Central Council for Nursing, Midwifery *and Health Visiting,* to the NMC) was detrimental.

The invisibility of the public health role of nurses was also highlighted from a strategic perspective in relation to workforce decisions as "only specialist PH nurses can be counted" with a variety of job titles used by nurses in public health roles.

5) Diminishing leadership

Diminishing nursing leadership particularly at a local level was noted as an emergent theme.

> *"There is less nursing leadership now than in the past ... there used to be more prominent nurses but now it's all GPs. There are no nursing posts locally above a band 7 – it's gone back to GPs being the leaders."* (Interview 6)

The comment was echoed elsewhere where it was felt that:

> *"nurses were making headway in the previously medically dominated world of public health with new programmes of study but since changes and funding and integration this has reduced."*

Other concerns about leadership were linked to moves to local authority management of public health with fears that decisions would be made about cuts to health and wellbeing budgets without the nursing contribution being understood.

National leadership in public health was recognised in all UK countries which it was felt helped raise the profile and strengthened nursing in practice. However locally a variety of models was noted which it was thought made nursing leadership of public health implicit rather than explicit in senior nurse leader roles.

Discussion

There are a number of positive messages for nursing from this project. Firstly, nurses' roles in clinical governance and clinical effectiveness featured strongly and nursing input into improving services was valued and the belief from commissioners that nursing should be involved in these areas is encouraging. However, public health nursing scored poorer in 'health protection' specifically in relation to working in chemicals and radiation. Nurses were perceived to rarely or never be involved in radiation protection, chemicals and poisons and environmental health hazards. This suggests that this is potentially an area for greater investment. It is also important to note it is just one part of health protection, Nurses are widely involved in health protection teams, infection prevention control, immunisation and screening. Employment, housing and homelessness, and commissioning also had low ratings in relation to nursing involvement. The desire that nursing should be involved in these areas was relatively high suggesting either a gap in demand and supply, or an unrealistic expectation for nurses to be involved in areas outside their traditional preparation and scope. We know that nurses are in fact working in many of these areas so there is a need for further debate and discussion to understand the needs more and which practitioners best fulfil the needs of commissioners in these areas. As well as to showcase examples where this is happening and working well.

For knowledge and skills, it appears that respondents had mixed satisfaction in some sector-specific areas. Further exploration is needed to clarify how best to fill the gaps in knowledge and skills whilst recognising the acknowledged added value public health nurses bring for employers in terms of transferrable skills such as local knowledge and communication skills. This may signify the level of importance and centrality of the nursing contribution to public health and the necessity to match this with increased investment in knowledge and skills in targeted areas.

Against the backdrop of recent changes to commissioning and on-going change in terms of the organisation of PH service this survey highlights the value that nurses can offer. However, the choice of nurses (or other practitioner) is sometimes based on convenience and on financial implications.

The strong theme of local knowledge being important is evident, and this suggests that all practitioners need to hone their skills in assessing, evaluating and understanding their communities, and that engagement with communities needs to be considered systematically. Given the diversity and complexity of nursing, with the inherent reach across all sectors of the community or locality, the findings here suggest that nurses can make well informed distinct public health offerings with local

knowledge helping to shape optimum delivery models. Nurses often provide organisational and professional group memory in terms of past interventions, knowledge of local culture and accessibility of support to other services, which can added value when targeting interventions. Arguably local knowledge can bring added value in terms of ensuring interventions are bespoke enough to meet the needs of local communities.

Nurses' roles in supporting and promoting healthier lifestyles is fundamental to what they do. It can however, be difficult to quantify and as such easy to miss. It is clear from this work that nursing's role is essential across a wide range of public health work.

This work complements and adds to the Public Health England work to develop a PH skills and knowledge framework (Public Health England 2015). Indeed the findings suggest that it is nurses' ability to integrate the art and science of public health that is particularly beneficial.

Key Messages and Recommendations

- Public health is everyone's responsibility and should not be seen as a niche or separate area of practice. Nurses have the skills and are best placed to provide meaningful public health interventions across all health and social care settings as part of holistic patient-centred care.
- Many aspects of what nurses do are hidden – these aspects need to be articulated by nurses and leaders to ensure those commissioning services and providers managing capacity understand the impact of changes to models of care.
- Nurses have enhanced assessment skills which are not always recognised, even by themselves. These need to be better identified and acknowledged as a key part of the unique role nurses have in wider public health work.
- Educationalists (policy makers, commissioners, lecturers and trainers) need to increase the focus on public health in all programmes. Public health across the curricula should be mapped not only where it is directly taught but also where attendant skills are developed. This is reinforced in the recommendations from the *Shape of caring review* (Willis, 2015) which clearly identified the need for nurses to develop public health skills and competence across in all areas of practice.

- Nursing leadership of the public health agenda needs to be scoped. So there are champions at local as well as national level to make sure nursing teams are contributing to public health at all applicable opportunities.
- Nursing staff are an integral and fundamental part of the public health workforce and this needs to be clearly reflected in policy and future commissioning.
- Nurses need to be “skilled-up” to work with commissioners so meaningful key performance indicators, service level agreements and local incentive targets (such as CQUINs (Commissioning for Quality and Innovation)) are set which reflect public health nursing.

References

Bennett V (2012) Every nursing contact counts for improving public health *Nursing Times* 108(1-2): 7.

Cowley S, Whittaker K, Malone M, Donetto S, Grigulis A and Maben J (2015) Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: A narrative review of the literature. *International Journal of Nursing Studies* 52(1): 465–480.

Donovan H (2015) Pushing the boundaries (Editorial). *Primary Health Care* 25(5): 5.

Faculty of Public Health (2015) *What is public health?* . Available at: www.fph.org.uk/what_is_public_health (accessed 15/10/15).

Harris R, Kelly D, Hunt JA, Plant H, Kelley K, Richardson A and Sitzia J (2008) Accessing elite nurses for research: reflections on the theoretical and practical issues of telephone interviewing. *Journal of Research in Nursing* 13(3): 236–248.

NHS England (2014) *The Forward View into action: planning for 2015/6*. Leeds: NHS England.

NHS Scotland (2012) *A Route Map to the 2020 Vision for Health and Social Care*. Edinburgh.

Public Health Agency (2015) *Annual Business Plan 2015-2016*. Belfast.

Public Health England (2015) *Review of the Public Health Skills and Knowledge Framework (PHSKF)*. London.

Public Health Wales (2015) *A healthier, happier and fairer Wales: Our strategic plan 2015-2018*. Cardiff.

RCN (2012) *Going upstream: nursing's contribution to public health*. London.

Ritchie J and Spencer L (1994) Qualitative data analysis for applied policy research. In: Bryman A and Burgess RG (eds) *Analysing Qualitative Data*. Abingdon: Routledge.

Rivas C (2012) Coding and analysing qualitative data. In: Searle C (ed) *Researching Society and Culture*. London: Sage.

Schaffer MA, Keller LO and Reckinger D (2015) Public Health Nursing Activities: Visible or Invisible? *Public health nursing (Boston, Mass.)*. Blackwell Publishing Inc.

Scottish Government (2015) Public Health Review http://www.gov.scot/Topics/Health/Healthy-Living/Public-Health-Review

Ward K, Gott M and Hoare K (2015) Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing* (On line early publication).

While AE (2014) Are nurses fit for their public health role? Guest Editorial. *International Journal of Nursing Studies* 51(9): 1191–1194.

Willis, P (2015) *Raising the Bar: Shape of Caring: A Review of the Future of Education and Training of Registered Nurses and Care Assistants*, London: Health Education England. Available at: https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf (Accessed 11 February 2016)

Appendices

Appendix 1: Reference Group Membership

Juliet Adkins, RCN Communications Officer, Royal College of Nursing
Palo Almond, Senior Lecturer in Public Health Nursing
Adrian Baker, Research and Innovation Analyst, Royal College of Nursing
Anda Bayliss, Research and Innovation Analyst, Royal College of Nursing
Ami David, Nursing Consultant
Nigel Davies, External Consultant
Helen Donovan, Professional Lead for Public Health, Royal College of Nursing
Cath Fenton, Public Health Consultant
John Forde, Public Health Consultant
Liz Fradd, RCN Fellow
Gary Kirwan, Senior Employment Relations Adviser, Royal College of Nursing
James Rodaway, Nursing Directorate Business Manager, Royal College of Nursing
Karen Stanfield, Senior Lecturer in Public Health Nursing

The Project Reference Group met formally three times during the course of the project and again via email.

Appendix 2: Case Study Template

Case studies template to demonstrate service initiatives or projects to improve Public Health

Please use the following to provide details of the initiative or project you are involved in. This template is intended as a guide so please adapt it to suit your particular project is necessary. Please try to avoid abbreviations and explain any acronyms.

Name	
Job-title	
Contact details (email preferably)	
Employer/organisation and Where are you based?	
Speciality/setting	

What is the initiative and or project you are involved in? Briefly describe what you are doing and any evidence you have used to back up the work or is it an area where there is no previous work done?

What prompted you to do this work? What were the reasons you decided to start the work; what was happening or what was the situation before you implemented the initiative or project.

How did you initiate the work? Were there any barriers and how did you overcome these? Did you develop a project or business case and did you negotiate a budget for the work. Are other organisations / groups / services involved and how have you managed them?

What have the challenges to implementing the service/intervention been? And what has enabled the implementation of the service/intervention?

Has the initiative or project made a difference to patients/service users and or staff? How do you know and what evidence or measures are you using? (Please include any outcome measures.)

If appropriate give details of any data; such as numbers of clients seen; numbers of clients and what has the impact been etc.

What are the long-term aims for the work?

Please let us know if you have any photographs or slides which will help show the work.

Helen Donovan RCN Professional Lead for Public Health Nursing
Email: helen.donovan@rcn.org.uk Twitter: @HelenDon21

Appendix 3: Case Study Scoring Criteria

The following criteria were used to determine which case studies were included and promoted.

	Score					
	Poor				Excellent	
Criteria contributing to the assessment score:	1	2	3	4	5	Comments
Case Study Narrative • Clear description of the innovation or project. • Explanation of the implementation including barriers and challenges encountered. • Relevant organisational and financial factors explored.						
Nursing Contribution clearly identified Includes evidence of: • Leadership of innovation or project by nurses • Involvement of a team rather than an individual • Evidence of inter-professional collaboration						
Outcomes Clearly addresses and provides outcome data related to one or more of the Public Health Outcomes Framework domains: • Improving the wider determinants of health • Health improvement • Health protection • Healthcare public health and preventing premature mortality.						
Impact Includes evidence of the impact on: • The nursing profession (such as impact on peers, spread to other areas, publication, conference presentation, replicated elsewhere) • Patients and the public (for example evidence of impact at a person or population level, endorsement from individuals or groups) • Evidence of sustainability (in place for appropriate period of time).						
Total Score range 4 (minimum) – 20 (maximum)						Overall assessment: ☐ Exclude ☐ Further details required ☐ Borderline (if required) ☐ Include

Appendix 4: Interview Topic Guide

Promoting the Value of Public Health Nursing

In-depth interviews with purposive sample of stakeholders

INTERVIEW GUIDE

Procedure:

Interviews will be conducted either face-to-face or by telephone, at the convenience of the participants. All interviews will be recorded and transcribed verbatim. Anonymity will be maintained in the transcripts. Ethical Considerations: Agree consent; confirm confidentiality and anonymity; confirm right to not answer or withdraw at any time.

Background/Preamble:

The project seeks to identify and promote the contribution that nurses are making and have potential to make to public health within the UK. The project has three phases:

1) Identification of case studies including an update of case studies previously showcased in the 2012 RCN publication *Going Upstream*.
2) A survey of public health strategic influencers and commissioners, including commissioning nurse leads, directors of public health, CCG Chief Officers/Chairs and Public Health England senior leaders.
3) Semi-structured interviews with a purposive sample (n=12) of respondents to the survey to explore in greater depth themes from the survey.

Interview aims:

The interview will seek to gain views from two overall perspectives:

1. A SWOT analysis (strengths, weaknesses, opportunities and threats) approach to explore factors from specific nursing perspectives. This will help identify the talents, skills and abilities that nurses have related to public health and help to reveal opportunities which they can take advantage of. Responses will build on the survey data to gain further insight into what distinguishes the contribution of nurses from other health professionals.

2. A PESTLE analysis to address external or strategic factors that might influence public health service provision. This approach will enable the survey to identify political, economic, socio-cultural, technological, legal and environmental

(PESTLE) influences on public health nursing. This approach is believed to be appropriate for the following reasons:

- to help identify multi-professional and health system opportunities giving advanced warning of any significant threats;
- to reveal the direction of change within public health in the context of wider health service reform, change and reorganisation. This will help shape recommendations so nurses in public health are able to work with change rather than against it;
- to help set direction so nurses do not embark on public health initiatives that are likely to fail for reasons beyond your control;
- to ensure recommendations and direction are not unduly influenced by unconscious assumptions based on traditional approaches to care helping the development of an objective view of the public health landscape.

QUESTION / TOPIC GUIDE

A. Strengths, Weaknesses, Opportunities and Threats

1) Can you tell me what strengths nurses individually or as a profession have with respect to public health?

Probes - Strengths

- What are the advantages of nurses providing public health input?
- What can nurses do better than other healthcare professionals?
- What existing skills can nurses draw upon without further training?
- As a manager/commissioner/senior leader do you see any advantages of nurses providing public health?
- In your view what strengths do patients and the public see in nurses providing public health people?
- Are there any aspects of public health that only nurses can do?
- What aspects of public health provision do nurses do better?
- Consider a successful public health initiative in your area/ example from your practice – can you identify the positive contribution that nurses made.

2) Are there any weaknesses?

Probes - Weaknesses

- What could nurses do better within the public health arena?

- What areas of public health should nurses avoid becoming involved in?
- What might patients and the public see as weaknesses in nurses providing public health?
- What aspects of public health do you think are done better by others? Who are "the others" – other health professionals, other sector (such as education or social care; non-professionals - for example volunteers, support/ lobby groups, media).

3) Can you think of any opportunities that there are currently for nurses in public health?

Probes - Opportunities

- What opportunities do you believe there are for nurses in public health?
- What innovations or new initiatives are you aware of for nurses in public health?
- Are there any changes in technology that you think could influence what nurses do related to public health? Broadly/generally? Specifically? – examples from practice
- What changes in government policy have there recently been or do you anticipate which may provide new opportunities for nurses in public health.
- What changes specifically in your area are there related to social patterns, population profiles, lifestyle changes, and so on that may affect the public health nursing role.
- Are there any other specific local considerations?

4) Are there any threats to public health nursing or fears that you have about nursing and public health?

Probes - Threats

- What obstacles do you anticipate nurses in public health may face?
- What are you aware of that other professionals are doing that nurses are not related to public health?
- Are any quality standards or specific health provisions requirements relating to public health changing which may affect nurses?
- Do you believe changing technology will change the role of nurses?
- Do you believe there are any economic factors or financial pressures that are preventing nurses from undertaking any aspects of public health?
- Do you believe any of the weaknesses identified in nursing public health offering could threaten their future role in public health?

B. Political/ Economic/Social context

In the discussion so far you have told me about some wider strategic aspects that impact on public health nursing. I would like to explore some of these a little more specifically your views from a professional or organisational perspective, and perhaps the role the RCN might play or what they should consider.

5) What political factors do you think should be considered in relation to nursing and public health?

Probes – Political Context

- Have recent government elections changed policy in any way either nationally, regionally or locally?
- Who are the most likely 'contenders' for influence or power? Do you know what their views are in relation to nursing and public health?
- Are you aware of any pending legislation changes that might affect public health and the nursing contribution, either positively or negatively?
- Are there any regulatory issues or planned changes which might affect public health nursing? Are there any trends we should be aware of?
- How does the way in which government or national bodies (such as NHS England) approach public health impact upon public health nursing? And is it likely to change?
- Are there any other political factors that are likely to change?

6) Could you tell me a little about the economic factors that impact on PHN?

Probes – Economic Factors

- Has the 'austerity' pressures of the last few years affected public health provision? What do you think the impact will be over the next few years?
- Do economic factors impact on the public health workforce and specifically what impact does this have on nursing?
- Are there any other economic factors that we should consider?

7) What are the socio-cultural factors affecting public health nursing?

Probes - Socio-Cultural Factors

- How is the changing population's growth rate and profile impacting?
- Are generational shifts in attitude likely to affect what you're doing?
- What are your society's levels of health, education, and social mobility? How are these changing, and what impact does this have?

- What employment patterns, job market trends, and attitudes toward work can you observe? Are these different for different age groups?
- What social attitudes and social taboos could affect public health provision in the future? Have there been recent socio-cultural changes that might affect this? How does this affect nursing?
- How do religious beliefs and lifestyle choices affect nursing's input to future public health provision?
- Are any other socio-cultural factors likely to drive change?

8) Can you identify any technological changes we should consider in relation to public health nursing?

Probes - Technological Factors

- Are there any new technologies available now or on the horizon specifically related to public health in your area of practice?
- Are you aware of any specific foci in innovation, research or education that may impact on public health nursing?
- How have infrastructure changes affected work patterns (for example, levels of remote working)?
- Are there any other technological factors that you should consider?

9) Are there any legal or environmental factors affecting public health nursing?

Probes – Legal Factors

- Have there been any changes in the law which have affected PHN?
- Are there any changes which the RCN should promote (lobby for) which would improve public health provision?
- Are there any other legal factors that you should consider?

10) Are there any environmental factors affecting public health nursing?

Probes – Environmental Factors

- Are changes to the environment affecting public health provision?
- Ask for specific examples - such as climate change; air pollution impacts on PHN.
- Are there any other environmental factors that you should consider?

C. Biographical details/Demographics

Remind that anonymity will be maintained but the following information is needed to aid analysis and ensure responses from a representative group/ sample. This will be obtained from a short self-completed questionnaire.