

systems

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Current government policy aims to create a wider 'community of public health practice' within local systems, working in a coherent and coordinated way in partnership with local people to reduce health inequalities. However, for this to happen policy-makers and practitioners across the public sector have to reconsider boundaries, role definitions, professional identities and responsibilities. On the basis of documentary analysis and fieldwork involving interviews with individuals from various sectors and nonparticipant observation of public health nursing and primary care organizations within two local health economies in England, the paper explores the ways in which these processes of reconfiguration have been developing in local health systems. It illuminates new exclusions and tensions emerging from inherent contradictions in national policy and from difficulties individuals have thinking beyond existing spatial, conceptual and organizational boundaries and divisions. Paradoxically, therefore, rather than opening up new spaces for public health practice these tensions may 'force' some people back into narrower more traditional roles or ultimately out of public health altogether. The paper also uses the notion of communities of practice to explore issues of 'agency' in professional practice – that is the way in which individuals reflexively construct their practice and in so doing engage with or resist the relevant policy imperatives. The research illuminates some of the boundaries that are operating to discourage people from engaging with public health. This analysis suggests people may need more time and support to respond constructively to the new public health agenda. Without this, potential members of the wider public health workforce may respond defensively and resist alignment to public health goals in order to protect their embattled workspaces.

Key words: communities of public health practice; health inequalities; primary care; public health; reflexive communities

Introduction

In recent years, the nature and scale of the policy and practice change agenda facing those working within primary care and public health has been evolving rapidly. Internationally, there has been a major resurgence of policy interest in the reduction of health inequalities and a renewed commitment to involve patients and the public more directly in policy and practice decisions that

affect their lives. In the UK, there has been a veritable flood of policy documents setting this agenda (see for example Acheson, 1998; Department of Health, 1997; 1999; 2001a; 2001b; 2002; 2003; Wanless, 2004; and a forthcoming White Paper on public health in the summer of 2004). Perhaps most importantly from the perspective of this paper, the key role for primary care organizations and practitioners in delivering improvements in population health and reducing inequalities has been reiterated by key international agencies (Busby *et al.*, 2000; WHO, 2003). In the UK reflecting this trend, lead responsibility for public health activities in local

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health economies has been located within new primary care organizations – primary care trusts (PCTs) – which are required to work in partnership with local government, local people and other stakeholders to improve population health and reduce health inequalities.

Parallel modernizing trends have been underway within local government including the extension of the local government brief to include the promotion of population social well-being and the establishment of overview and scrutiny committees (with a remit including oversight of health-related developments) and local strategic partnerships. Major urban regeneration initiatives involving the active engagement of disadvantaged communities are also being implemented in many areas, including New Deal for Communities.

The overall aim of these policy initiatives at the local level is to create a wider 'community of public health practice' – including policymakers, managers and front-line service providers within primary care, other NHS organizations, local authority services and the voluntary and community sectors – working in a coherent and coordinated way to address agreed local priorities to reduce health inequalities and connecting up local services to provide easier access to high quality services for those most in need. Public sector institutions and service providers are required to be 'flexible and responsive' to the diverse needs of consumers and communities who are to be active participants in policy development and implementation. In principal, at least, these changes are opening up new spaces within local systems for public health work aimed at addressing health inequalities to be 'practised' in new ways by new wider communities of practitioners. However, for these new institutions, practitioners, communities and practices to develop there will have to be a reconsideration of boundaries, role definitions, professional identities and responsibilities.

In this paper we summarize the main results of research funded by the Department of Health in the UK which aimed to explore the ways in which these processes of reconfiguration have been developing in local health systems and to illuminate the factors that are acting to promote and/or constrain new ways of working in public health. More details of this research are provided elsewhere (see for example, MacKian *et al.*, 2003; Mallinson *et al.*, 2004; Popay *et al.*, 2004a;

2004b). In the following section the research methods are described and then the results of the two main strands of the work are reported. Finally, we briefly explore some of the implications of the research for future policy.

The research design

The research reported here was based in two inner city localities in Greater Manchester and London: both have significant levels of socio-economic disadvantage, but one is culturally very diverse, whilst the other is overwhelmingly white. This chapter presents findings from work conducted during this project concerned to develop an understanding of the factors shaping public health practice and policymaking across professional groups and agencies within localities. Two waves of fieldwork were conducted – one wave in 1999/2000 and the second in the autumn/winter 2001/2002. The fieldwork involved nonparticipant observation, in-depth interviews with a purposive sample of public and voluntary sector workers and document analysis. In both localities the in-depth interviews involved 21 individuals drawn from the health sector (London (L) 11 and Greater Manchester (GM) 14), local government (L 2; GM 6) and the voluntary/community sector (L 5; GM 3). The interviews lasted around an hour on average and most (38/42) were tape recorded and then fully transcribed – detailed notes were taken on the other four. A topic guide was used to ensure that interviewees reflected on similar issues in all the interviews. The key headings in the topic guide were: perceptions of public health, people's roles in relation to public health, their views on partnership working, the relevance and impact of national and local policy initiatives on daily work, and the barriers and/or facilitating features of various policies for effective joint work to tackle public health issues.

The interview transcripts were content analysed and thematically indexed (Spencer and Ritchie, 1994). The different strands of work involved different types of data and therefore different approaches to analysis. Only the analysis of interview transcripts is described here. This indexing process involves identifying key themes from an initial read of all transcripts, constructing a series of categories with which to label the data, and

then systematically analysing all transcripts. Three members of the team read all the transcripts and agreed the categories for the indexing system. To ensure that our analysis processes were transparent two transcripts were independently indexed by two researchers and then compared. During the course of the analysis, we reflected upon the strength of the categories we developed by considering if they were able to capture the full range of views, experiences and theories expressed by our diverse sample and amended them where necessary. The fieldwork also involved the collation and analysis of various local and national policy documents and this material provided a general context or background to the accounts given by individual research participants.

The research results

Understanding the dynamics of change in local systems

The development of new institutions and practice in public health requires changes in understandings of roles, identities and responsibilities at the level of individual workers and agencies. Some insights into the processes and/or factors shaping these changes are provided by theoretical and empirical exploration of two concepts from the social sciences – ‘reflexive communities’ and ‘communities of practice’.

‘Reflexive communities’: a framework for studying policy implementation

The idea that we inhabit an increasingly ‘reflexive’ society in late modernity is gaining currency (Beck, 1992). It is argued that individuals are now faced with a wider range of options and decisions than in the past and that there is an opening up of possibilities for individuals to reflect critically on the changes impacting on them and potentially influence these changes. This is an interesting proposition in the case of public health activity in the UK where government policy has sought to break with familiar delivery structures and create more possibilities for public health practitioners to make choices and exert influence.

From this perspective interpretation and implementation of policy is a highly situated process – spatially, temporally and socially – as local actors perceive and respond to the wider

forces around them. Central policy directives can only provide possible route maps for the reflexive communities who inhabit the world of public health to colonize and in so doing shape to make their own. Thus the local implementation of public health policy and practice is shaped by national and local policy initiatives and structural arrangements – both historical and contemporary – as well as by the reflexive construction of roles and relationships in the minds of people operating in the system.

In attempting to reveal these reflexive processes at work our analysis has drawn on the long standing tradition within public health of using maps and mapping techniques. It has sought to map how different groups (from central government to individual public health practitioners) reflexively construct less tangible relationships in their minds and how the resulting multidimensional conceptual maps influence their understanding of public health roles and the routine day-to-day work they do. The results, briefly described below, are discussed in more detail elsewhere (MacKian *et al.*, 2003).

Our empirical analysis traces one recurring and dominant concept in the rhetoric of public health, that of ‘partnership’. This empirical journey takes us from the vision of partnership coming from central government; through the perspective of a primary care group (the transitional organizational form that preceded primary care trusts); to the day-to-day operation of less formally structured partnerships between individuals in their working lives.

Looking at the language and discourse of partnership in central government documents there appears to be an almost universal belief that partnership is ‘a good thing’ and there have been increasing efforts to provide structural opportunities for such partnerships to develop including the establishment of interagency local strategic partnerships and public health networks. This partnership drive is indicative of an attempt, at least in rhetoric, to move away from a centralized, hierarchical model of government (Figure 1), towards a more flexible, responsive process of local governance (Figure 2) in which responsibility for policy formulation and delivery is, theoretically, increasingly handed over to networks of public and private sector actors, working to meet shared goals (Stoker, 1999). However, despite this

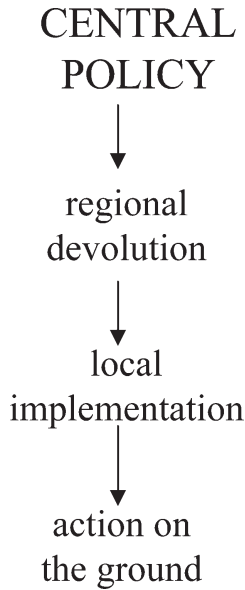


Figure 1 Hierarchical policy design. Here there is a layered implementation, with the drive coming from ‘above’ at central level

rhetoric of devolution and community empowerment, public health policy documentation combines a mixture of strong central direction and monitoring, suggesting ‘vertical’ control, with the softening of old boundaries ‘horizontally’ (Dixon and Preker, 1999). The resulting conceptual map (Figure 3) is almost a hybrid of the two, with

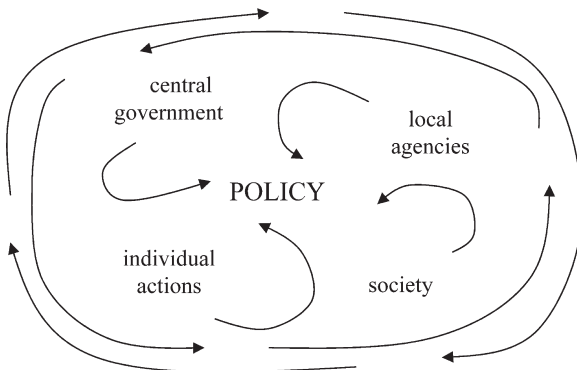


Figure 2 Fluid policy design. Here policy implementation is a discursive process with numerous partners working together on a more level playing field

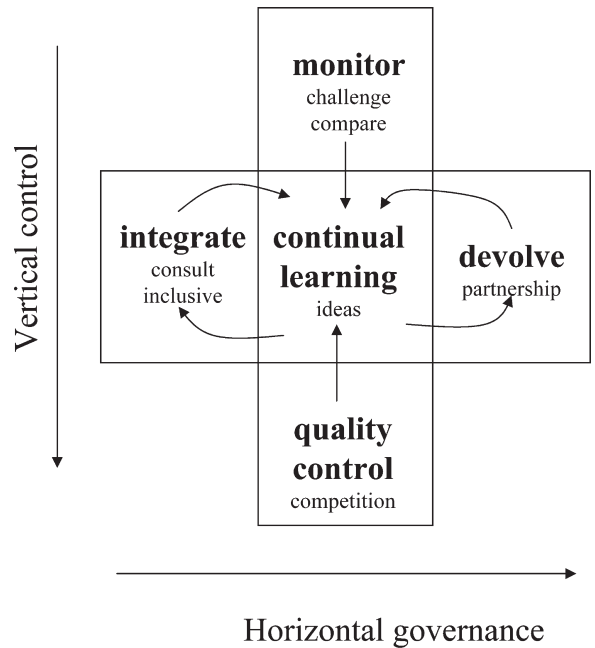


Figure 3 Integrating the vertical and horizontal?

Using key words from relevant policy documentation, in the centralized map there is a tension between the element of vertical control, and the drive towards a more horizontal, enabling framework for public health working. Devolution and greater local integration enable a more reflexive form of learning through day-to-day operations, but constant monitoring and control act as forces of restraint, squeezing the increased fluidity

some fluidity allowed through the generation of partnerships and iterative learning being squeezed by forces of regulation, set through targets and monitoring mechanisms.

Having mapped the new spaces of public health sign-posted in central policy discourse we turn to the local, as it is the work of reflexive communities in particular places which will have the greatest influence on how those spaces will materialize in practice. As others have argued, shifts in power relationships at all levels within the public sector and with service users are key to the evolution of effective partnership working (Nelson and Wright, 1995; Petersen and Lupton, 1996). However, as one of our study sites illustrated, there are powerful constraints on agencies and individuals challenging old relationships of power and control, despite facilitative structural change. During the collaborative development of the

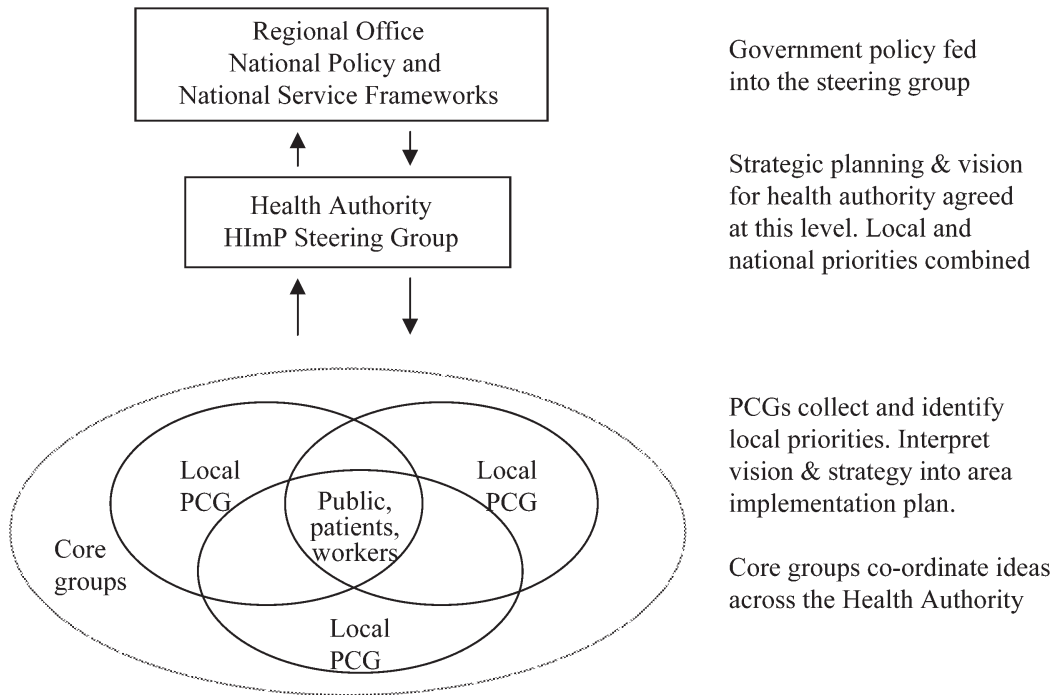
annual health improvement programme (HIImP) in 2001 involving the local health authority, the PCG, local government and voluntary/community groups, the PCG board saw its role as central. It was therefore concerned at an apparent criticism 'from above', at the Health Authority level that local agencies were acting almost independently of the content of the HIImP. The PCG was very keen to change this perception – they saw themselves and their work with partners operating as the 'engine house' of the HIImP, rather than independent of, or passively subjected to it. Their understanding was that they held a central role in a discursive process – involving joined-up working across national, regional and local partnerships. This is very much in line with the 'fluid map' of modernized government depicted in Figure 2. However, in their own documentation they continued to portray their position at the bottom of a distinctly vertical map with three clear layers – national, regional, local – much more indicative of the layered map of policy implementation (Figure 4). Contrary to the message they wanted to portray, this inevitably suggested a hierarchy and a certain detachment, rather than the more fluid discursive playing field they were keen to emphasize.

Despite apparent opportunities for an increasingly reflexive approach, the PCG was limited by existing systems of knowledge and power. Thus established power-laden processes, practices and language have the potential to perpetuate existing patterns despite well intentioned attempts to foster change (Christie and Mittler, 1999). How far this situation was the result of central control and purposeful design, or the inability of participating agencies to think beyond existing spatial, conceptual and organizational boundaries and divisions, remains an important empirical question. The way in which this PCG depicted its role reflected the long established conceptual models of the actors involved. Vertical centralized control continued to dominate the way in which 'horizontal' partnerships were conceptualized, experienced and represented. Although this may not directly prevent horizontal linkages, it could potentially prevent any real breaking of the mould.

Finally, individual workers will of necessity be involved in the frontline of partnership operations both formally through, for example, the organization in which they work and on a more

informal basis with the people they work alongside. Figure 5 was developed from shadowing two health visitors working with refugee and homeless populations. They told how their public health function was being expanded and they were encountering difficulties in managing the bulging boundary around this role. They both noted that they acted as advocates for their clients arguing that this meant they had to liaise with numerous other professionals and services. Building trust was seen as an essential part of that process, and they believed they worked effectively 'in partnership'. However, they found this role demanded both a professional and a personal input which they felt exceeded that which was reasonable and was not taken into account in their job training, nor recognized and acknowledged by fellow professionals. They therefore found themselves hiding the true extent of their partnerships from colleagues, whilst feeling increasingly isolated from a profession that on the whole did not engage so extensively with the wider world of public health. They felt official recognition for their public health work was not available within their profession, and therefore used their relationships with people outside their profession – including for example, welfare benefit(s) or housing staff, interpreters, or even clients – to give them the support they needed. These were inhabitants of the same reflexive place, with a shared understanding of how that space was constituted.

These health visitors were engaging wholeheartedly with the expanding territory of public health, carving out a supportive core for their involvement. Their self-reflexivity was enabling them to visualize themselves at the centre of a fluid world of intense relationships, emerging out of the changing policy climate. However, there were tensions in the wider reflexive community of which they were a part, yet to be resolved. In an attempt to deal with these tensions they had taken additional training, and sought support in unusual places. Nonetheless for both these health visitors, the strain was becoming overwhelming, and each harboured plans to move on in the near future, either to a health visiting position with a more bounded public health role, or outside the field of public health altogether. For them, the uncertainties associated with the fluidity of their public health role represented an almost unmanageable risk. The daily job of crossing



(Developed from PCG documentation to demonstrate roles of main groups)

Figure 4 Cutting across the map: understanding local actions. The PCG combined their own sense of being in the driving seat for change, with the hangover of a vertical framework for public health policy design and implementation. Thus, although there is a space for reflection and fluidity, this is distinct from the ‘upper layers’ where decisions are made. They were creating their own reflexive community to interpret vision and strategy, rather than influence it. Reproduced from MacKian, S., Elliot, H., Busby, H., Popay, J. 2003. *Health and Place*, 9: 219–229. Copyright Elsevier Science.

professional boundaries was developing strong working relationships and a sense of partnership, but it was also destabilizing a sense of professional identity. Their working relationships outside their profession had developed into relationships of support, but this way of working was also causing an unsustainable burden of internal stress and feelings of professional inadequacy and disillusionment, with the ultimate threat of migration from the service.

Far from the aim of bringing ‘empowered’ people together to share workloads and develop reflexive communities of understanding to carve out a meaningful role in the expanding territory of public health, the shifting boundaries of the health visiting role would seem to be leading to

secrecy within the profession and increased levels of individual stress. Partnership in this example was therefore having some of the complex knock-on effects in the wider system that are given relatively little recognition in a literature that almost exclusively promotes and supports this way of working (Medd, 2001).

A ‘communities of practice’ perspective on developing the public health workforce

A second conceptual vehicle for unpicking some of the factors shaping change in public health within local health systems is the notion of communities of practice. (Wenger, 1998) Like the notion of reflexive communities Wenger’s work focuses attention on to issues of ‘agency’ in pro-

fessional practice – that is, the way in which individuals reflexively construct their practice and in so doing engage with or resist the relevant policy imperatives. In particular, this concept provides a framework for looking at the collective and organizational context for practice change and development – on the relationships through which knowledge is shared and practice developed amongst people sharing a commitment to a task or goal. As Wenger argues, opportunities for learning and development are at their richest within the context of a community of practice (CoP).

According to CoP theory, how individuals within specialist public health services and/or in the various agencies and organizations they are trying to connect with manage the new agenda around multidisciplinary and multi-agency working will depend to a large extent on the way they

define their identity. CoP theory suggests that identities are developed through participation and nonparticipation – in other words, what people ‘choose’ (although choices are not entirely unconstrained) to devote energy and interest to and what they do not. People may be members of several communities of practice at any one time (e.g. as a health visitor, school governor, hockey player), but it is always necessary for an individual (consciously or unconsciously) to define the limits of relevance of different areas of practice by creating boundaries. Once defined, these boundaries determine openness to or resistance to activities at a personal and professional level. This has a direct impact on engagement – the active process of involvement – with a community of practice.

Throughout the interviews we explored aspects of work practices that had some relevance to the

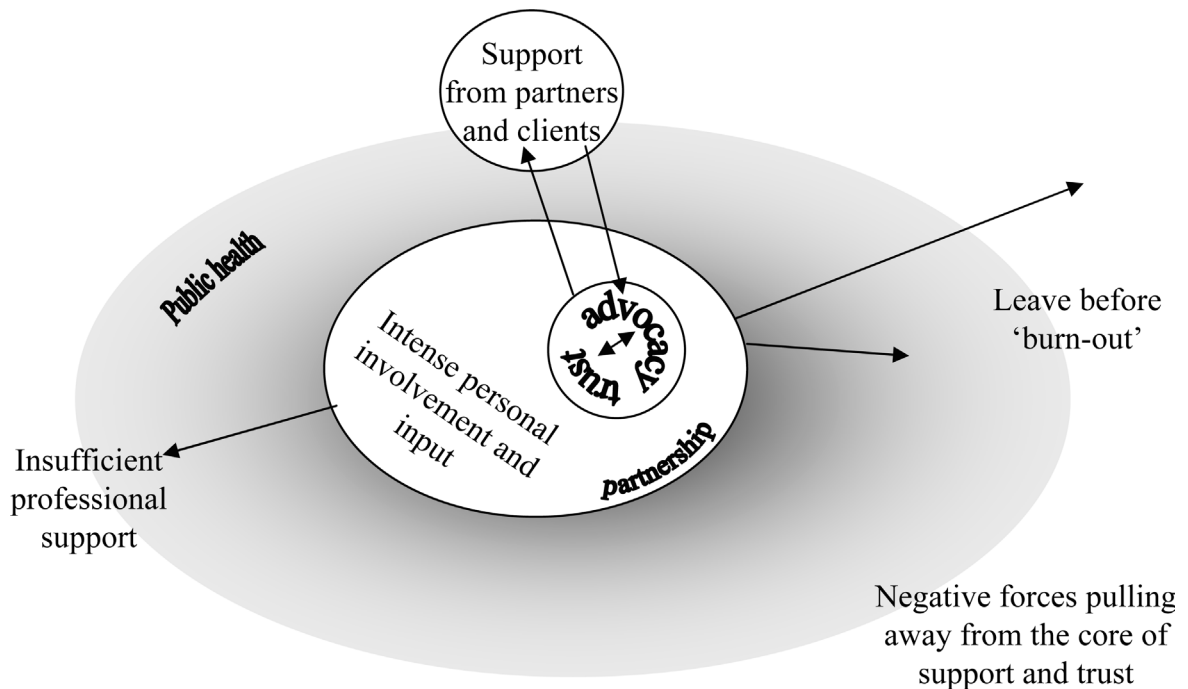


Figure 5 Health visitors' world of partnership and public health. This map represents the process of reflexivity of two health visitors who were trying to reconcile the wide remit of public health with the challenges of their own day-to-day work. The expanding world of public health had an intensely supportive core. The key anchor of advocacy and trust, together with support from certain partners and clients, kept them 'afloat'. However, beyond the world of partnership, that was not designed to support this inner core, negative forces detracted from that core. These negative forces were working to erode their enjoyment of the job, and there was a clear sense that the future may lie outside public health all together. Reproduced from MacKian, S., Elliot, H., Busby, H., Popay, J. 2003. *Health and Place*, 9: 219–229. Copyright Elsevier Science.

health inequalities agenda, regardless of whether or not these practices were explicitly defined as public health work. Analysis of these reflections on the nature of public health practice and people's relationship to this area of work revealed different types of engagement with a 'community of public health practice' amongst our interviewees – an analysis that is described in more detail elsewhere (Mallinson *et al.*, 2004). These 'types' of engagement with public health work mirror the three layers of CoP form identified by Wenger – a core membership, a peripheral/marginal membership, and nonmembers beyond. Additionally, however, as we discuss below our analysis points to important subdivisions within each 'type' of engagement.

Core membership: engagement and practice in public health

At the heart of the local public health systems we explored there are, as one might predict, people whose organizational and professional histories seem fully aligned with current public health strategy. These are mostly people who have been public health consultants and non-medical specialists in public health departments in the NHS or have been part of these departments in some other capacity. Their interest in and engagement with the core activities of public health is therefore well established. Accounts of public health work given by these respondents tended to reflect the contemporary discourse on public health within government documents, academic literature and amongst senior leaders in the service. Their talk was of the wider determinants of population health and inequalities, of local action to improve health and reduce inequalities and of delivering health improvement through partnership with local agencies. There was a strong suggestion amongst this group that recent policies and government strategies were facilitating engagement because they encouraged the widening of public health vistas.

At the periphery: pragmatic engagement with public health

Some respondents acknowledged the connection between their perception of public health goals and their current work role, but did not identify themselves as public health practitioners.

Our analysis suggests that there were two main reasons for their detachment: first, some individuals were already fully committed to other interests and activities and this precluded a more active involvement; secondly, some appeared to value a position 'outside' the community of public health practice because of the freedoms they felt it gave them. The accounts given by 'peripheral' members suggest that maintaining a connection with local public health practitioners was valuable because they had knowledge/interests that they wanted taken into account by local decision-makers or because they had a pragmatic interest in funding sources within the primary care groups/trusts that public health practitioners could help them access.

An important feature of the accounts of interviewees who we define as at the periphery of local communities of public health practice were the expressions of discontent with the way new public health strategies were being developed. This contrasted with the more positive tone of core members. There was more discussion amongst this group of restrictions operating to exclude a wider workforce from actively engaging with public health practice. These included concerns that strategic direction was not being appropriately translated into local action and concerns that the messages about the wider focus of public health practice were not understood by people outside the management structures of the newly established primary care trust. In essence then, this group adopted a more critical stance and questioned the extent to which 'old' public health was really widening its scope and softening its boundaries to encourage new partnerships and engage new knowledge pointing perhaps to some of the border restrictions operating to constrain more active participation in the public health agenda.

Nonmembership: misunderstanding and exclusion

A third and final group of interviewees positioned themselves as entirely separate from public health practice. However, two somewhat different processes were seemingly contributing to this 'excluded' identity.

First, amongst this group of respondents definitions of public health practice effectively established a boundary that excluded them from this terrain. In contrast to accounts in other

groups, most of the people in this group often focused their definition of public health on medical and/or environmental issues. One social service worker, for example, characterized public health as being about 'sanitation'. Throughout the rest of her interview this respondent talked about the interrelationship between health and social care and strategic links with what are readily defined as 'public health' practices around social inclusion, tackling crime and managing social need. Nevertheless, while she linked to NHS colleagues in the PCT and general practice she regarded this as separate from 'public health'. Whilst it might be expected that people from nonhealth organizations may have difficulty seeing a connection between what they are doing and public health practice, accounts of public health as 'marginal' to an individual's work were not confined to non-NHS respondents. For example, two of the GPs interviewed were very dismissive of the idea that public health was potentially part of their role as frontline NHS practitioners.

A second strand in these narratives of exclusion focused on the difficulties people had penetrating the 'health circles' they perceived to be controlling public health practice locally. In some instances this was linked to the particularly turbulent period in which the research took place with newly formed primary care trusts getting to grips with new policy, new roles and new faces. The lack of continuity in personnel was argued to be putting strain on existing partnerships and making the pursuit of new connections more difficult. Respondents described what was, in effect, a pause in the development of local relationships as health sector employees caught their breath. However, outside the NHS there was some frustration expressed at not being able to gain entry to areas of interest.

The new public health nurse

Observational research with health visitors in one of the two study areas – a group given a central role in public health policy in the new national agenda – reveals how the new public health policy agenda is reflexively constructed at the level of individual public health practitioners and illu-

minates the processes that operate to constrain the development of new ways of working. Two main themes have emerged from this strand of our research: first the way in which community nurses narratively construct themselves as public health practitioners with a key role to play in reducing health inequalities and secondly, the problematic way in which they experience this role on a day to day basis.

Nurses' perceptions of their public health role and the tensions within it

There was widespread acceptance among community nurses that they had a key public health role in relation to the wider social causes of population health and health inequalities. Particular dimensions of this role were highlighted including: health promotion, planning care, communicable disease control, community development, work as an advocate for clients and identifying and responding to 'hidden' social problems such as domestic violence and child abuse. Additionally, for the nurses involved in this research although tackling health inequalities was a long standing element of their practice – eroded during the 1980s but now coming to the fore again – it was also an aspect of practice around which there was some ambiguity, a recurrent theme in previous research on the role of community nursing professionals (Edwards and Popay, 1994). There appear to be two aspects to this ambiguity.

First, far from being cohesive, various aspects of the public health nurse role could compete with each other for limited time and resources. For example, at the time of the research school nurses and health visitors were involved in an intensive immunization programme, which made the delivery of other public health tasks difficult. In such situations there was a feeling that the more clinical/medical aspects of the role were given priority by managers. Secondly, community nurses are uneasy about the difficulties inherent in measuring the impact of the wider public health aspects of their roles compared with the relative ease with which the volume, if not the impact, of work on immunizations and developmental checks could be measured. Because of the difficulties involved in judging the effectiveness of the less tangible aspects of community nursing it

was widely felt that these activities were less likely to be acknowledged and valued by managers who were also perceived to be ill informed about the nature of the wider public health work in community nursing.

During the observational fieldwork, the tensions and contradictions inherent in three key aspects of the wider public health nursing role were revealed: tackling social exclusion, advocacy on behalf of clients and nursing involvement in the planning of services.

Tackling social exclusion

Community nurses encounter a great deal of social exclusion in the course of routine work and demonstrated considerable initiative, creativity and determination in their responses. The starkest examples in this study came from observation of specialist teams working with the homeless and refugees. One nurse, for example, described how she had seen one of her clients 'walking funny'. It transpired that he had had a minor stroke but had been discharged from hospital after only one night because he was homeless and there were concerns that he would block a bed indefinitely. The nurse had had to return him to the hospital and insist that he was readmitted. Other nurses described clients being extremely wary of services, often exacerbated by bad experiences of trying to access care. Nurses responded to these difficulties in a variety of ways including: working on a long-term intensive basis with individuals; finding practitioners who spoke the same language as clients; and matching patients with providers who had experience of working with particular client groups.

Advocacy on behalf of clients

Being called upon or pro-actively volunteering to act as advocates for clients would appear to be a common aspect of routine public health nursing amongst the groups involved in this research. There was potential for almost limitless involvement with clients, smoothing access to services; intervening with other public services including the benefit agency, housing departments, immigration and legal services, as well as mediating between clients and other family members.

The intensity of involvement was a matter for the consciences of individual professionals. For

some it was presented as a core part of their work, motivated by personal conviction as much as by the way in which they constructed their professional roles – though these workers often kept their level of involvement in advocacy work hidden from colleagues and managers as they felt it would not be seen to be a legitimate use of their time. Others were more hesitant to get involved in advocacy work. A variety of factors were important here. In some instances, clients' requests were seen as extravagant or inappropriate. There were also concerns that by getting involved they would raise clients' hopes of success or waste time on cases they knew to be hopeless. Some requests for help were seen to be beyond a respondent's competency – particularly in relation to benefits advice. There were also concerns about being drawn too far away from core clinical and health promotion competencies.

Public health nursing input to service planning

The newly revitalized public health nurse role in the UK includes a contribution to the planning of services through the management structures of the new primary care organizations – the rationale for this is that it will bring their specialist knowledge of localities and clients 'on the ground' into the policymaking processes. As already noted in the UK reforms, primary care groups were initially established and these moved over time to become primary care trusts. Nurses had a planning role in both organizational forms being represented on the board of primary care groups (PCG) and on the professional executive committee (PEC) of the newly forming primary care trusts (PCT). However, at the time of the observational fieldwork in the London locality proposals for transfer to trust status were at an early stage so the potential role for community nursing on the PEC was not raised. More significantly, however, neither did there seem to be much interest amongst community nursing staff in the strategic role they could play on the board of their primary care group. Perhaps not surprisingly, at this early stage of their development primary care groups and trusts were generally presented as external policy initiatives with little relevance to routine practice, rather than as a potential vehicle for revitalizing the public health nurse role.

Nurse members of PCG boards commented on the lack of interest in their role amongst their colleagues on the ground and at more senior levels with one board nurse describing the PCG as ‘the great unmentionable’. This situation started to change in the course of the fieldwork and as the pace of change towards PCT status accelerated a more active interest in the implications for nursing practice began to develop, albeit only amongst senior nurse managers. Even if there had been wider interest in their role, nurse members of the PCG board felt that there would have been little of relevance to report as concerns from and about general practice and acute sector issues dominated board/committee business. As a result membership of management groups within primary care organizations was described as an isolating experience by the nurses involved.

Conclusion

The research reported here has highlighted some of the more subtle but still significant factors that are operating to constrain the engagement with public health work amongst a wider workforce. These findings have important implications for future policy concerned to address the wider social determinant of health inequalities and to develop the multidisciplinary public health workforce this requires. In particular the research suggests that action is needed to support the development of a public health ‘work view’ in the wider workforce relevant to public health and to provide more support for the public health nursing role.

Fostering a public health ‘workview’ in the wider community of practice

Getting local ‘buy in’ to public health practice is a complex process. Although it is important to get the structure and location of public health right, it is also recognized that the most important imperative is to ensure that the culture and mindset of those working in and around public health shift in appropriate ways (House of Commons Select Committee, 2001).

Our research suggests that organizational and professional ‘work views’ were leading to resistance to, rather than engagement with the public

health agenda within local systems. There are now major initiatives underway within the public sector in the UK to improve opportunities for organizational and professional development which have the potential to contribute to a new public health ‘workview’ amongst the wider practice community. However, the challenges for such initiatives are:

- To provide more ‘spaces’ within organizational and professional development for the reflexive reconstruction of public health practice and the ‘unlearning’ of old ideas about professional and organizational boundaries, as well as the development of new skills and competencies to practice with.
- To invest more resources in the development of a wider understanding of the ‘rationale’ underpinning the new public health agenda.
- To develop within performance management systems a greater sensitivity to, and/or more explicit recognition of, the wider public health aspect of organizational and professional roles within local systems.

Developing the public health nurse role

Our research has highlighted a serious mismatch between the rhetoric in policy concerning the pivotal role for public health nursing in addressing the wider social determinants of health inequalities and the daily experience of individual public health nurses. Either strategies to increase the legitimacy and hence the visibility of the wider elements of this role – tackling social exclusion, advocating on behalf of clients, and contributing to policy development – need to be developed and the support and resources required to deliver these need to be clearly delineated, or the expectations placed on community nurses working in the public health sphere should be reduced.

The public health nurse role encompasses a wide canvass ranging from involvement with strategic management structures, through activities focusing directly on the social causes of ill health, such as community development and advocacy to the more ‘clinical’ aspects of public health nursing. Ensuring that this wide ranging and ambitious vision for an enhanced public health role for community nurses is delivered in practice is a complex and challenging agenda

both for individual professionals and the organizations in which they work. Our research has revealed how contradictions embedded in policy at both a rhetorical and operational level nationally and locally combine with limitations in the practical options open to individual nurses as they seek to meet clients needs to severely restrict the way in which this role can develop. There is evidence that the wider public health work aimed at addressing the social causes of health inequalities continues to lack legitimacy and is therefore done 'on the side' in an ad hoc fashion, a situation that creates intolerable burdens for the individual professionals involved and reduces the effectiveness of these responses. Similarly, whilst public health nurses have now been given a place at the strategic table within new primary care organizations, at the time of our fieldwork the imperatives coming out from the centre and the continuing imbalances in power between doctors and other health professionals were severely restricting the contribution they could make.

On the face of it the current policy climate appears to allow public health practitioners to transform their working practices and provide more locally sensitive solutions. In theory at least this opportunity to negotiate the new territory of public health within a local context allows for the development of reflexive communities, developing shared or unique ways of 'being in the world'. However, our data suggest that beneath this picture of fluidity and reflexivity, there remain major political, structural, professional and personal barriers to successfully changing public health practice creating new exclusionary processes. These, in turn, exert strong influence over the emerging reflexive communities. If these are not addressed then there will in practice be relatively little scope for new spaces to open up within local systems in which public health work aimed at addressing health inequalities can be 'practised' in new ways by new wider communities of practitioners. Perhaps the most important message from our research and that of others is that despite these difficulties there remain many people willing – if not yet enabled – to populate whatever spaces become available for new practices. There is therefore much to be gained from opening up these spaces more effectively than would seem to have been the case when our research was conducted.

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